HOUSE HEALTH AND WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2005 Legislative Session

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IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0311

NOTICE OF CORRECTION TO THE PENDING RULE

CORRECTION: The following notice corrects omissions that occurred during the publication of the pending rule. This correction is being done in conjunction with the Office of the Administrative Rules Coordinator.

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is August 1, 2004. This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency is correcting omissions in the pending text and amending the temporary rule in conjunction with the Office of the Administrative Rules Coordinator. These corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the nature of the correction being made to the pending rule and amendment to the temporary rule.

Based on comment received, corrections are being made to the list of professionals who can be reimbursed by Medicaid for conducting a psychiatric diagnostic interview exam.

Only the Sections that have changes are printed in this bulletin. The amendments to the temporary rule were published with the notice of pending rule in the July 7, 2004, Idaho Administrative Bulletin, Volume 04-7 on pages 51 through 72. The original text of the proposed rule was published in the November 5, 2003, Idaho Administrative Bulletin, Volume 03-11, pages 38 through 63.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this correction, contact Paul Leary at (208) 364-1833.

DATED this 17th day of November, 2004.

The Following Notice Was Published With The Pending Rule

EFFECTIVE DATE: The effective date of the amendments to the temporary rule is August

1, 2004. This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), 56-1004(l)(a), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Based on input from service providers, staff, and other interested stakeholders, amendments were made to the temporary rule in order to clarify requirements related to psychosocial rehabilitation (PSR) services and mental health clinics. Areas of substantive change include:

1. Clarification of PSR eligibility requirements following discharge from psychiatric hospitalization;
2. Clarification of PSR provider responsibilities regarding comprehensive assessment;
3. Clarification and revision of requirements regarding the individualized treatment plan and replacement of the term "service plan" with the term "individualized treatment plan" throughout docket text;
4. Clarification of the criminal history check requirements both for PSR agencies and mental health clinics;
5. Clarification of physician requirements for mental health clinics;
6. Replacement of the term "paraprofessional" by the term "support staff";
7. Clarification of requirements for provider agencies vs. requirements of agency staff delivering services;
8. Clarification and revision of the requirements for those conducting psychological testing; and
9. Reduction in the limit on treatment hours for the partial care service from 56 to 36 hours per week.

Other more minor clarifications, revisions, and corrections were made to the text of the temporary rule, as needed.

Pursuant to Section 67-5228, Idaho Code, typographical, transcriptional, and/or clerical corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in

place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the November 5, 2003, Administrative Bulletin, Volume 03-11, pages 38 through 63.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Pat Guidry at (208) 364-1833.

DATED this 1st day of June, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: The effective date of the temporary rule is December 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), and 56-1004(l)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

Date:	**Thursday, November 13, 2003**	**Tuesday, November 18, 2003**	**Thursday, November 20, 2003**
Time:	**6:00 - 8:00 p.m.**	**6:00 - 8:00 p.m.**	**6:00 - 8:00 p.m.**
Place:	**Region IV** **1720 Westgate Drive** **Suite D, Room 119** **Boise, ID**	**Region VI** **Human Development Center** **421 Memorial Drive** **Pocatello, ID**	**Region I** **333 Ironwood Drive** **(Ameritel Inn)** **Coeur d'Alene, ID**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

The rules regarding psychosocial rehabilitation (PSR) are being changed to reflect new business practices that are a direct result of the budgetary holdbacks in SFY 2003. The resulting mandated staff reductions led to the elimination of Regional Mental Health Authority (RMHA) staff positions. Consequently, the functions of assessment and service planning have been transferred to the private mental health psychosocial rehabilitation (PSR) providers.

The rules regarding the partial care service are being changed in response to complaints

from both internal and external sources that there are providers of the partial care service who are endangering the safety and well-being of program participants through their interpretation of the partial care rules.

For the PSR rules, the changes:

1. **Add definitions to reflect the new business practice;**
2. **Specify the timeline for development of service plan following discharge from inpatient hospitalization;**
3. **Describe the responsibilities of the Department;**
4. **Describe of the responsibilities of the service provider;**
5. **Clarify the service description;**
6. **Add criminal history check as a provider qualification;**
7. **Add specifications for record requirements; and**
8. **Explain service limitations in greater detail.**

For the rules regarding mental health clinics and the partial care services, the changes:

1. **Expand mental health clinic provider agency requirements;**
2. **Add criminal history check as a provider qualification;**
3. **Redefine and expand the definition of the partial care service; and**
4. **Provide new requirements for building safety standards.**

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(a) and (b), Idaho Code and are necessary in order to protect the public health, safety, or welfare and to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted prior to the publication of the temporary and proposed rule because of the timeframes for submission. However, rule changes are being made, in part, in response to unsolicited public input. Public hearings have been scheduled during the comment period.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Pat Guidry at (208) 364-1844.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before November 26, 2003.

DATED this 30th day of September, 2003.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0309-0311***
The Medical Assistance Program ***PENDING RULE***

450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

The original effective date was (12-1-03)T,
the effective date on the pending rule is (8-1-04)T,
the effective date on the Correction to the pending rule is (8-1-04)T

401. -- 44~~9~~8. (RESERVED).

449. DEFINITIONS FOR PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR).

01. Assessment Hours. Time allotted for completion of evaluation and diagnostic services. (12-1-03)T

02. Demographic Information. Information that identifies participants and is entered into the Department's database collection system. (12-1-03)T

03. Goal. The desired outcome related to an identified issue. (12-1-03)T

04. Initial Contact. The date a participant, ~~or~~ parent, *or legal* guardian signs the request for assessment hours. ~~*(12-1-03)T*~~(8-1-04)T

05. Issue. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (12-1-03)T

06. Licensed Practitioner Of The Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing psychotropic medication. (12-1-03)T

07. Objective. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (12-1-03)T

08. Psychosocial Rehabilitative Services (PSR). Rehabilitative services provided both to children with serious emotional disturbance and to adults with severe and persistent mental illness to address functional deficits due to psychiatric illness and to restore independent living, socialization, and effective life management skills. (12-1-03)T

09. Tasks. Specific, time-limited activities and interventions designed to accomplish the objectives in the ~~*service*~~ *individualized treatment* plan. ~~*(12-1-03)T*~~(8-1-04)T

450. PSYCHOSOCIAL REHABILITATIVE SERVICES~~—MENTAL HEALTH~~ *(PSR)*. ~~*Pursuant to*~~ Under 42 CFR 440.130(d) and in accordance with Section 39-3124, Idaho Code, the Department ~~*shall*~~ or its designee in each region ~~*must*~~ ~~*purchase*~~ *will cover* psychosocial rehabilitative services (PSR) for maximum reduction of mental disability. ~~*These services are intended to promote the highest possible functional level through restoration and skill maintenance. Rehabilitative Services, are hereafter referred to as the Psychosocial Rehabilitative Services (PSR). Eligibility for PSR services shall be assessed, plans will be developed, and services prior authorized by the Department of Health Welfare, hereinafter referred to as the Department, or its designee in each region, in accordance with Section 39-3124, Idaho Code.*~~ For ~~*psychosocial rehabilitative services*~~ *PSR* provided by a school district under an individualized education plan *(IEP)*, refer to Section 560 of these rules. ~~*(3-15-02)*~~(8-1-04)T

01. PSR Eligibility Criteria For Children. A seriously emotionally disturbed child is an individual under the age of eighteen (18) who has a serious emotional disturbance (SED). The following definition of the SED target population is based on ~~*the guidelines taken from Section 1912(c) of the Public Health Services Act as amended by Public Law 102-321;*~~ the *definition of SED found in the* Children's Mental Health Services Act, ~~*Title 16, Chapter 24*~~ *Section 16-2403*, Idaho Code~~*; and IDAPA 16.06.01, "Rules Governing Family and Children's Services"*~~. ~~*(3-15-02)*~~(8-1-04)T

a. Presence of an emotional or behavioral disorder, according to the DSM-IV-TR or subsequent revisions to the DSM, which results in a serious disability; and ~~*(3-15-02)*~~(12-1-03)T

b. Requires sustained treatment interventions; and (3-15-02)

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (3-15-02)

d. The disorder ~~*shall be*~~ is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment ~~*shall*~~ must be assessed using the Child and Adolescent Functional Assessment Scale*/Preschool and Early Childhood Functional Assessment Scale* (CAFAS*/PECFAS*). Substantial impairment ~~*shall*~~ requires a full eight (8) scale score of eighty (80) or higher with "moderate" impairment in at least one (1) of the following three (3) scales: ~~*(3-15-02)*~~(8-1-04)T

i. Self-Harmful Behavior; (3-15-02)

ii. Moods/Emotions; or (3-15-02)

iii. Thinking. (3-15-02)

e. A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. ~~*(3-15-02)*~~(12-1-03)T

02. PSR Eligibility Criteria For Adults. A severely and persistently mentally ill adult is any individual eighteen (18) years or older who has a severe and persistent mental illness. The following criteria are required to be a member of the target population based on the

guidelines taken from the Federal Register ~~*pursuant to*~~ under Section 1912(c) of the Public Health Services Act and as amended by Public Law 102-321 "adults with a serious mental illness". ~~*(3-15-02)*~~(12-1-03)T

a. The individual must have a diagnosis under DSM-IV-TR or subsequent revisions to the DSM, of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder recurrent severe, Delusional Disorder, or Borderline Personality Disorder. ~~*Also*~~ The only NOS diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a more conclusive diagnosis~~,~~; and ~~*(3-15-02)*~~(12-1-03)T

b. The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following areas on either a continuous or an intermittent (at least once per year) basis: (3-15-02)

i. Vocational/~~*academic*~~ educational; ~~*(3-15-02)*~~(12-1-03)T

ii. Financial; (3-15-02)

iii. Social~~*/interpersonal*~~ relationships/support; ~~*(3-15-02)*~~(12-1-03)T

iv. Family; (3-15-02)

v. Basic living skills; (3-15-02)

vi. Housing; (3-15-02)

vii. Community/legal; or (3-15-02)

viii. Health/medical. (3-15-02)

03. PSR Eligibility Following Discharge From Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, ~~*shall be*~~ described in Subsections 450.01.a. for children, and in 450.02.a. for adults, are considered immediately eligible for PSR ~~*and a plan will be completed*~~ services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The ~~*service*~~ *individualized treatment* plan must be ~~*submitted to the Department or its designee*~~ *completed* within ten (10) days of discharge. ~~*(3-15-02)*~~(8-1-04)T

a. *Up to two (2) hours of plan development hours may be prior authorized for coordinating with hospital staff and others the participant chooses. These prior authorized plan development hours are to be used for the development of an individualized treatment plan based solely on the participant's hospital records and past history. The provider agency does not have to perform any additional assessment nor does the participant need to qualify as described in Subsection 453.01 of these rules.* *(8-1-04)T*

b. *Upon submission of the completed individualized treatment plan to the Department or its designee, PSR services may be prior authorized for no more than one hundred twenty (120) days. For services to continue beyond one hundred twenty (120) days, the*

requirements of Section 452 in these rules must be met by the provider agency. *(8-1-04)T*

04. Place Of Service. PSR services are to be home and community-based. ~~*(3-15-02)*~~(12-1-03)T

a. PSR services ~~*shall*~~ must be provided to the ~~*recipient*~~ participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the ~~*task*~~ *individualized treatment* plan and is prior authorized. ~~*(3-15-02)*~~(8-1-04)T

b. PSR services may be provided to a ~~*recipient*~~ participant living in a residential ~~*and*~~ or assisted living facility ~~*(RALF)*~~ if the PSR services are determined by the Department or its designee to be appropriate, desired by the resident, and are not the responsibility of the ~~*RALF*~~ facility or another agency under the ~~*RALF*~~ Negotiated Service Agreement for residential or assisted living facilities. ~~*(3-15-02)*~~(12-1-03)T

451. RESPONSIBILITIES OF ~~*REGIONS*~~ THE DEPARTMENT REGARDING PSR SERVICES.
~~*Each region shall enter into a*~~ The Department will administer the provider agreement ~~*with the Division of Medicaid for the provision of PSR*~~ for the provision of PSR services and ~~*shall also be*~~ is responsible for the following tasks: ~~*(3-15-02)*~~(12-1-03)T

01. Service System. ~~*Each region*~~ The Department is responsible for the development, maintenance and coordination of ~~*a*~~ regional ~~*wide*~~, comprehensive and integrated service systems ~~*including the Department and private providers*~~. ~~*(3-15-02)*~~(12-1-03)T

02. ~~***Service Provision****. Each region shall provide PSR services directly, and through private providers with whom the Department or its designee has negotiated a Supplemental Service Agreement.*~~ **Assessment Authorization**. The Department or its designee will review requests for assessment hours and authorize as appropriate. ~~*(3-15-02)*~~(12-1-03)T

~~***03. Service Availability****. Assure provision of PSR services to recipients on a twenty-four (24) hour basis.* (3-30-01)~~

~~***04. Comprehensive Assessment And Service Plan Development****. The Department or its designee is responsible to conduct a comprehensive assessment and develop a service plan for each recipient determined eligible for PSR services. At the point a decision is made that an individual is not eligible for PSR, a Notice of Decision citing the reason(s) the recipient is not eligible for PSR services will be issued by the Department or its designee. The Notice of Decision will be sent to the adult recipient and a copy to their guardian. When the recipient is a minor child, the Notice of Decision will be sent to the minor child's parent(s) or guardian. The adult or family of the minor child will receive appropriate referrals to meet their identified needs.* (3-15-02)~~

0~~5~~3. ~~*Service*~~ *Individualized Treatment* Plan Authorization~~s~~ Requirements. ~~*All PSR services must be authorized by the Department or its designee.*~~ ~~*Service*~~ *Individualized treatment* plan authorizations must include the following: ~~*(3-15-02)*~~(8-1-04)T

a. Required Documentation. The required documentation for ~~*all service*~~ *each individualized treatment* plan~~*s*~~ includes: ~~*(12-1-03)T*~~(8-1-04)T

i. Participant demographic information; (12-1-03)T

ii. A comprehensive assessment as provided in Subsection 453.01 of these rules; and (12-1-03)T

iii. A written ~~*service*~~ *Individualized treatment* plan as provided in Subsection 453.02 of these rules. ~~*(12-1-03)T*~~(8-1-04)T

iv. Adult service plans also require a rehabilitation outcome database. (12-1-03)T

v. Children's ~~*service*~~ *individualized treatment* plans also require the Child and Adolescent Functional Assessment Scale/*Preschool and Early Childhood Functional Assessment Scale* (CAFAS/*PECFAS*). ~~*(12-1-03)T*~~(8-1-04)T

~~*a*~~**b.** ~~*The signature of a physician, or other licensed practitioner of the healing arts within the scope of his practice under state law according to Title 54, Chapter 18, Idaho Code, is required on the service plan indicating the services are medically necessary. The date of the plan is the date it is signed by the physician.*~~ Physician's Signature and Receipt of Required Documentation. Reimbursement for services will be authorized from the date of the physician's signature if the required documentation is received by the Department or its designee within thirty (30) days from the request of assessment hours. If the documentation is received after thirty (30) days from the date of the request of assessment hours, or after the expiration of the plan, the date to begin services is the date the ~~*service*~~ *individualized treatment* plan and other required documentation are received by the Department or its designee. For the annual update, all required documentation must be received by the Department or its designee before the expiration date of the current assessment and plan. In order for a prior authorization to remain valid throughout the ~~*service*~~ *treatment* plan year, documentation of the one hundred twenty (120) day reviews must comply with Subsection 457.05 of these rules. ~~*(3-15-02)*~~(8-1-04)T

~~*b*~~**c.** Hours and Type of Service. The Department or its designee ~~*shall*~~ must authorize the number of hours and type of services which could be reasonably expected to lead to achievement of the ~~*service*~~ *individualized treatment* plan objectives. ~~*(3-15-02)*~~(8-1-04)T

~~*c*~~**d.** Authorization Time Period. Service authorizations are limited to a twelve (12) month period and must be reviewed and updated at least annually. ~~*(3-15-02)*~~(12-1-03)T

~~*d*~~**e.** No Duplication of Services. The Department or its designee ~~*shall*~~ must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to PSR ~~*recipients*~~ participants through other Medicaid reimbursable and non-Medicaid programs. ~~*(3-15-02)*~~(12-1-03)T

~~***06. Task Plan Oversight****. Task plan oversight is the responsibility of the Department or its designee.* *(3-15-02)*~~

~~***a.*** *The task plan shall be reviewed by the Department or its designee to assure that the tasks can be reasonably expected to lead to achievement of the objectives outlined in the service plan.* *(3-15-02)*~~

~~***b.*** *The recipient shall participate in the development of the task plan to the fullest extent possible.* *(3-15-02)*~~

~~***c.*** *The final task plan shall be reviewed, authorized and signed by the Department or its designee within ten (10) working days of receipt.* *(3-15-02)*~~

~~***d.*** *The Department or its designee may prior authorize PSR hours for a maximum of thirty (30) days during the task plan development.* *(3-15-02)*~~

~~***07.*** ***Minor Changes To The Task Plan****. When the Department or its designee is notified, in writing, by the provider of necessary and specific amendments to the task plan which require no change in total hours or service type, as well as the rationale for those changes, the Department or its designee shall have ten (10) working days to respond to any or all of the amendments. If no response is received, the provider shall proceed to incorporate those and only those, specific amendments to the task plan. A copy of the amended task plan shall be forwarded to the Department or its designee. While task amendments may result in reassignment of available hours among tasks, under no circumstances does this permit the provider to increase the total number of hours prior authorized.* *(3-15-02)*~~

04. ***Notice Of Decision****. At the point a decision is made that a participant is ineligible for PSR services, a notice of decision citing the reason(s) the participant is ineligible for PSR services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian.* *(8-1-04)T*

0~~8~~5. Changes In ~~*Task*~~ ~~*Service*~~ *Individualized Treatment* Plan Hours Or Service Type. When the Department or its designee is notified, in writing, by the provider of recommended increases in hours or change in type of service provided, the Department or its designee ~~*will*~~ must review the request and either approve or deny within ten (10) working days of receipt. A clear rationale for the change in hours or service type must be included with the request. ~~*(3-15-02)*~~(8-1-04)T

0~~9~~6. Changes To ~~*Service*~~ *Individualized Treatment* Plan Objectives. When a provider believes that a ~~*service*~~ *individualized treatment* plan needs to be revised, the provider should include that recommendation and rationale in documentation of the next one hundred twenty (120) day review. The Department or its designee will review the information, and if appropriate, act on the recommendation. In the event substantial changes in the ~~*recipient's*~~ participant's mental status or circumstances occur requiring immediate changes in the plan objectives, the provider ~~*shall*~~ must notify the Department or its designee, in writing, of its recommendation and rationale for the change. The Department ~~*will have*~~ has ten (10) working days to respond to and either approve or deny the request for change. ~~*(3-15-02)*~~(8-1-04)T

0~~6~~7. Minor Changes To ~~*Service*~~ *Individualized Treatment* Plan Tasks. When the Department or its designee is notified in writing by the provider of necessary and specific changes

to ~~*service*~~ *individualized treatment* plan tasks that require no change in total hours or service type, a copy of the amended ~~*service*~~ *individualized treatment* plan tasks must be forwarded to the Department or its designee including rationale for those changes. The Department or its designee has ten (10) working days to respond to the changes. If no response is received, the provider may proceed to incorporate those and only those specific task changes *in*to the ~~*service*~~ *individualized treatment* plan. While task changes may result in reassignment of available hours among tasks, under no circumstances does this permit the provider to increase the total number of prior authorized hours. ~~*(12-1-03)T*~~(8-1-04)T

~~*1*~~0*8*. **Quality Of Services**. The Department or its designee ~~*shall*~~ must monitor the quality and outcomes of PSR services provided to ~~*recipients*~~ participants, in coordination with the Divisions of Medicaid, Management Services, and Family and Community Services. ~~*(3-15-02)*~~(12-1-03)T

~~***a.*** *An outcome-based quality assurance review shall be conducted on each case at least annually as defined in the provider agreement. A billing audit shall be conducted through a sampling of cases. These activities shall be conducted by the Department or its designee.* *(3-15-02)*~~

~~***b.*** *Effectiveness of services as measured by a consumer's achievement of their plan objectives will be monitored by the provider and the Department or its designee by using one hundred twenty (120) day reviews. The written reviews, including a summary of objectives met and not met by consumers, will be used to develop provider profiles to assist recipients with provider selection.* *(3-15-02)*~~

452. RESPONSIBILITIES OF PSR PROVIDERS.

01. Provider Agreement. Each provider must enter into a provider agreement with the Division of Medicaid for the provision of PSR services and also is responsible for the following tasks: (12-1-03)T

02. Service Provision. Each provider must have a negotiated Supplemental Service Agreement with the Department. (12-1-03)T

03. Service Availability. Each provider must assure provision of PSR services to participants on a twenty-four (24) hour basis. (12-1-03)T

04. Comprehensive Assessment And ~~*Service*~~ *Individualized Treatment* Plan Development. The provider *agency* is responsible to conduct a comprehensive assessment and develop a*n* ~~*service*~~ *individualized treatment* plan for each participant. ~~*At the point a decision is made that a participant is ineligible for PSR services, a notice of decision citing the reason(s) the participant is ineligible for PSR services must be issued by the Department or its designee. The notice of decision must be sent to the adult participant and a copy to their guardian. When the participant is a minor child, the notice of decision must be sent to the minor child's parent(s) or guardian. The adult or family of the minor child must receive appropriate referrals to meet their identified needs.*~~ *In the event the agency makes a determination that it cannot serve the participant, the agency must make appropriate referrals to other agencies to meet the participant's identified needs.* ~~*(12-1-03)T*~~(8-1-04)T

05. ***~~Service~~ Individualized Treatment*** **Plan**. The provider must develop a*n ~~service~~ individualized treatment* plan in accordance with Subsection 453.02 of these rules. The signature of a physician, or other licensed practitioner of the healing arts within the scope of his practice under state law is required on the *~~service~~ individualized treatment* plan indicating the services are medically necessary. The date of the plan is the date it is signed by the physician if all the required documentation is received by the Department or its designee within thirty (30) days of the date of the request for assessment hours. *~~(12-1-03)T~~*(8-1-04)T

06. **Changes To *~~Service~~ Individualized Treatment* Plan Objectives**. When a provider believes that a*n ~~service~~ individualized treatment* plan needs to be revised, the provider should include that recommendation and rationale in the documentation for the next one hundred twenty (120) day review. *~~(12-1-03)T~~*(8-1-04)T

07. **Effectiveness Of Services**. Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the *~~service~~ individualized treatment* plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included on the participant's one hundred twenty (120) day review. *~~(12-1-03)T~~*(8-1-04)T

08. **Healthy Connections Referral Number**. Providers must obtain a Healthy Connections referral number if the participant is enrolled in the Healthy Connections program. (12-1-03)T

45~~2~~3. PSR SERVICE DESCRIPTIONS.
The goal of PSR services is to aid participants in work, school, family, community, or other issues related to their mental illness. It is also to aid them in obtaining developmentally appropriate skills for living independently and to prevent movement to a more restrictive living situation. All services provided must be clinically appropriate in content, service location and duration and based on measurable and behaviorally specific and achieveable objectives. *In order to prevent duplication, PSR services must be coordinated with all other services received by the participant.* PSR *~~shall~~* consists of the following services: *~~(3-15-02)~~*(8-1-04)T

01. Comprehensive Assessment. A comprehensive assessment *~~shall~~* must be completed for each *~~recipient~~* participant determined eligible for PSR. The assessment *~~shall~~* must address the *~~individual's~~* participant's strengths and supports, deficits and needs, and *~~shall~~* must be directed toward formulation of a diagnosis and *a* written *~~service~~ individualized treatment* plan *~~including the task plan~~*. The *~~recipient shall participate~~* participant must take part in the assessment to the fullest extent possible. The assessment *~~shall~~* must be directly related to the *~~individual's~~* participant's mental illness and level of functioning. Information *regarding services received* from any of the *~~recipient's~~* participant's service provider(s) *~~shall~~* must be collected *and reported on the comprehensive assessment*. The assessment and supplemental psychiatric, psychological, or other specialty evaluations and tests must be written, dated, signed and be retained in the *~~recipient's~~* participant's file. The assessment is reimbursable if conducted by *~~a~~* qualified provider *~~named in~~ agency staff listed under* Section 45~~5~~6 of these rules. Each of the following areas must be assessed initially and at least annually thereafter: *~~(3-15-02)~~*(8-1-04)T

a. *~~Psychiatric history and current mental status including at a minimum, age at~~*

~~*onset, childhood history of physical or sexual abuse, number of hospitalizations, precursors of hospitalizations, symptoms of decompensation the recipient participant manifests, the recipient's participant's ability to identify his symptoms, medication history, substance abuse history, history of mental illness in the family, current mental status, any other information that contributes to the assessment of to the recipient's participant's current psychiatric status. This section must contain the diagnosis documented by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under state law;*~~ *Psychiatric history and current mental status which includes, at a minimum:* ~~*(3-15-02)*~~(8-1-04)T

i. Diagnosis documented within the last twelve (12) months by a licensed physician or other licensed practitioner of the healing arts, licensed master's level psychiatric nurse, licensed psychologist, licensed clinical professional counselor, or licensed clinical social worker within the scope of his practice under state law; *(8-1-04)T*

ii. Age of the participant at onset; *(8-1-04)T*

iii. Childhood history of physical or sexual abuse; *(8-1-04)T*

iv. Number of hospitalizations; *(8-1-04)T*

v. Precursors of hospitalizations; *(8-1-04)T*

vi. Symptoms of decompensation the participant manifests; *(8-1-04)T*

vii. Participant's ability to identify his symptoms; *(8-1-04)T*

viii. Medication history; *(8-1-04)T*

ix. Substance abuse history; *(8-1-04)T*

x. History of mental illness in the family; *(8-1-04)T*

xi. Current mental status; and *(8-1-04)T*

xii. Any other information that contributes to the assessment of the participant's current psychiatric status. *(8-1-04)T*

b. Medical history and current medical status which includes at a minimum, history of any major non-psychiatric illnesses, surgeries, hospitalizations, dates of last physical, dental, or eye examinations, pertinent family history of medical illness, current health problems/needs, current medications, name of current primary physician; (3-15-02)

c. Vocational/Educational status which includes at a minimum, current and past job status, level of satisfaction with the vocation, educational level, military status, strengths and barriers to employment. For children, this area addresses relevant school enrollment, performance, achievement levels and school-related social functioning; (3-15-02)

d. Financial status which includes at a minimum, adequacy and stability of the

~~*recipient's*~~ participant's financial status, financial difficulties of the ~~*recipient*~~ participant, resources available, and the ~~*recipient's*~~ participant's ability to manage personal finances; ~~*(3-15-02)*~~(12-1-03)T

e. Social relationships/support which includes, at a minimum, ~~*recipient's*~~ participant's ability to establish/maintain personal support systems or relationships and ~~*recipient's*~~ participant's ability to develop leisure, recreational, or social interests; ~~*(3-15-02)*~~(12-1-03)T

f. Family status which includes, at a minimum, the ~~*recipient's*~~ participant's ability or desire to carry out family roles, ~~*recipient's*~~ participant's perception of the support he receives from his family, and the role the family plays in the ~~*recipient's*~~ participant's mental illness. For children this area addresses the child's functioning within the family and the impact of the child's mental illness on family functioning; ~~*(3-15-02)*~~(12-1-03)T

g. Basic living skills which include at a minimum, ~~*recipient's*~~ participant's ability to meet age appropriate basic living skills including transition to adulthood; ~~*(3-15-02)*~~(12-1-03)T

h. Housing which includes at a minimum, current living situation and level of satisfaction with the arrangement, and appropriateness of current living situation with respect to ~~*recipient's*~~ the participant's needs, ~~*their*~~ his health and safety; ~~*and*~~ ~~*(3-15-02)*~~(12-1-03)T

i. Community/Legal status which includes at a minimum, legal history with law enforcement, transportation needs, supports the ~~*recipient*~~ participant has in the community, and daily living skills necessary for community living~~.~~; and ~~*(3-15-02)*~~(12-1-03)T

j. Health or medical issues, or both, including medical complications that result from the mental illness. (12-1-03)T

02. Written ~~*Service*~~ *Individualized Treatment* Plan. A written ~~*service*~~ *individualized treatment* plan ~~*shall*~~ must be developed and implemented for each ~~*recipient*~~ participant of PSR services as a ~~*vehicle*~~ means to address the rehabilitative service needs of the ~~*recipient*~~ participant. Services must support the goals of PSR which are maximum reduction of mental disability and achievement of the highest possible functioning level for that ~~*individual*~~ participant. For adults this means becoming independent or maintaining the highest level of independence. For children this means learning or maintaining developmentally appropriate role functioning. The ~~*service*~~ *individualized treatment* plan identifies the issue(s), goal(s), areas of need, the objectives and the total number of hours and types of services estimated to achieve all objectives based on the ability of the ~~*recipient*~~ participant to effectively utilize services. The ~~*service*~~ *individualized treatment* plan ~~*shall*~~ must be developed by the ~~*recipient*~~ participant, his family, other support systems and the ~~*Department or its designee*~~ *provider agency*. ~~*Service*~~ *Treatment* planning is reimbursable if conducted by ~~*a*~~ qualified provider~~*, in accordance with*~~ *agency staff listed under* S~~*ubs*~~ection~~*s*~~ 455~~6*.01 through 455.12 and 455.14*~~ of these rules.The ~~*service*~~ *individualized treatment* plan ~~*shall*~~ must be documented by the ~~*Department or its designee*~~ *provider agency*. ~~*(3-15-02)*~~(8-1-04)T

a. A ~~*service*~~ *individualized treatment* plan must include the following, at a minimum: ~~*(3-15-02)*~~(8-1-04)T

i. An issue statement specifically describing the participant's behavior that directly

relates to his mental illness and functional impairment. (12-1-03)T

ii. A statement which identifies the ~~*recipient's*~~ participant's goal relative to the goals of PSR as per Section 450 and Subsection 45~~2~~3.02 of these rules; ~~*(3-15-02)*~~(12-1-03)T

iii. Overall goal(s) and concrete, measurable objectives to be achieved, including time frames for completion. At least one (1) objective is required for the focus areas which ~~*will*~~ must likely lead to the greatest stabilizing impact. At a minimum, this should include at least one (1) objective in each of the two (2) focus areas which qualify the ~~*recipient*~~ participant for PSR; ~~*(3-15-02)*~~(12-1-03)T

iv. Tasks that are specific, time-limited activities and interventions designed to accomplish the objectives in the ~~*service*~~ *individualized treatment* plan and are developed by the participant and the selected provider(s). *Each task description must specify the anticipated place of service, the frequency of services, the type of service, and the person(s) responsible to assist the participant in the completion of tasks.* ~~*(12-1-03)T*~~(8-1-04)T

~~*iii*~~v. Documentation of who participated in the development of the ~~*service*~~ *individualized treatment* plan~~,~~. ~~*t*~~The ~~*recipient*~~ participant, if possible, must ~~*be a participant*~~ take part in the development of the ~~*service*~~ *individualized treatment* plan. The adult ~~*recipient*~~ participant or the adult ~~*recipient's*~~ participant's legal guardian must sign the ~~*service*~~ *individualized treatment* plan or documentation must be provided why this was not possible, including ~~*recipient*~~ participant refusal to sign. For a minor child ~~*recipient*~~ participant, the child's parent~~*(s)*~~ or *legal* guardian~~*(s)*~~ must sign the plan. A copy of the plan ~~*shall*~~ must be given to the adult ~~*recipient*~~ participant and ~~*their*~~ his *legal* guardian or to the parent~~*(s)*~~ or *legal* guardian ~~*of the*~~ *when the participant is a* minor child; ~~*(3-15-02)*~~(8-1-04)T

b. A*n* ~~*service*~~ *individualized treatment* plan ~~*shall*~~ must be developed within thirty (30) calendar days from initial face-to-face contact between the ~~*Department or its designee*~~ *provider agency staff* and the ~~*consumer*~~ participant, or ~~*in the case of a minor child,*~~ the ~~*child's*~~ parent~~*s*~~ or *legal* guardian~~*s*~~ *when the participant is a minor child*. ~~*(3-15-02)*~~(8-1-04)T

c. A*n* ~~*service*~~ *individualized treatment* plan review by the ~~*Department or its designee*~~ *provider agency staff* and the ~~*recipient shall*~~ participant must occur at least annually. During the review, the ~~*Department or its designee*~~ *provider agency staff* and the ~~*recipient*~~ participant review any objectives which may be added to or deleted from the ~~*service*~~ *individualized treatment* plan. Input from other participants in the plan including *service* provider(s) ~~*will*~~ must be considered. ~~*Who*~~ *Other* attend*ee*s *of* the *individualized treatment plan* review ~~*is a decision of*~~ *may be chosen by* the adult ~~*consumer*~~ participant ~~*and*~~ *or his legal* guardian *if any* or, ~~*in the case of*~~ *when the participant is* a *minor* child, *by* his family or legal guardian~~*(s),*~~ and the ~~*Department or its designee*~~ *provider agency staff*. ~~*The Department or its designee's signature is necessary to approve any changes.*~~ ~~*(3-15-02)*~~(8-1-04)T

d. Each ~~*service*~~ *individualized treatment* plan ~~*shall*~~ must be reviewed and signed by a physician *or a licensed practitioner of the healing arts* at least annually. Once the date of a plan is established, that date ~~*shall*~~ continue*s* to be the annual date of the plan. ~~*Failure of*~~ *If the physician* ~~*to*~~ *does not* ~~*sign a subsequent plan on or before the date of the plan*~~, ~~*will result in expiration of the plan*~~ *is expired* ~~*and a new plan will be required*~~ *must be developed*. ~~*The date of the physician's*~~

~~*signature on subsequent plans shall must not be after the established annual date. This in no way precludes the Department or its designee from reformulating a completely new plan annually.*~~ *Any subsequent treatment plans must be received by the Department or its designee on or before the expiration date of the current plan. If a subsequent plan is not received on or before the expiration date of the current plan, services that are provided in the interim will not be reimbursed.*
~~*(3-15-02)*~~(8-1-04)T

e. ~~*Each recipient must*~~ The eligible participant will be allowed to choose ~~*a*~~ whether or not he desires to receive PSR services and who the provider(s) of services will be to assist ~~*them*~~ him in accomplishing the objectives stated in ~~*their*~~ his ~~*service*~~ *individualized treatment* plan. Documentation must be included in the participant's file showing that the participant has been informed of his rights to refuse services and choose providers. ~~*(3-15-02)*~~(8-1-04)T

~~***03. Task Plan****. The task plan is developed by the recipient and the selected provider(s). It identifies specific, time-limited activities designed to accomplish the objectives of the service plan. The task plan must be completed within fourteen (14) working days from completion of the service plan. The task plan must be completed by a qualified provider in accordance with Section 455 of these rules. Each task shall specify the place of service, the frequency of services, the type of service, and the person(s) responsible to assist the recipient in the completion of tasks.*~~
~~*(3-15-02)*~~

0~~4~~3. Pharmacological Management. Pharmacological management services ~~*shall*~~ must be provided in accordance with the ~~*service*~~ *individualized treatment* plan. Pharmacological management, alone, may be provided if the plan indicates that this service is necessary and sufficient to prevent relapse or hospitalization and that functional deficits are either manageable by the participant or absent but expected to return if pharmacological management is not provided. The telephoning of prescriptions to the pharmacy is not a billable service. Medication prescription must be done by a licensed physician or other practitioner of the healing arts within the scope of practice defined in their license in visual contact with the ~~*recipient*~~ participant.
~~*(3-15-02)*~~(8-1-04)T

0~~5~~4. Individual Psychosocial Rehabilitation *(PSR)*. Individual ~~*P*~~psychosocial ~~*R*~~rehabilitation ~~*shall*~~ must be provided in accordance with the objectives specified in the ~~*service*~~ *individualized treatment* plan. ~~*The service plan goal is to aid recipients in work, school, or with other issues related to their mental illness, by obtaining skills to live independently or by preventing movement to a more restrictive living situation.*~~ Individual PSR is a service provided to an individual participant on a one-to-one basis. Individual ~~*psychosocial rehabilitation*~~ PSR is reimbursable if provided by an agency with a current provider agreement and the agency~~*'s providers*~~ *staff delivering the service* meet the qualifications, in accordance with Section 45~~5~~6 of these rules. Individual ~~*Psychosocial Rehabilitation*~~ PSR includes one (1) or more of the following: ~~*(3-15-02)*~~(8-1-04)T

a. Assistance in gaining and utilizing skills necessary to undertake school, employment, or independence. This includes helping the ~~*recipient*~~ participant learn personal hygiene and grooming, selecting and acquiring appropriate clothing, time management and other skills related to ~~*recipient's*~~ participant's psychosocial circumstances; ~~*(3-15-02)*~~(12-1-03)T

b. Ongoing on-site assessment, evaluation, and feedback sessions, including one

hundred twenty (120) day reviews, to identify symptoms or behaviors related to the participant's mental illness and to develop interventions with the ~~*recipient*~~ participant and his employer or teacher; ~~*(3-15-02)*~~(12-1-03)T

c. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior directly related to the ~~*individuals*~~ participant's mental illness; ~~*(3-15-02)*~~(12-1-03)T

d. Problem solving, support, and supervision related to activities of daily living to assist ~~*recipients to*~~ participants in gaining and utilize~~e~~ing skills such as personal hygiene, household tasks, use of transportation ~~*utilization*~~, and money management; ~~*(3-15-02)*~~(12-1-03)T

e. ~~*To a*~~Assisting ~~*recipient*~~ the participant with receiving necessary services when ~~*they have*~~ he has difficulty or ~~*are*~~ is unable to obtain them. (8-1-04)T

i. This assistance may be given by accompanying ~~*them*~~ him to Medicaid-reimbursable appointments. For reimbursement purposes, ~~*T*~~the PSR ~~*provider*~~ *agency staff person* must be present during the appointment and deliver a PSR service during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable*; however, reimbursement is available for the delivery of prior authorized PSR services occurring during these times*. (8-1-04)T

ii. To be eligible for this service, the participant must have a functional impairment that affects his ability to communicate accurately due to a mental illness and be unable to report symptoms to a licensed practitioner, as identified in Subsection 456.01, or *be unable to* understand the practitioner's instructions. The impairment must be identified in the assessment. The ~~*service*~~ *individualized treatment* plan must identify how the impairment is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's responsibility in advocating for or attending appointments for their child; ~~*(3-15-02)*~~(8-1-04)T

f. Medication education may be provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating the ~~*recipient*~~ participant about the role and effects of medications in treating symptoms of mental illness and symptom management. ~~*(3-15-02)*~~(12-1-03)T

g. Development of coping skills and symptom management to identify the symptoms of mental illness ~~*which*~~ that are barriers to successful community integration and crisis prevention. ~~*(3-15-02)*~~(12-1-03)T

h. May assist ~~*recipient*~~ participant with "self" administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts ~~*will*~~ must be delivered face-to-face and an assessment of the ~~*consumer's*~~ participant's functioning ~~*will*~~ must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized. ~~*(3-15-02)*~~(12-1-03)T

0~~6~~5. Group Psychosocial Rehabilitation (PSR). Group ~~*psychosocial rehabilitation shall*~~ PSR must be provided in accordance with the objectives specified in the ~~*service*~~

individualized treatment plan. ~~*This*~~ Group PSR is a service provided to two (2) or more individuals~~*, at least one (1) of whom is a recipient participant concurrently. The service plan goal is to aid recipients in work, school or other problems related to their mental illness, in obtaining skills to live independently or in preventing movement to a more restrictive living situation.*~~ Group ~~*psychosocial rehabilitation*~~ PSR is reimbursable if provided by an agency with a current provider agreement and the agency~~*'s provider*~~ *staff person delivering the service* meets the qualifications in accordance with Section 45~~5~~6 of these rules. This service includes one (1) or more of the following: ~~*(3-15-02)*~~(8-1-04)T

a. Medication education groups provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating ~~*recipients*~~ participants about the role and effects of medications in treating symptoms of mental illness and symptom management. These groups ~~*shall*~~ must not be used solely for the purpose of group prescription writing; ~~*(3-15-02)*~~(12-1-03)T

b. Employment or school-related groups to focus on symptom management on the job or in school, symptom reduction, and education about appropriate job or school-related behaviors; ~~*(3-15-02)*~~(12-1-03)T

c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior~~*. The recipient must be present*~~; ~~*(3-15-02)*~~(12-1-03)T

d. Symptom management groups to identify mental illness symptoms which are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons; and (3-15-02)

e. Activities of daily living groups which help ~~*recipients*~~ participants learn skills related to personal hygiene, grooming, household tasks, use of transportation ~~*utilization*~~, socialization, and money management. ~~*(3-15-02)*~~(12-1-03)T

0~~7~~6. ~~*Community*~~ Crisis ~~*Support*~~ Intervention Service. ~~*Community c*~~Crisis support ~~*which*~~ that includes intervention for ~~*recipients*~~ a participant in crisis situations to ensure ~~*the*~~ his health and safety or to prevent his hospitalization or incarceration~~*of a recipient*~~. ~~*Community c*~~Crisis ~~*support*~~ intervention service is reimbursable if provided by an agency with a current provider agreement and the agency~~*'s providers*~~ *staff delivering the service* meet the qualifications ~~*of*~~ *under* Section 45~~5~~6 of these rules~~*and according to limitations contained in Subsection 458.03. of these rules*~~. ~~*(3-15-02)*~~(8-1-04)T

~~*a.*~~ A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. PSR ~~*providers*~~ *agency staff* may ~~*provide*~~ *deliver* direct services within the scope of these rules or link the participant to community resources to resolve the crisis or both. ~~*(7-1-94)*~~

~~*b.*~~ ~~*Community c*~~Crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service and the ~~*services are*~~ *individualized treatment* is either authorized the next

business day following the beginning of the crisis or prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis. ~~*(3-15-02)*~~(8-1-04)T

a. Crisis Support in a Community. Limitations to reimbursement in this place of service are described in Subsection 459.03 of these rules. (12-1-03)T

~~*08*~~**b.** ~~*Crisis Intervention (ER)*~~ Crisis Support in an Emergency Department. (12-1-03)T

i. A service provided in a hospital emergency ~~*room*~~ department as an adjunct to the medical evaluation completed by the emergency ~~*room*~~ department physician. This evaluation may include a psychiatric assessment. (12-1-03)T

ii. The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the ~~*recipient*~~ participant. ~~*This service must be reported to, reviewed and authorized, when appropriate, by the Department or its designee on the next working day. Crisis Intervention (ER) is reimbursable if provided by an agency with a current provider agreement and the agency's providers meet the qualifications of Section 4545 of these rules.*~~ ~~*(3-15-02)*~~(12-1-03)T

0~~9~~7. Collateral Contact. *Collateral* ~~*C*~~contacts *are contacts* made with significant individuals in the ~~*recipient's*~~ participant's environment for the purpose of assisting the ~~*recipient*~~ participant to live in the community. Collateral~~*s*~~ *contacts* may include a parent, *legal* guardian, relatives, family members, landlords, employers, teachers, providers or other individuals with a primary relationship to the ~~*recipient*~~ participant. The purpose of collateral contacts is to gather and exchange information with individuals specifically identified in the ~~*service or task*~~ *individualized treatment* plan. Collateral contacts must be prior authorized. Collateral ~~*C*~~contact is reimbursable if provided by an agency with a current provider agreement and the agency~~*'s providers*~~ *staff making the contacts* meet the qualifications ~~*of*~~ *under* S~~*ubs*~~ection ~~*453.06 and*~~ 456 of these rules. Subsection 454.06 of these rules describes limitations on reimbursement for collateral contacts between provider~~*s*~~ *agency staff*. The types of collateral contact are as follows: ~~*(3-15-02)*~~(8-1-04)T

a. Collateral contact face-to-face. When two persons meet visually at the same time; (3-15-02)

b. Collateral contact telephone. When it is the most expeditious and effective way to exchange information; and (3-15-02)

c. Collateral contact parent group. When two (2) or more parents of children, under the age of eighteen (18), with similar serious emotional disturbances meet to share information and learn about their children's needs. (3-15-02)

~~*1*~~**08. Nursing Service**. A service performed by licensed and qualified nursing personnel within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code. This may include supervision, monitoring, and administration of medications. (3-15-02)

~~*11*~~**09. Psychotherapy**. Individual, group and family psychotherapy must be prior authorized and provided in accordance with the objectives specified in the written ~~*service*~~

individualized treatment plan. *Staff* ~~*Q*~~*q*ualified ~~*providers for*~~ *to deliver psychotherapy* and qualified supervisors of psychotherapy are identified in ~~*Clinic Services-Mental Health Clinics,*~~ Subsection 469.06 of these rules. Family psychotherapy must include the ~~*recipient*~~ participant and at least one (1) family member at any given time and must be delivered in accordance with objectives as specified in the written ~~*service*~~ *individualized treatment* plan. An agency ~~*shall*~~ must assure clinical supervision is available to all staff ~~*who*~~ that provide psychotherapy. The amount of supervision should be adequate to insure that the ~~*service*~~ *individualized treatment* plan objectives are achieved. ~~*Clinical supervision of psychotherapy must be provided by individuals whose training, experience, and license qualify them to provide clinical supervision of psychotherapy. Supervision may be provided by individuals in Subsections 455.01 through 455.06 of these rules.*~~ Documentation of supervision must be maintained by the agency and be available for review by the Department or its designee. ~~*(3-15-02)*~~(8-1-04)T

1~~2~~0. Occupational Therapy. Occupational therapy services must be prior authorized by the Department or its designee, based on the results of an occupational therapy evaluation completed by a licensed Occupational Therapist in accordance with Subsections ~~*455.14*~~ 456.~~*0*~~12 and 45~~*7*~~8.08 of these rules. ~~*(3-15-02)*~~(8-1-04)T

45~~*3*~~4. EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID PSR. Excluded services are those services ~~*which*~~ that are not reimbursable under Medicaid PSR. The following is a list of those services: ~~*(3-15-02)*~~(12-1-03)T

01. Inpatient. Treatment services rendered to ~~*recipients*~~ participants residing in inpatient medical facilities including nursing homes, or hospitals, ~~*or correctional facilities including jail and detention*~~ except those identified in Subsection 458.09 of these rules; ~~*(3-15-02)*~~(12-1-03)T

02. Recreational And Social Activities. Activities which are primarily social or recreational in purpose; (3-15-02)

03. Employment. Job-specific interventions, job training and job placement services which includes helping the ~~*recipient*~~ participant develop a resume, applying for a job, and job training or coaching; ~~*(3-15-02)*~~(12-1-03)T

04. Household Tasks. Staff performance of household tasks and chores; (3-15-02)

05. Treatment Of Other Individuals. Treatment services for persons other than the identified ~~*recipient*~~ participant; ~~*(3-15-02)*~~(12-1-03)T

06. Client Staffing Within An Agency. A client staffing between two (2) staff who both provide PSR services within the same agency is not reimburs~~*e*~~able. A client staffing may fall under the definition of collateral contact when it is prior authorized and occurs between two (2) staff who are providing services from different Medicaid programs either within or outside the same agency. ~~*(3-15-02)*~~(12-1-03)T

07. Medication Drops. Delivery of medication only; (3-15-02)

08. Services Delivered On An Expired ~~*Service*~~ *Individualized Treatment* Plan.

Services provided between the expiration date of one (1) plan and the start date of the subsequent *treatment* plan; and ~~*(3-15-02)*~~(8-1-04)T

09. **Transportation**. The provision of transportation services and staff time to transport. (12-1-03)T

10. ***Inmate Of A Public Institution***. *Treatment services rendered to participants who are residing in a public institution as defined in 42 CFR 435.1009;* *(8-1-04)T*

~~**09**~~**11.** **Services Not Listed**. Any other services not listed in Section 45~~2~~3 of these rules. ~~*(3-15-02)*~~(12-1-03)T

45~~4~~5. PSR PROVIDER AGENCY REQUIREMENTS.
Each agency ~~*who*~~ *that* enters *into* a provider agreement with the ~~*Division of Medicaid*~~ *Department* for the provision of PSR services ~~*shall*~~ must meet the following requirements:~~*(3-15-02)*~~(8-1-04)T

01. **Agency**. A *PSR agency must be a* proprietorship, partnership, corporation, or other entity, employing at least two (2) ~~*providers*~~ *staff qualified to deliver PSR services under Section 456 of these rules*, and offering both PSR services and administrative services. Administrative services may include such activities as billing, hiring staff, assuring staff qualifications are met and maintained, setting policy and procedure, payroll. ~~*(3-15-02)*~~(8-1-04)T

02. ***Criminal History Checks***. *(8-1-04)T*

a. *The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks".* *(8-1-04)T*

b. *Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check.* *(8-1-04)T*

c. *Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department or its designee when the agency learns of the conviction.* *(8-1-04)T*

0~~2~~3. ***PSR Agency*** **Staff Qualifications**. ~~*An*~~ *The* agency ~~*shall*~~ must assure that ~~*all*~~ *each* agency staff *person delivering PSR services* meet*s at least one (1) of* the qualification*s* in Section 45~~5~~6 of these rules. ~~*The agency must verify that all employees, subcontractors, or agents coming into direct contact with participants have passed a Department criminal history check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". The agency must report criminal convictions of employees, subcontractors, or agents to the Department or its designee.*~~ ~~*(3-15-02)*~~(8-1-04)T

0~~3~~4. Supplemental Services Agreement. ~~*An*~~ *The* agency must have negotiated a Supplement Services Agreement (SSA) with the Department or its designee. The SSA ~~*shall*~~ must specify what PSR services ~~*shall*~~ must be provided by the agency. ~~*An*~~ *The* agency's Supplemental Services Agreement ~~*shall*~~ must be reviewed at least annually and may be revised or cancelled at

any time. ~~*(3-15-02)*~~(8-1-04)T

0~~4~~5. Agency Employees And Subcontractors. Employees and subcontractors of ~~*an*~~ *the* agency ~~*shall be*~~ are subject to the same conditions, restrictions, qualifications and rules as the agency. ~~*(3-15-02)*~~(8-1-04)T

0~~5~~6. Supervision. ~~*An*~~ *The* agency ~~*shall*~~ must provide staff with adequate supervision to insure that the tasks on a ~~*recipient's task*~~ participant's ~~*service*~~ *individualized treatment* plan can be implemented effectively in order for the ~~*service*~~ *individualized treatment* plan objectives to be achieved. Case-specific supervisory contact ~~*shall*~~ must be made weekly, at a minimum, with staff for whom supervision is a requirement. Individuals in Subsections ~~*455.11*~~ 456.09 through ~~*455.14*~~ 456.12 of these rules~~,~~ must be supervised by individuals in Subsections 45~~5~~6.01 through ~~*455.10*~~ 456.08. Documentation of supervision must be maintained by the agency and be available for review by the Department or its designee. ~~*(3-15-02)*~~(8-1-04)T

0~~6~~7. Continuing Education. The agency ~~*shall*~~ must assure that all staff complete twenty (20) hours of continuing education annually from the date of hire. Four (4) hours every four (4) years must be in ethics training. Staff who are not licensed ~~*shall*~~ must select the discipline closest to their own and use the continuing education standards attached to that professional license. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. ~~*(3-15-02)*~~(12-1-03)T

0~~7~~8. Crisis Service Availability. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services. (12-1-03)T

45~~5~~6. PSR ~~*PROVIDER*~~ *AGENCY STAFF* QUALIFICATIONS.
All ~~*individuals providing*~~ *agency staff delivering* PSR services must meet at least one (1) of the following qualifications: ~~*(3-15-02)*~~(8-1-04)T

01. Licensed Physician Or Psychiatrist. A physician, psychiatrist, or other licensed practitioners of the healing arts within the scope of his practice under state law ~~*shall*~~ must be licensed in accordance with Title 54, Chapter 18, Idaho Code, to practice medicine. A licensed practitioner of the healing arts in Idaho may include Physician Assistants and Nurse Practitioners; ~~*(3-15-02)*~~(12-1-03)T

02. Licensed Master's Level Psychiatric Nurse. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, ~~*shall*~~ must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree; ~~*(3-15-02)*~~(12-1-03)T

03. Licensed Psychologist. A psychologist ~~*shall*~~ must be licensed in accordance with Title 54, Chapter 23, Idaho Code; ~~*(3-30-01)*~~(12-1-03)T

04. Licensed Clinical Professional Counselor Or Licensed Professional Counselor. A clinical professional counselor ~~*shall*~~ or professional counselor must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, “Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists”;

~~*(3-15-02)*~~(12-1-03)T

05. Licensed Marriage And Family Therapist. A marriage and family therapist ~~*shall*~~ must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; ~~*(3-15-02)*~~(12-1-03)T

06. Licensed Masters Social Worker~~,~~ Or Licensed Clinical Social Worker. A masters social worker (LMSW) or clinical social worker (LCSW), ~~*shall*~~ must hold a license in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; ~~*(5-3-03)*~~(12-1-03)T

~~***07. Psychologist Extender**. A psychologist extender shall work under the supervision of a licensed psychologist and be registered with the Bureau of Occupational Licenses. A copy of that registration shall be retained in the extender's personnel file; (3-15-02)***

~~***08. Professional Counselor**. A professional counselor shall be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (3-15-02)***

0~~9~~7. Clinician. A clinician ~~*shall*~~ must hold a master's degree, be employed by a state agency and meet the minimum standards established by the Idaho State Division of Human Resources and the Idaho Department of Health and Welfare Division of Human Resources; ~~*(3-15-02)*~~(12-1-03)T

~~*1*~~08. Licensed Pastoral Counselor. A pastoral counselor ~~*shall*~~ must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists". Training and experience in a mental health setting are required~~.~~; ~~*(3-15-02)*~~(12-1-03)T

~~*11*~~09. Licensed Social Worker. A social worker ~~*shall*~~ must hold a license in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; ~~*(3-30-01)*~~(12-1-03)T

1~~*2*~~0. ~~*Registered*~~ Licensed Professional Nurse (RN). A ~~*registered*~~ licensed professional nurse~~,~~ or R~~.~~N~~.~~, ~~*shall*~~ must be licensed in accordance with Title 54, Chapter 14, Idaho Code~~.~~; ~~*An R.N. shall have a minimum of a bachelor's degree in nursing to be reimbursed for service planning.*~~ ~~*(3-15-02)*~~(12-1-03)T

1~~*3*~~1. Psychosocial Rehabilitation (PSR) Specialist. A ~~*psychosocial rehabilitation*~~ PSR specialist ~~*shall*~~ must hold at least a bachelor's degree from a nationally accredited university or college in ~~*a*~~ behavioral science education, or medicine. A PSR specialist must have at least twenty-one (21) semester credit hours (or quarter hour equivalent) in human service fields such as psychology, social work, special education, counseling, and psychosocial rehabilitation. An individual who has been denied licensure, or who is qualified to apply for licensure to the State of Idaho, Bureau of Occupational Licenses in the professions identified in Subsections 456.01 through 456.10 of this rule, is not eligible to provide services under the designation of Psychosocial Rehabilitation Specialist. Individuals approved as PSR specialists under previous

rules in this section will be able to continue as qualified PSR specialists as long as they continue to work in the same agency as they did prior to the effective date of this rule~~.~~; or
~~*(3-15-02)*~~(12-1-03)T

1~~4~~2. Licensed Occupational Therapist. An occupational therapist ~~*shall*~~ must be licensed in accordance with Title 54, Chapter 37, Idaho Code, and IDAPA 22.01.09, "Rules for the Licensing of Occupational Therapists and Occupational Therapist Assistants". Training and experience in a mental health setting are required. ~~*(3-15-02)*~~(12-1-03)T

13. Psychologist Extender. A psychologist extender must work under the supervision of a licensed psychologist and be registered with the Bureau of Occupational Licenses. A copy of that registration must be retained in the extender's personnel file. (12-1-03)T

45~~6~~7. RECORD REQUIREMENTS FOR PSR PROVIDERS.
In addition to the development and maintenance of the ~~*task*~~ ~~*service*~~ *individualized treatment* plan, the following documentation must be maintained by the provider of PSR services:
~~*(3-15-02)*~~(8-1-04)T

01. Name. Name of ~~*recipient*~~ participant; ~~*(3-15-02)*~~(12-1-03)T

02. Provider. Name of the provider agency and *the agency staff* person ~~*providing*~~ *delivering* the service; ~~*(3-15-02)*~~(8-1-04)T

03. Date, Time, Duration Of Service, And Justification. Date, time, and duration of services. Documentation must justify the length of time which is billed; (3-15-02)

04. Documentation Of Progress. The written description of the service provided, the place of service, and the response of the ~~*recipient shall*~~ participant must be included in the progress note. A separate progress note is required for each contact with a ~~*recipient*~~ participant;
~~*(3-15-02)*~~(12-1-03)T

05. ~~*Review Of Progress*~~ One Hundred Twenty Day Review. A ~~*D*~~documented review of progress toward each ~~*service*~~ *individualized treatment* plan goal and objective must be kept in the participant's file. ~~*and*~~ *For children*, a copy *of the review must be* sent to the Department or its designee within five (5) working days of the due date. *For adults, a copy of the review must be sent to the Department or its designee upon request.* Failure to do so may result in the loss of a prior authorization or result in a recoupment of reimbursement provided for services delivered after the one hundred twenty (120) day review due date. The review must also include a reassessment of ~~*recipient's*~~ the participant's continued need for services. The review must occur at least every one hundred twenty (120) days~~*. The one hundred twenty (120) day review shall*~~ and be conducted in visual contact with the ~~*recipient*~~ participant. For children, the review must include a new CAFAS/*PECFAS* for the purpose of measuring functional impairment. After eligibility has been determined, subsequent CAFAS/*PECFAS* scores are used to measure progress and functional impairment and should not be used to terminate services; ~~*(3-15-02)*~~(8-1-04)T

06. ~~*Service Provider's*~~ Signature *Of Staff Delivering Service*. The legible, dated signature, with degree credentials listed, of the staff ~~*member performing*~~ *person delivering* the service; and ~~*(3-15-02)*~~(8-1-04)T

07. **Choice Of Provider**. Documentation of the participant's choice of provider must be maintained in the participant's file prior to the implementation of the ~~*service*~~ *individualized treatment* plan. ~~*(12-1-03)T*~~(8-1-04)T

08. **Closure Of Services**. A discharge summary must be included in the participant's record and submitted to the Department or its designee identifying the date of closure, reason for ending services, progress on objectives, and referrals to supports and other services. (12-1-03)T

09. **Payment Limitations**. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. For services paid at the fifteen (15) minute incremental rate, providers will not be reimbursed for more than one (1) contact during a single fifteen (15) minute time period. (12-1-03)T

45~~7~~8. PAYMENT FOR PSR SERVICES.
Payment for PSR services must be in accordance with rates established by the Department. The rate paid for services includes documentation. ~~*(3-30-01)*~~(12-1-03)T

01. **Duplication**. Payment for services ~~*shall*~~ must not duplicate payment made to public or private entities under other program authorities for the same purpose. ~~*(3-30-01)*~~(12-1-03)T

02. **Number Of Staff Able To Bill**. Only one (1) staff member may bill for an assessment, ~~*service*~~ *individualized treatment* plan, or case review when multiple PSR staff are present. ~~*(3-15-02)*~~(8-1-04)T

03. **Medication Prescription And Administration**. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18 Idaho Code. (3-15-02)

04. **Recoupment**. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules ~~*shall*~~ must be cause for recoupment of payments for services, sanctions, or both. ~~*(3-30-01)*~~(12-1-03)T

05. **Access To Information**. Upon request, the provider ~~*shall*~~ must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request ~~*shall*~~ must result in termination of the Medicaid PSR Provider Agreement. ~~*(3-15-02)*~~(12-1-03)T

06. **Evaluations And Tests**. Evaluations and tests may be provided as a reimbursable service in conjunction with the assessment. (3-15-02)

0~~6~~7. Psychological Evaluations. Psychological evaluations are reimbursable if provided ~~*by a licensed psychologist, or by qualified clinician or psychologyist extender*~~ in accordance with *the requirements in* ~~*Section 455-456*~~ *Subsection 468.06* of these rules ~~*and under the direction of a licensed psychologist*~~. ~~*(3-15-02)*~~(12-1-03)T

08. Evaluations By Occupational Therapists. Evaluations performed by qualified licensed occupational therapists, performed in conjunction with development of a*n* ~~*service*~~ *individualized treatment* plan are reimbursable. ~~*(3-15-02)*~~(8-1-04)T

09. Psychiatric Or Medical Inpatient Stays. Services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those included in the responsibilities of the inpatient facility. Treatment services are the responsibility of the facility. ~~*(3-15-02)*~~(12-1-03)T

45~~*8*~~9. PSR SERVICE LIMITATIONS.
The following service limitations ~~*shall*~~ apply to PSR services, unless otherwise authorized by the Department or its designee in each region. ~~*(3-15-02)*~~(12-1-03)T

01. ~~*Evaluation Or Diagnosis*~~ Assessment And ~~*Service*~~ *Individualized Treatment* Plan Development. Any combination of ~~*any*~~ evaluations or diagnostic services ~~*are*~~ is limited to a maximum of six (6) hours annually. Additional hours may be approved by the Department or its designee under the following situations: ~~*(3-30-01)*~~(8-1-04)T

a. When the participant selects more than one (1) provider. (12-1-03)T

b. When ~~*service*~~ *individualized treatment* plan development is being done by an agency that did not do the assessment. ~~*(12-1-03)T*~~(8-1-04)T

02. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. (3-30-01)

03. ~~*Community*~~ Crisis ~~*Support*~~ Intervention Service. A maximum of twenty (20) hours of ~~*community*~~ crisis support in a community may be reimbursed per crisis during any consecutive five (5) day period. Authorization must follow procedure described above at Subsection ~~*452.07*~~ 453.06 of these rules. ~~*(3-15-02)*~~(12-1-03)T

04. Psychosocial Rehabilitation. Individual and group ~~*psychosocial rehabilitation*~~ PSR services are not to exceed twenty (20) hours per week and must receive prior authorization from the Department or its designee. Services in excess of twenty (20) hours require additional review and prior authorization by the Department or its designee in each region. The prior authorization of additional hours must be documented in the ~~*service*~~ *individualized treatment* plan and written approval must be retained in the ~~*recipient's*~~ participant's file. ~~*(3-15-02)*~~(8-1-04)T

~~***459. (RESERVED).***~~

(BREAK IN CONTINUITY OF SECTIONS)

461. -- 46~~*4*~~3. (RESERVED).

46~~*5*~~4. CLINIC SERVICES -- MENTAL HEALTH CLINICS (MHC).

~~*Pursuant to*~~ Under 42 CFR 440.90, the Department will pay for preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by a mental health clinic to a ~~*recipient*~~ participant who is not an inpatient in a hospital or nursing home or correctional facility except as specified under Subsection 469.05.a. ~~*The mental health clinic must be approved by the Department and be under the direction of a licensed physician.*~~ ~~*(3-30-01)*~~(12-1-03)T

465. MENTAL HEALTH CLINIC PROVIDER AGENCY REQUIREMENTS.
Each agency that enters into a provider agreement with the Department for the provision of mental health clinic services must meet the following requirements: *(8-1-04)T*

01. Mental Health Clinic. A mental health clinic, also referred to as "agency," must be a proprietorship, partnership, corporation, or other entity, in a distinct location, employing at least two (2) ~~*providers*~~ *staff qualified to deliver clinic services under this rule* and operating under the direction of a physician. The Department must approve the enrollment of the agency as a Medicaid provider. *Each location of the agency must meet these requirements. All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual.* ~~*(12-1-03)T*~~(8-1-04)T

02. Physician Requirement *For Clinic Supervision*. ~~*Each participant's care must be under the supervision of a physician directly affiliated with the clinic.*~~ In order to fulfill the requirement ~~*for*~~ *that* the clinic be~~*ing*~~ under the direction of a physician, ~~*the physician must see the program participant at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care*~~ *the clinic must have a contract with the physician.* ~~*(12-1-03)T*~~(8-1-04)T

a. *The contract must specifically require that the physician spend as much time in the facility as is necessary to assure that participants are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.* *(8-1-04)T*

b. *The supervising physician of the clinic may also serve as the supervising physician of a participant's care.* *(8-1-04)T*

03. Physician Requirement For Supervision Of A Participant's Care*. Each participant's care must be under the supervision of a physician directly affiliated with the clinic. Documentation of the affiliation must be kept in the clinic location. The clinic may have as many physician affiliations as is necessary in order to meet the needs of the volume of participants served in that location. The physician who supervises a participant's care does not have to deliver this service at the clinic nor does the physician have to be present at the clinic when the participant receives services at the clinic. In order to fulfill the requirement for physician supervision of a participant's care, the following conditions must also be met:* *(8-1-04)T*

a. *The clinic and the physician must enter into a formal arrangement in which the physician must assume professional responsibility for the services provided;* *(8-1-04)T*

b. *The physician must see the participant at least once to determine the medical necessity and appropriateness of clinic services;* *(8-1-04)T*

c. *The physician must review and sign the individualized treatment plan as an*

indicator that the services are prescribed; and *(8-1-04)T*

d. *The physician must review and sign all updates to the individualized treatment plan that involve changes in the types or amounts of services.* *(8-1-04)T*

04. ***Assessment****. All treatment in mental health clinics must be based on an individualized assessment of the patient's needs, including a current mental status examination, and provided under the direction of a licensed physician.* *(8-1-04)T*

05. ***Criminal History Checks****.* *(8-1-04)T*

a. *The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or clinical services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks".* *(8-1-04)T*

b. *Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check.* *(8-1-04)T*

c. *Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department or its designee when the agency learns of the conviction.* *(8-1-04)T*

0~~3~~*6.* **Staff Qualifications**. ~~A~~ *The* mental health clinic must assure that ~~all~~ *each* agency staff *person* delivering clinical services ~~meet the~~ *to eligible MA participants has, at a minimum, one (1) or more of the following* qualifications*:* ~~as listed in Subsection 466.03 of these rules. The clinic must verify that all employees, subcontractors, or agents coming into direct contact with participants have complied with IDAPA 16.05.06 "Rules Governing Mandatory Criminal History Checks". The clinic must report criminal convictions of employees, subcontractors, or agents to the Department or its designee.~~ ~~(12-1-03)T~~(8-1-04)T

a. *Licensed Psychiatrist;* *(8-1-04)T*

b. *Licensed Physician or licensed practitioner of the healing arts;* *(8-1-04)T*

c. *Licensed Psychologist;* *(8-1-04)T*

d. *Psychologist extender, registered with the Bureau of Occupational Licenses;* *(8-1-04)T*

e. *Licensed Masters Social Worker, Licensed Clinical Social Worker, or Licensed Social Worker;* *(8-1-04)T*

f. *Licensed Clinical Professional Counselor or Licensed Professional Counselor;* *(8-1-04)T*

g. *Licensed Marriage and Family Therapist;* *(8-1-04)T*

h. *Certified Psychiatric Nurse, R.N., as described in Subsection 456.02 of these rules;* *(8-1-04)T*

i. *Licensed Professional Nurse, R.N.; or* *(8-1-04)T*

j. *Registered Occupational Therapist, O.T.R.* *(8-1-04)T*

0~~4~~*7*. ~~***Paraprofessionals***~~ ***Support Staff***. For the purposes of this rule, ~~*a paraprofessional*~~ *support staff* is any person who does not meet the qualifications of professionals as listed in Subsection ~~*466.03*~~ *465.06* of these rules. ~~*A Mental Health Clinic provider*~~ *The agency* may elect to employ ~~*paraprofessionals*~~ *support staff* to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. ~~*Paraprofessionals*~~ *Support staff* must not ~~*be employed in any capacity to*~~ deliver or assist in the delivery of ~~*partial care*~~ services ~~*or any other services in the clinic*~~ that are reimbursable by Medicaid. ~~*(12-1-03)T*~~(8-1-04)T

0~~5~~*8*. **Agency Employees And Subcontractors**. Employees and subcontractors of ~~*an*~~ *the* agency are subject to the same conditions, restrictions, qualifications and rules as the agency. ~~*(12-1-03)T*~~(8-1-04)T

0~~6~~*9*. **Supervision**. ~~*An*~~ *The* agency must ensure that staff providing clinical services are supervised according to the following guidelines: ~~*(12-1-03)T*~~(8-1-04)T

a. Standards and requirements for supervision set by the Bureau of Occupational Licenses are met; (12-1-03)T

b. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement; and (12-1-03)T

c. Documentation of supervision must be maintained by the agency and be available for review by the Department or its designee. (12-1-03)T

~~*07*~~*10*. **Continuing Education**. The agency must ensure that all staff complete twenty (20) hours of continuing education annually in the field in which they are licensed. Documentation of the continuing education hours must be maintained by the agency and be available for review by the Department or its designee. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (12-1-03)T

11. ***Informed Consent****. The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For minors, informed consent must be obtained from the minor's parent or legal guardian.* *(8-1-04)T*

466. ~~*CARE AND SERVICES PROVIDED IN*~~ *INDIVIDUALIZED TREATMENT PLAN FOR* MENTAL HEALTH CLINIC~~S~~ *SERVICES*.
A written individualized treatment plan is a medically-ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 465.06 of these rules. *(8-1-04)T*

01. ~~***Treatment Plan Of Care***~~. *Service~~s~~ in mental health clinics must be provided ~~specifically in conjunction with a medically ordered plan of care, referred to as the treatment plan, signed by a physician when and delivered by licensed, qualified professionals employed full or part-time within a clinic~~. ~~All~~* ***Individualized Treatment Plan Development****. The individualized* treatment plan~~s~~ must *be developed by the following*: ~~*(3-30-01)*~~(8-1-04)T

a. ~~*Be dated and fully signed with title identification by both the prime therapist(s) and licensed physician*~~ *The clinic staff providing the services*; *and* ~~*(12-1-03)T*~~(8-1-04)T

b. ~~*Contain the diagnosis documented by an examination and by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under state law; including signature, problem list, type, frequency, and duration of treatment;*~~ *The adult participant, if capable, and the adult participant's legal guardian, or, in the case of a minor, the minor's parent or legal guardian. The participant or his parent or legal guardian may also choose others to participate in the development of the plan.* ~~*(12-1-03)T*~~(8-1-04)T

~~***c.***~~ ~~*Be reviewed and authorized and signed within thirty (30) days of implementation; and*~~ ~~*(12-1-03)T*~~

~~***d.***~~ ~~*Be reviewed within one hundred twenty (120) days and every one hundred twenty (120) days thereafter;*~~ ~~*(12-1-03)T*~~

~~***e.***~~ ~~*Be completely rewritten and authorized annually. Authorization for services after the first year must be based on documentation that the participant has specifically benefited from services but continues to need additional services. The participant's progress toward the service no longer being necessary must also be documented.*~~ ~~*(12-1-03)T*~~

02. ~~***Assessment***~~. *All treatment in mental health clinics must be based on an ~~individualized assessment of the patient's needs, including a current mental status examination, and provided under the direction of a licensed physician.~~* ***Individualized Treatment Plan Requirements****. An individualized treatment plan must include the following, at a minimum:* ~~*(12-1-03)T*~~(8-1-04)T

a. *Statement of the overall goals and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized and must be directly related to the clinic service needs that are identified in the assessment.* *(8-1-04)T*

b. *Documentation of who participated in the development of the individualized treatment plan.* *(8-1-04)T*

i. The authorizing physician must sign and date the plan within (30) thirty calendar days from the initiation of treatment. *(8-1-04)T*

ii. The adult participant, the adult participant's legal guardian or, in the case of a minor, the minor's parent or legal guardian, must sign the treatment plan indicating their participation in its development. If these signatures indicating participation in the development of the treatment plan are not obtained, then the agency must document in the participant's record the reason the signatures were not obtained, including the reason for the participant's refusal to sign. A copy of the treatment plan must be given to the adult participant and his legal guardian or to his parent or legal guardian if the participant is a minor. *(8-1-04)T*

iii. Other individuals who participated in the development of the treatment plan must sign the plan. *(8-1-04)T*

iv. The author of the treatment plan must sign the plan and include his title and credentials. *(8-1-04)T*

c. *The diagnosis of the participant must be documented by an examination and be made by a licensed physician or other licensed practitioner of the healing arts, licensed psychologist, licensed clinical professional counselor, or licensed clinical social worker within the scope of his practice under state law; and* *(8-1-04)T*

d. *A problem list, and the type, frequency, and duration of treatment estimated to achieve all objectives based on the ability of the participant to effectively utilize services.* *(8-1-04)T*

~~***03. Care Plans**. All medical care plans must:*~~ ~~*(3-30-01)*~~

~~***a.** Be dated and fully signed with title identification by both the prime therapist(s) and licensed physician; and*~~ ~~*(11-10-81)*~~

~~***b.** Contain the diagnosis documented by an examination and by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under state law; including signature, problem list, type, frequency, and duration of treatment; and*~~ ~~*(3-30-01)*~~

~~***c.** Be reviewed and authorized and signed within thirty (30) days of implementation; and*~~ ~~*(11-10-81)*~~

~~***d.** Be reviewed within one hundred twenty (120) days and every one hundred twenty (120) days thereafter; and*~~ ~~*(11-10-81)*~~

~~***e.** Be completely rewritten and authorized annually.*~~ ~~*(11-10-81)*~~

04~~3~~. ~~***Provider Qualifications**. Licensed, qualified professionals providing mental health clinic services to eligible MA recipients participants must have, at a minimum, one (1) or more of the following qualifications:~~ ***Treatment Plan Review**. The treatment plan review by the clinic and the participant must occur within one-hundred-twenty (120) days and every one-hundred-twenty (120) days thereafter. During the review, the clinic staff providing the services and the participant*

must review progress made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the adult participant or his legal guardian, or, in the case of a minor, his parent or legal guardian and clinic staff providing the services. ~~(3-30-01)~~(8-1-04)T

~~**a.** *Licensed Psychiatrist, M.D.; or* (11-10-81)(12-1-03)T~~

~~**b.** *Licensed Physician, M.D.; or* (11-10-81)(12-1-03)T~~

~~**c.** *Licensed Psychologist; or* (7-1-99)~~

~~**d.** *Psychologist extender, registered with the Bureau of Occupational Licenses; or* (7-1-99)~~

~~**e.** *Licensed Masters Social Workers, or Licensed Clinical Social Workers, or Licensed Social Worker*~~; or ~~(5-3-03)(12-1-03)T~~

~~**f.** *Licensed Clinical Professional Counselor or Licensed Professional Counselor; or* (5-3-03)(12-1-03)T~~

~~**g.** *Licensed Marriage and Family Therapist; or* (3-15-02)~~

~~**h.** *Certified Psychiatric Nurse, R.N., as described in Subsection 4546.02 of these rules; or* (3-15-02)(12-1-03)T~~

~~**i.** *Licensed Social Workers; or* (4-5-00)~~

~~**j**~~**i.** ~~*Licensed Registered Nurse, R.N.; or* (4-5-00)~~

~~**k**~~**j.** ~~*Registered Occupational Therapist, O.T.R.* (7-1-99)~~

04. ***Physician Review Of Treatment Plan****. Each individualized treatment plan must be reviewed and be completely rewritten and signed by a physician at least annually. Changes in the types or amount of services that are determined during treatment plan reviews must be reviewed and signed by a physician. Projected dates for the participant's reevaluation and the rewrite of the individualized treatment plan must be recorded on the treatment plan.* *(8-1-04)T*

05. ***Authorization For Services****. Authorization for services after the first year must be based on documentation of the following:* *(8-1-04)T*

a. *Description of the ways the participant has specifically benefited from clinic services, and why he continues to need additional clinical services; and* *(8-1-04)T*

b. *The participant's progress toward the achievement of therapeutic goals that would eliminate the need for the service to continue.* *(8-1-04)T*

467. CARE AND SERVICES IN MENTAL HEALTH CLINICS NOT ~~*COVERED*~~ REIMBURSED.

01. Inpatient Medical Facilities. The MA Program will not pay for mental health clinic services rendered to MA recipients residing in in-patient medical facilities including~~, *but not limited to,*~~ nursing homes, hospitals, or ~~*correctional facilities*~~ *public institutions as defined in 42 CFR 435.1009*; or ~~*(3-30-01)*~~(8-1-04)T

02. Scope. Any service or supplies not included as part of the allowable scope of the MA Program; or (3-30-01)

03. Non-Qualified Persons. Services provided within the mental health clinic framework by persons other than those qualified to ~~*render*~~ *deliver* services as specified in ~~*Section 465*~~ Subsection ~~*466.03*~~ *465.06* of these rules. ~~*(3-30-01)*~~(8-1-04)T

468. EVALUATION AND DIAGNOSTIC SERVICES IN MENTAL HEALTH CLINICS.

01. Medical Psychosocial Histories. Medical psychosocial intake histories must be contained in all case files. (3-30-01)

02. Diagnosis And *Individualized* Treatment Plan. Information gathered will be used for establishing a ~~*recipient*~~ participant data base used in part to formulate the diagnosis and *individualized* treatment plan. ~~*(3-30-01)*~~(8-1-04)T

03. Qualified Therapist. The medical psychosocial intake and plan development is reimbursable if conducted by a primary therapist who, at a minimum, has one (1) or more of the following qualifications: (3-30-01)

a. Licensed Psychologist; or (7-1-99)

b. Psychologist extender, registered with the Bureau of Occupational Licenses; or (7-1-99)

c. Licensed Masters Social Worker, or Licensed Clinical Social Worker, or Licensed Social Worker; or ~~*(5-3-03)*~~(12-1-03)T

d. Certified Psychiatric Nurse, R.N.; or (7-1-99)

e. Licensed Clinical Professional Counselor or Licensed Professional Counselor; or ~~*(5-3-03)*~~(12-1-03)T

f. Licensed Physician~~, *M.D.,*~~ or Licensed Psychiatrist~~, *M.D.*~~; or ~~*(7-1-99)*~~(12-1-03)T

~~***g.*** *Licensed Social Worker (not to include plan development, unless employed by the clinic prior to February 27, 1998); or* *(3-30-01)*~~

~~***h***~~**g.** Licensed Marriage and Family Therapist; or (3-15-02)

~~***i***~~**h.** ~~*Registered Nurse (not to include plan development, unless employed by the clinic prior to February 27, 1998)*~~ Licensed Professional Nurse (RN). ~~*(3-30-01)*~~(12-1-03)T

04. Intake Assessment. If an individual who is not eligible for MA receives intake services from any staff not having the required degree(s) as provided in Subsection 468.03 of these rules, and later becomes eligible for MA, a new intake assessment and *individualized* treatment plan will be required which must be developed by a qualified staff person and authorized prior to any reimbursement. ~~*(3-15-02)*~~(8-1-04)T

05. Non-Qualified ~~*Providers*~~ *Staff*. Any ~~*provider*~~ *delivery* of evaluation, diagnostic service, or treatment designed by any person other than a*n agency staff* person designated as qualified ~~*by*~~ *under Section 468 or Sections 466 or 469 of* these rules, is not eligible for reimbursement under the MA Program. ~~*(3-30-01)*~~(8-1-04)T

06. ~~*Psychiatric Or*~~ Psychological Testing. ~~*Psychiatric or p*~~Psychological testing ~~*may be provided in conjunction with the medical psychosocial intake history as a reimbursable service when provided by those persons with qualifications listed in Subsections 469.06.a. through 469.06.dc. and 469.06.j*~~ *refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments*.
~~*(3-30-01)*~~(8-1-04)T

a. *Psychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question.* *(8-1-04)T*

b. *The psychological report must contain the reason for the performance of this service.* *(8-1-04)T*

c. *Agency staff may deliver this service if they meet one (1) of the following qualifications:* *(8-1-04)T*

i. *Licensed Psychologist;* *(8-1-04)T*

ii. *Psychologist extenders as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners"; or* *(8-1-04)T*

iii. *A qualified therapist listed in Subsection 469.06 of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing.* *(8-1-04)T*

07. Psychiatric ~~*Evaluation*~~ *Diagnostic Interview Exam*. *A ~~P~~p*sychiatric ~~*evaluation*~~ *diagnostic interview exam* may be provided ~~*in conjunction with the medical psychosocial intake history*~~ as a reimbursable service when ~~*provided by those persons with qualifications listed in Subsections 469.06.a. and 469.06.b.*~~ *delivered by* ~~*qualified agency staff identified in Subsections 469.06.a. through 469.06.e. of these rules.*~~ one (1) of the following licensed professionals:
~~*(8-1-04)T*~~(8-1-04)T

a. *Psychiatrist;* *(8-1-04)T*

b. *Physician;* *(8-1-04)T*

c. *Practitioner of the healing arts;* *(8-1-04)T*

d. *Psychologist;* *(8-1-04)T*

e. *Clinical social worker; or* *(8-1-04)T*

f. *Clinical professional counselor.* *(8-1-04)T*

0~~7~~8. Evaluations Performed By Occupational Therapists. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with the development of a*n* ~~*medical care*~~ *individualized* treatment plan are reimbursable. ~~*(3-30-01)*~~(8-1-04)T

0~~8~~9. Documentation. All intake histories, psychiatric evaluations, psychological testing, or specialty evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the ~~*recipient's*~~ participant's file for documentation purposes. ~~*(3-30-01)*~~(12-1-03)T

~~*09*~~**10. Data**. All data gathered must be directed towards formulation of a written diagnosis, problem list, and *individualized* treatment plan which specifies the type, frequency, and anticipated duration of treatment. ~~*(3-30-01)*~~(8-1-04)T

1~~0~~1. Limitations. A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services and ~~*care*~~ *individualized* treatment plan development provided to an eligible ~~*recipient*~~ participant in a calendar year. ~~*(3-30-01)*~~(8-1-04)T

469. TREATMENT SERVICES IN MENTAL HEALTH CLINICS.

01. Psychotherapy. Individual and group psychotherapy must be provided in accordance with the goals specified in the ~~*written medical*~~ *individualized* treatment plan. ~~*(3-30-01)*~~(8-1-04)T

02. Family ~~*Centered Services*~~ *Psychotherapy*. Family~~*-centered*~~ psycho~~*social*~~*therapy* services must include at least two (2) family members and must be delivered in accordance with the goals of treatment as specified in the ~~*medical*~~ *individualized* treatment plan. ~~*(3-30-01)*~~(8-1-04)T

03. Emergency Services. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (3-30-01)

a. Emergency services provided to an eligible ~~*recipient*~~ participant prior to intake and evaluation is a reimbursable service but must be fully documented in the ~~*recipient's*~~ participant's record; and ~~*(11-10-81)*~~(12-1-03)T

b. Each emergency service will be counted as a unit of service and part of the

allowable limit per ~~*recipient*~~ participant unless the contact results in hospitalization. *Provider agencies may submit claims for the provision of psychotherapy in emergency situations in accordance with Subsections 469.06 and 469.07 of these rules even when contact does not result in the hospitalization of the participant.* ~~*(11-10-81)*~~(8-1-04)T

04. Collateral/Contact Consultation. Collateral contact ~~*may*~~ *will* be ~~*provided*~~ *covered by Medicaid* if *it is conducted* face to face *by agency staff qualified to deliver clinical services*, and *if it is* included on ~~*care*~~ the *individualized* treatment plan and is necessary to gather *and exchange* information ~~*from an*~~ *with* individuals having a primary relationship to the ~~*client*~~ participant. ~~*(3-30-01)*~~(8-1-04)T

05. Nursing Facility. Psychotherapy services may be provided to ~~*recipients*~~ participants residing in a nursing facility if the following criteria are met: ~~*(3-30-01)*~~(12-1-03)T

a. The ~~*recipient*~~ participant has been identified through the PASARR Level II screening process as requiring psychotherapy as a specialized service; and ~~*(11-29-91)*~~(12-1-03)T

b. The service is provided outside the nursing facility at a clinic location; and (3-30-01)

c. Services provided are: (11-29-91)

i. Supported by the independent evaluations completed and approved by the ~~*Mental Health Authority*~~ Department or its designee; and ~~*(11-29-91)*~~(12-1-03)T

ii. Incorporated into the ~~*recipient's*~~ participant's medical care plan; and ~~*(11-29-91)*~~(12-1-03)T

iii. Directed toward the achievement of specific measurable objectives which include target dates for completion. (11-29-91)

06. ~~*Provider*~~ *Staff* Qualifications *For Psychotherapy Services*. Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 469.01 through 469.0~~*4*~~3 of these rules must have, at a minimum, one (1) or more of the following degrees: ~~*(3-15-02)*~~(8-1-04)T

a. Licensed Psychiatrist~~*, M.D.*~~; or ~~*(11-10-81)*~~(12-1-03)T

b. Licensed Physician~~*, M.D.*~~; or ~~*(11-10-81)*~~(12-1-03)T

c. Licensed Psychologist; or (7-1-99)

d. ~~*Psychologist extender, registered with the Bureau of Occupational Licenses*~~ Licensed Clinical Social Worker; or ~~*(7-1-99)*~~(12-1-03)T

e. ~~*Licensed Masters Social Worker or*~~ Licensed Clinical ~~*Social Worker*~~ Professional Counselor; or ~~*(5-3-03)*~~(12-1-03)T

f. Licensed ~~*Clinical Professional Counselor*~~ Marriage and Family Therapist; or ~~*(5-3-03)*~~(12-1-03)T

g. ~~*Licensed Marriage and Family Therapist*~~ Certified Psychiatric Nurse (RN), as described in Subsection 45~~5~~6.02 of these rules; or ~~*(3-15-02)*~~(8-1-04)T

h. ~~*A licensed social worker who was employed by the clinic prior to February 27, 1998*~~ Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 469.06.a. through 469.06.g. of this rule; or ~~*(7-1-99)*~~(12-1-03)T

i. ~~*Certified Psychiatric Nurse, R.N. as described in Subsection 454.02 of these rules*~~ Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or ~~*(3-15-02)*~~(12-1-03)T

j. A ~~*Registered Nurse, R.N., who was employed by the clinic prior to February 27, 1998*~~ Psychologist Extender, registered with the Bureau of Occupational Licenses. ~~*(7-1-99)*~~(8-1-04)T

07. Psychotherapy Limitations. Psychotherapy services as set forth in Subsections 469.01 through 469.03 of these rules are limited to forty-five (45) hours per calendar year. (3-15-02)

08. ~~***Chemotherapy***~~ ***Pharmacological Management***. ~~*Chemotherapy*~~ *Pharmacological management* consultations must be provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the ~~*recipient*~~ participant. ~~*(3-15-02)*~~(8-1-04)T

a. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the *individualized* treatment plan; and ~~*(11-10-81)*~~(8-1-04)T

b. ~~*Chemotherapy treatment can*~~ *Pharmacological management, if provided, must* be part of the ~~*medical care*~~ *individualized* treatment plan and frequency and duration of the treatment must be specified. ~~*(11-10-81)*~~(8-1-04)T

09. Nursing Services. Nursing services, when physician ordered and supervised, can be part of the ~~*recipient's medical care*~~ participant's *individualized* treatment plan. ~~*(3-30-01)*~~(8-1-04)T

a. Licensed and qualified nursing personnel can supervise, monitor, and~~*/or*~~ administer medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code; and ~~*(11-10-81)*~~(8-1-04)T

b. ~~*Such treatment can be part of the recipient's medical care*~~ *participant's treatment plan*~~*, and f*~~*Frequency*~~ *The frequency* and duration of the treatment must be specified *on the participant's individualized treatment plan*. ~~*(11-10-81)*~~(8-1-04)T

10. Partial Care. Partial ~~*c*~~Care ~~*services will be a structured program and will be*~~

~~*directed toward the maintenance of socio-emotional levels, reduction of psychosocial dysfunctioning, and the promotion of psychosocial levels of functioning insuring the optimal level of function and independence.*~~ is ~~*intensive*~~ treatment for those whose functioning is sufficiently disrupted so as to ~~*seriously*~~ interfere with their productive involvement in daily living. Partial Care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. The goal of Partial Care services is to decrease the severity and acuity of presenting symptoms so that the program participant may be maintained in ~~*home and school*~~ *the least restrictive* setting~~s~~ and to increase the program participants' interpersonal skills in order to obtain the optimal level of interpersonal adjustment. ~~*(3-30-01)*~~(8-1-04)T

a. ~~*To qualify as a*~~ Qualifications of Partial Care Services. ~~*it must include an individual treatment plan based on concrete measurable goals and outcomes. The service must be offered a minimum of three (3) continuous hours daily, four (4) days per week; and*~~ In order to be considered a Partial Care service, the service must: ~~*(3-30-01)*~~(12-1-03)T

i. Be provided in a structured environment within the MHC setting; (12-1-03)T

ii. Be a needed service as indicated on the *individualized* treatment plan with documented, concrete, and measurable goals and outcomes; and ~~*(12-1-03)T*~~(8-1-04)T

iii. Provide interventions for relieving symptoms and acquiring specific skills. ~~*Every intervention must have a therapeutic intent as identified on the treatment plan. No other interventions are sanctioned nor are they reimbursable.*~~ *These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives.* ~~*(12-1-03)T*~~(8-1-04)T

b. Limit on Treatment Hours. Treatment will be limited to ~~*fifty*~~ *thirty*-six (~~*5*~~*3*6) hours per week per eligible ~~*recipient; and*~~ participant. ~~*(7-8-90)*~~(8-1-04)T

c. Criteria for Partial Care Service Program Participants. In order for a MHC program participant to be eligible for Partial Care Services the following criteria must be met and documented: (12-1-03)T

i. Assessments completed within the previous twelve (12) months have documented that the participant has any combination of emotional, behavioral, neurobiological or substance abuse problems that significantly impair social and occupational functioning. The intake assessment must document that the participant is presently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration which would interfere with the participant's ability to maintain current level of functioning. (12-1-03)T

ii. Other ~~*less intensive*~~ services have failed or are not appropriate for the clinical needs of the participant. ~~*For purposes of this rule, intensive services are interventions designed to be provided in an on-going or iterative process.*~~ ~~*(12-1-03)T*~~(8-1-04)T

iii. For each participant, the services can reasonably be expected to improve the

participant's condition or prevent further regression so that the current level of care is no longer necessary *or may be reduced*. ~~*(12-1-03)T*~~(8-1-04)T

~~c~~d. Partial care services~~ *offered on an extension basis less than this standard are allowable when such services are directly affiliated with a partial care service that meets this standard; and*~~ is not appropriate for certain people. Persons identified in the list below are disqualified from participating in Partial Care services: ~~*(11-10-81)*~~(12-1-03)T

i. Persons at immediate risk of self-harm or harm to others; (12-1-03)T

ii. Persons needing more restrictive care or inpatient care; and (12-1-03)T

iii. Persons who have not fulfilled the requirements of Subsection 469.10.c. of this rule. (12-1-03)T

~~d~~e. Partial Care Services Must Be on the *Individualized* Treatment Plan. Partial care services ~~*will*~~ must be part of the ~~*recipient's medical care*~~ participant's *individualized* treatment plan which must *identify the specific objective to be addressed through the service and* specify the amount, frequency, and expected duration of treatment~~*; and*~~. ~~*(11-10-81)*~~(8-1-04)T

~~e~~f. ~~*Provider*~~ *Staff* Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in Subsection ~~*466.04*~~ ~~*466.03*~~ *465.06* of these rules. ~~*(3-15-02)*~~(8-1-04)T

g. Excluded Services. Services that focus on ~~*socialization,*~~ vocation, recreation or education are not reimbursable under Medicaid Partial Care. *Services that are provided outside the clinic facility are not reimbursable.* ~~*(12-1-03)T*~~(8-1-04)T

470. RECORD KEEPING REQUIREMENTS FOR MENTAL HEALTH CLINICS.

01. Maintenance. Each mental health clinic will be required to maintain records on all services provided to MA ~~*recipients*~~ participants. ~~*(3-30-01)*~~(12-1-03)T

02. Record Contents. The records must contain ~~*a*~~ *the* current *individualized* treatment plan ordered by a physician and must meet the requirements as set forth in S~~*ubs*~~ection 466~~*.031*~~*1*. ~~*(3-30-01)*~~(8-1-04)T

03. Requirements. The records must: (3-30-01)

a. Specify the exact type of treatment provided; and (11-10-81)

b. Who the treatment was provided by; and (11-10-81)

c. Specify the duration of the treatment *and the time of day delivered*; and ~~*(11-10-81)*~~(8-1-04)T

d. Contain detailed records which outline exactly what occurred during the therapy session or ~~*recipient*~~ participant contact documented by the person who delivered the service; and

~~*(11-10-81)*~~(12-1-03)T

e. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. (11-10-81)

04. Non-Reimbursable. Any service not adequately documented in the ~~*recipient's*~~ participant's record by the signature of the therapist providing the therapy or ~~*recipient*~~ participant contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department. ~~*(3-30-01)*~~(12-1-03)T

05. Non-Eligible ~~*Providers*~~ *Staff*. Any treatment or contact provided as a result of a*n individualized* treatment plan *that is* performed by any staff other than ~~*as set forth herein will*~~ *those qualified to deliver services under Subsection 465.06 of these rules is* not be eligible for reimbursement by the Department. ~~*(3-30-01)*~~(8-1-04)T

06. Recoupment. If a record is determined not to meet minimum requirements as set forth herein any payments made on behalf of the ~~*recipient*~~ participant are subject to recoupment. ~~*(3-30-01)*~~(12-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

472. BUILDING STANDARDS FOR MENTAL HEALTH CLINICS.

01. Accessibility. Mental health clinic service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard. (12-1-03)T

02. Environment. Clinics must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control. (12-1-03)T

03. Capacity. Clinics must provide qualified staff as listed in Subsection ~~*466.03*~~ *465.06* of these rules to meet a staff to participant ratio that ensures safe, effective and clinically appropriate interventions. (12-1-03)T

04. Fire And Safety Standards. (12-1-03)T

a. Clinic facilities must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and (12-1-03)T

b. The clinic facility must be structurally sound and must be maintained and

equipped to assure the safety of participants, employees and the public; and (12-1-03)T

c. In clinic facilities where natural or man-made hazards are present, suitable fences, guards or railings must be provided to protect participants; and (12-1-03)T

d. Clinic facilities must be kept free from the accumulation of weeds, trash and rubbish; and (12-1-03)T

e. Portable heating devices are prohibited except units that have heating elements that are limited to not more than two hundred twelve (212F) degrees Fahrenheit. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (12-1-03)T

f. Flammable or combustible materials must not be stored in the clinic facility; and (12-1-03)T

g. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (12-1-03)T

h. Water temperatures in areas accessed by participants must not exceed one hundred twenty (120) degrees Fahrenheit; and (12-1-03)T

i. Portable fire extinguishers must be installed throughout the clinic facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 472.04 of these rules; and (12-1-03)T

j. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved, in writing, by the local fire or building authority. (12-1-03)T

k. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can be easily accessed; and (12-1-03)T

l. Furnishings, decorations or other objects must not obstruct exits or access to exits. (12-1-03)T

05. Emergency Plans And Training Requirements. (12-1-03)T

a. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building. (12-1-03)T

b. There must be written policies and procedures covering the protection of all persons in the event of fire or other emergencies; and (12-1-03)T

c. All employees must participate in fire and safety training upon employment and at least annually thereafter; and (12-1-03)T

d. All employees and partial care participants must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and (12-1-03)T

e. A brief summary of the fire drill and the response of the response of the employees and partial care participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. (12-1-03)T

06. Food Preparation And Storage. (12-1-03)T

a. If foods are prepared in the clinic facility, they must be stored in such a manner as to prevent contamination and be prepared by sanitary methods. (12-1-03)T

b. Except during actual preparation time, cold perishable foods must be stored and served under forty-five (45F) degrees Fahrenheit and hot perishable foods must be stored and served over one hundred forty (140F) degrees Fahrenheit. (12-1-03)T

c. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily-readable thermometer. Refrigerators must be maintained at forty-five (45F) degrees Fahrenheit or below. Freezers must be maintained at zero (0F) to ten (10F) degrees Fahrenheit or below. (12-1-03)T

d. When meals are prepared or provided for by the clinic, meals must be nutritional. (12-1-03)T

07. Housekeeping And Maintenance Services. (12-1-03)T

a. The interior and exterior of the clinic facility must be maintained in a clean, safe and orderly manner and must be kept in good repair; and (12-1-03)T

b. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and (12-1-03)T

c. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and (12-1-03)T

d. The clinic facility must be maintained free from infestations of insects, rodents and other pests; and (12-1-03)T

e. The clinic facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. (12-1-03)T

f. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. (12-1-03)T

08. **Firearms**. No firearms are permitted in the clinic facility. (12-1-03)T

09. **Plumbing**. Restroom facilities must be maintained in good working order and available and accessible to participants while at the clinic in accordance with the Americans with Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands. (12-1-03)T

10. **Lighting**. Lighting levels must be maintained throughout the clinic facility which are appropriate to the service being provided. (12-1-03)T

11. **Drinking Water**. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department. (12-1-03)T

47~~2~~3. -- 475. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the May 5, 2004 Idaho Administrative Bulletin, Volume 04-5, pages 109 through 111.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paul Leary at (208) 364-1840.

DATED this 6th day of October, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than May 19, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and

purpose of the proposed rule making:

Several widely prescribed federal legend medications have changed to non-legend status. The Department needs to be able to include non-legend drug products based upon appropriate criteria in order to contain Medicaid Program expenditures to meet legislative appropriation. Additionally, the Department needs some discretion to exempt drugs from prior authorization. This rule will allow the public to benefit by allowing physicians to prescribe equally effective medications at a lower cost to the Department.

This rule was published as a temporary rule with the effective date of May 20, 2002 in the February 4, 2004 Idaho Administrative Bulletin, Volume 04-2, pages 96 through 98.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because immediate action was needed to protect the public health, safety or welfare. There will be opportunity to obtain public comment during the comment period for this rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Paul Leary at (208) 364-1840.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before May 26, 2004.

DATED this 31st day of March, 2004.

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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

810. PRIOR AUTHORIZATION.

01. Items Requiring Prior Authorization. Pharmaceutical items requiring prior authorization include: (3-20-04)

a. Amphetamines and related CNS stimulants; (3-20-04)

b. Growth hormones; (3-20-04)

c. Retinoids; (3-20-04)

d. Brand name drugs when an acceptable generic form exists; (3-20-04)

e. Medication otherwise covered by the Department for which there is a therapeutically interchangeable alternate medication identified by the Department. ~~*For purposes of Subsection 810.01,*~~ ~~*t*~~Therapeutically interchangeable means a medication that is interchangeable with another medication within the same pharmacologic or therapeutic class and is at least as effective as the medication for which it is being interchanged. The Director may exempt a drug from the prior authorization requirement described in Subsection 810.01 based upon appropriate criteria, including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the P&T committee. The Department determines, and will make available to providers, which drugs are therapeutically interchangeable using a number of resources that may include: ~~*(5-20-02)T*~~(5-20-04)T

i. Peer-reviewed medical literature; (3-20-04)

ii. Randomized clinical trials; (3-20-04)

iii. Drug comparison studies; (3-20-04)

iv. Pharmacoeconomic studies; (3-20-04)

v. Outcomes research data; (3-20-04)

vi. Idaho practice guidelines; and (3-20-04)

vii. Consultation with practicing physicians, pharmacists, and the Idaho Medicaid Medical Director. (3-20-04)

f. Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines. (3-20-04)

g. Lipase inhibitors. (3-20-04)

h. Medications prescribed outside of the Food and Drug Administration approved indications. (3-20-04)

i. Medications excluded in Section 811 of these rules that the Department accepts for

other medically approved indications. (3-20-04)

02. Request For Prior Authorization. The prior authorization procedure is initiated by the prescriber who must submit the request to the Department in the format prescribed by the Department. (3-20-04)

03. Notice Of Decision. The Department will determine coverage based on this request, and will notify the client~~, *prescriber, and pharmacy, if known*~~ of a denial.
~~*(5-20-02)T*~~(5-20-04)T

04. Emergency Situation. The Department will provide for the dispensing of at least a seventy two (72) hour supply of a covered outpatient prescription drug in an emergency situation as required in 42 USC 1396r-8(d)(5)(B). (3-20-04)

05. Response To Request. The Department will respond within twenty-four (24) hours to a request for prior authorization of a covered outpatient prescription drug as required in 42 USC 1396r-8(d)(5)(A). (3-20-04)

811. EXCLUDED DRUG PRODUCTS.
The following categories and specific products are excluded from coverage by Medicaid:
+ ~~*(4-5-00)*~~(5-20-04)T

01. Non-Legend Medications. ~~*Non-legend medications unless included in Subsection 812.02. This includes f*~~Federal legend medications that change to non-legend status, as well as their therapeutic equivalents regardless of prescription, status~~.~~ unless: ~~*(4-5-00)*~~(5-20-04)T

a. They are included in Subsection 812.02; or (5-20-04)T

b. The Director determines that non-legend drug products are covered based upon appropriate criteria including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the P&T committee. Therapeutically interchangeable is defined in Subsection 810.01.e. (5-20-04)T

02. Legend Drugs. Any legend drugs for which federal financial participation is not available. (4-5-00)

03. Diet Supplements. Diet supplements and weight loss products, except lipase inhibitors when prior authorized as outlined in Subsection 812.03 of these rules. (3-20-04)

04. Amphetamines And Related Products. Amphetamines and related products for cosmetic purposes or weight loss. Amphetamines and related products which are deemed to be medically necessary may be covered if prior authorized as outlined in Subsection 812.03 of these rules. (3-20-04)

05. Ovulation/Fertility Drugs. Ovulation stimulants, fertility drugs, and similar products. (3-20-04)

06. **Impotency Aids**. Impotency aids, either as medication or prosthesis. (4-5-00)

07. **Nicotine Products**. Nicotine chewing gum, sprays, inhalers, transdermal patches and related products. (4-5-00)

08. **Medications Utilized For Cosmetic Purposes**. Medications utilized for cosmetic purposes or hair growth. Prior authorization may be granted for these medications if the Department finds other medically necessary indications. (4-5-00)

09. **Vitamins**. Vitamins unless included in Subsection 812.01. (4-5-00)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0402

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the August 4, 2004 Idaho Administrative Bulletin, Volume 04-8, pages 159 through 161.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paul Leary at (208) 364-1840.

DATED this 6th day of October, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: Temporary rules for return of unused drugs are effective July 1, 2004.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DEPARTMENT OF HEALTH AND WELFARE **Docket No. 16-0309-0402**
Rules Governing the Medical Assistance Program **PENDING RULE**

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a non-technical explanation of the substance and purpose of the proposed rulemaking:

Rule amendments are being made for return of unused and unopened drugs effective July 1, 2004. These changes were necessary because of changes adopted by the 2004 Legislature in IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," and IDAPA 16.03.22 "Rules for Licensed Residential or Assisted Living Facilities," which allow these facilities to return unused and unopened drugs. This rule amendment also allows the dispensing pharmacy to receive payment for acceptance of the returned drugs.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

The rules being adopted are necessary in order to protect the public health, safety and welfare; and to comply with amendments to governing law.

FEE SUMMARY: No fee is being imposed or increased by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule is necessary to avoid a conflict in rules due to the passage of the new service coordination chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Paul Leary at (208) 364-1840.

Anyone can submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be postmarked on or before August 25, 2004.

DATED this 30th day of June, 2004.

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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

817. PAYMENT PROCEDURES.
The following protocol shall be followed for proper reimbursement. (4-5-00)

01. Filing Claims. Pharmacists shall file claims electronically with Department approved software or by submitting the appropriate claim form to the fiscal contractor. Upon request, the contractor will provide pharmacies with a supply of claim forms. The form shall include information described in the pharmacy guidelines issued by the Department. (4-5-00)

02. Claim Form Review. Each claim form may be subject to review by a contract claim examiner, a pharmaceutical consultant, or a medical consultant. (3-30-01)

03. Billed Charges. A pharmacy's billed charges are not to exceed the usual and customary charges defined as the lowest charge by the provider to the general public for the same service including advertised specials. (4-5-00)

04. Reimbursement. Reimbursement to pharmacies shall be limited to the lowest of the following: (4-5-00)

a. Federal Upper Limit (FUL), as established by the Health Care Financing Administration (HCFA), of the U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; (4-5-00)

b. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned dispensing fee; (4-5-00)

c. Estimated Acquisition Cost (EAC), as established by the Department following negotiations with representatives of the Idaho pharmacy profession defined as an approximation of the net cost of the drug and a reasonable operating margin, plus the assigned dispensing fee; or (4-5-00)

d. The pharmacy's usual and customary charge to the general public as defined in Subsection 817.03. (4-5-00)

05. Dispensing Fees. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any recipient as an outpatient or a resident in a care facility except: (4-5-00)

a. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (4-5-00)

b. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (4-5-00)

c. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or

(4-5-00)

d. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (4-5-00)

06. Remittance Advice. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic claims transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (4-5-00)

07. Return of Drugs. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05, shall be returned to the dispensing pharmacy when the client no longer uses the medication as follows: (3-15-02)

a. A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05. (3-15-02)

b. A licensed skilled nursing care facility must return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. ~~*(3-15-02)*~~(7-1-04)T

c. A residential or assisted living facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. (7-1-04)T

~~**c**~~**e.** The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the dispensing fee. (3-15-02)

e. The pharmacy provider may receive a fee for acceptance of returned unused drugs. The value of the unused drug being returned must be cost effective as determined by the Department. (7-1-04)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0403

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202(b) and Section 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed with no changes. The original text of the proposed rules was published in the September Administrative Bulletin, Volume 04-9, pages 111 through 142.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paul Leary at (208) 364-1840.

DATED this 3rd day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 15, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and

purpose of the proposed rulemaking:

This docket reflects changes necessary because of rules approved by the 2004 Legislature. The changes in IDAPA 16.03.09 are required due to approval of the new chapter IDAPA 16.03.17, "Service Coordination," and will prevent conflicts for service coordinators. Those sections of rule dealing with service coordination in IDAPA 16.03.09 are deleted or revised in this docket.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased. N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule is necessary to avoid a conflict in rules due to the passage of the new service coordination chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Paul Leary at (208) 364-1840.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before September 22, 2004.

DATED this 27th day of July, 2004.

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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

118. ~~*TARGETED*~~ DEVELOPMENTAL DISABILITIES SERVICE COORDINATION.
The Department will purchase ~~*targeted case management, hereafter referred to as Targeted S*~~service ~~*C*~~coordination ~~*(TSC)*~~ services for Medicaid-eligible participants with developmental disabilities when authorized through the Department's prior authorization process in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services," and provided by an organized service coordination provider agency who has entered into a written provider agreement with the

Department. The purpose of these services, as described in IDAPA 16.03.17, "Service Coordination," is to assist eligible individuals to obtain needed health, educational, vocational, residential, and social services. ~~*(3-20-04)*~~( )

~~***01. Eligible Target Group****. Only Medicaid eligible adults, eighteen (18) years of age or older, and adolescents, age fifteen (15) through the month of their eighteenth birthday, who are eligible for the Idaho State School and Hospital (ISSH) waiver who desire to live, learn, or work in community based settings are eligible. All participants must have a diagnosis of developmental disability.*~~ ~~*(3-20-04)*~~

~~***a.*** *The following diagnostic and functional criteria will be applied to determine eligibility for Targeted Service Coordination: "Developmental Disability," as defined in Section 66-402, Idaho Code, means a chronic disability of a person that appears before twenty-two (22) years of age and:*~~ ~~*(3-20-04)*~~

~~*i. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and*~~ ~~*(10-1-94)*~~

~~*ii. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and*~~ ~~*(3-20-04)*~~

~~*iii. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned or coordinated.*~~ ~~*(10-1-94)*~~

~~***b.*** *Eligible individuals may reside in certified family homes, residential care, semi-independent living, room and board, their own homes, or be homeless.*~~ ~~*(3-20-04)*~~

~~***c.*** *Eligible individuals may be receiving DDA services, waiver services, or other services. These individuals may not be receiving any other types of service coordination.*~~ ~~*(3-20-04)*~~

~~***02. TSC Service Description****. Targeted service coordinators may be paid plan developers and plan monitors as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". TSC consists of the following core functions:*~~ ~~*(3-20-04)*~~

~~***a.*** *Linking the Participant to Needed Services. Linking includes finding, arranging, and assisting the participant with maintaining the services, supports, and community resources identified on the plan of service. Linking also includes advocating for the unmet needs of the participant and encouraging his independence.*~~ ~~*(3-20-04)*~~

~~***b.*** *Monitoring and Coordination of Services. Monitoring and coordination of services includes assisting the participant and his family or guardian to coordinate and retain services and assure consistency and nonduplication between services. This includes assuring that the services are satisfactory to the participant and making adjustments to the plan of service when needed.*~~

~~*Targeted service coordinators must report immediately all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the Regional Medicaid Services (RMS), the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law.* (3-20-04)~~

~~***03. Targeted Service Coordination Agency Qualifications****. Targeted Service Coordination agencies must meet the following criteria:* (10-1-94)~~

~~***a.*** *Have demonstrated the ability to provide supervision over and assure the provision of all the core functions of Targeted Service Coordination to the target population as described in Subsection 118.02 of these rules* (3-20-04)~~

~~***b.*** *Employ individuals qualified to do Targeted Service Coordination;* (3-20-04)~~

~~***c.*** *Not provide service coordination to any individual for whom the agency, owners or employees also provide direct services. Agencies must disclose any interest by the owners of the agency, their employees or their contractors in any other agency that provides services to people with developmental disabilities;* (3-20-04)~~

~~***d.*** *Assure that all targeted service coordinators they employ successfully complete the service coordination certification specified by the Department;* (3-20-04)~~

~~***e.*** *Follow the written procedures for service coordination authorized and adhered to by the Department;* (3-20-04)~~

~~***f.*** *Adhere to the Department's mission and value statements for "right service," "right setting," and "right cost"; and* (3-20-04)~~

~~***g.*** *Adhere to the Department's requirements, billing, and reimbursement procedures.* (3-20-04)~~

~~***04. TSC Provider Staff Qualifications****. All individual service coordinators, paid plan developers, and paid plan monitors must be employees or contractors of an organized provider agency that has a valid provider agreement with the Department. The employing entity will supervise the individual service coordinators, paid plan developers, and paid plan monitors and assure that they meet the following qualifications:* (3-20-04)~~

~~***a.*** *Must be a psychologist, Ph.D., Ed.D., M.A./M.S.; nurse, B.S.N., M.S., Ph.D.; Q.M.R.P.; Developmental Specialist; M.D.; D.O.; or possess a valid Idaho social work license issued by the Board of Social Work Examiners;* (3-20-04)~~

~~***b.*** *Must have documentation of at least twelve (12) months based on an average of twenty (20) hours per week, of on-the-job experience providing direct service to the target population, or be working under the supervision of a fully qualified service coordinator;* (3-20-04)~~

~~***c.*** *Must satisfactorily complete a criminal history check as required by IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks";* (3-20-04)~~

~~***d.*** *Must be supervised by an individual with the authority to oversee the service delivery, and to remove the individual if the participant's needs are not met; provider agencies will supervise their service coordinators, plan developers, and plan monitors;* *(3-20-04)*~~

~~***e.*** *Cannot be the service coordinator, plan developer, or plan monitor for any participant for whom the service coordinator has individual responsibility for the provision of any other care or treatment;* *(3-20-04)*~~

~~***f.*** *Must have at least six (6) months work experience both as an EPSDT service coordinator, as described in Section 530 of these rules, and as a targeted service coordinator if they are providing services for adolescents on the ISSH waiver;* *(3-20-04)*~~

~~***g.*** *Must not at any time have a total caseload so large as to violate the purpose of the program or adversely affect the health and welfare of any participant served by the service coordinator.* *(3-20-04)*~~

~~***h.*** *Paraprofessionals may be used to assist in the implementation of the plan of service. They may not be paid plan developers or plan monitors. Paraprofessionals must meet the following qualifications:* *(3-20-04)*~~

~~*i.* *Be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.);* *(3-20-04)*~~

~~*ii.* *Be able to read and write at a level commensurate with the general flow of paperwork and forms; and* *(3-20-04)*~~

~~*iii.* *Complete a training program developed by the Department and be working under the supervision of a fully qualified targeted service coordinator.* *(3-20-04)*~~

~~*iv.* *All paraprofessionals must satisfactorily complete the Department's criminal history check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks".* *(3-20-04)*~~

~~***05.*** ***Participant's Choice****. The participant may choose to receive or not to receive TSC services. The participant has the choice of:* *(3-20-04)*~~

~~***a.*** *Developing and monitoring his own plan of service, with the choice of still using the services described in Subsection 118.02.a. of these rules; or* *(3-20-04)*~~

~~***b.*** *Using the targeted service coordinator for plan development, monitoring, and service coordination; or* *(3-20-04)*~~

~~***c.*** *Selecting a non-paid plan developer, and receiving plan monitoring and service coordination by a targeted service coordinator; or* *(3-20-04)*~~

~~***d.*** *Selecting a non-paid plan developer and a non-paid plan monitor and not receiving service coordination.* *(3-20-04)*~~

~~***06.*** ***Payment for Services****. Payment for services includes the following conditions:* ***(3-20-04)***~~

~~***a.*** *Service coordination includes coordinating services and plan monitoring paid at a monthly rate.* ***(3-20-04)***~~

~~***b.*** *Plan development is paid as a separate service on an hourly basis.* ***(3-20-04)***~~

~~***c.*** *Plan monitoring is paid as a separate service on an hourly basis when there is no service coordination.* ***(3-20-04)***~~

~~***d.*** *Targeted service coordinators, plan developers, and plan monitors may not deliver or be paid for direct services.* ***(3-20-04)***~~

~~***e.*** *Payment will not be made for TSC services provided to individuals who are inpatients in NFs, ICFs/MR, or hospitals, except as follows.* ***(3-20-04)***~~

~~*i.* *Medicaid will reimburse for TSC on the same date a participant is admitted or discharged from NF, ICF/MR or other institutional setting, as long as the participant is not yet admitted or has been discharged at the time of the service delivery.* ***(3-20-04)***~~

~~*ii.* *TSC may be provided during the last thirty (30) days of inpatient stay or when the inpatient stay is not expected to last longer than thirty (30) days when not duplicating those services included in the responsibilities of the facility.* ***(10-1-94)***~~

~~***f.*** *The Department will not provide Medicaid reimbursement for on-going TSC services delivered prior to the completion of assessments and plan of service.* ***(3-20-04)***~~

~~***g.*** *Medicaid reimbursement will be provided only for the following TSC services:* ***(10-1-94)***~~

~~*i.* *Face-to-face contact between the service coordinator and the participant, the participant's family members, guardian, service providers, legal representatives, primary caregivers, or other interested persons;* ***(3-20-04)***~~

~~*ii.* *Telephone contact between the service coordinator and the participant, the participant's family, guardian, service providers, legal representatives, primary caregivers, or other interested persons;* ***(3-20-04)***~~

~~*iii.* *Plan development, review, and addenda as needed, if the service coordinator is chosen as the plan developer;* ***(3-20-04)***~~

~~***h.*** *The provider will provide the Department with access to all information required to review compliance with these rules.* ***(1-7-94)***~~

~~***i.*** *Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both.*~~

~~*(1-7-94)*~~

~~***j.*** *The Department will not provide Medicaid reimbursement for TSC provided to a group of individuals.* *(10-1-94)*~~

~~***k.*** *The TSC agency must release all pertinent information to direct service providers when written informed consent is obtained from the participant.* *(3-20-04)*~~

~~***l.*** *The targeted service coordinator may be paid separately for community crisis supports as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services".* *(3-20-04)*~~

~~***07.*** **Record Requirements**. *In addition to the development and maintenance of the plan of service, the following documentation must be maintained by the provider:* *(3-20-04)*~~

~~***a.*** *Name of participant;* *(3-20-04)*~~

~~***b.*** *Name of provider agency and person providing the service;* *(1-7-94)*~~

~~***c.*** *Date, time, and duration of service;* *(1-7-94)*~~

~~***d.*** *Place of service delivery;* *(1-7-94)*~~

~~***e.*** *Activity record describing the service(s) provided;* *(1-7-94)*~~

~~***f.*** *Documented review of progress toward each service plan goal, and assessment of the participant's need for TSC and other services as the participant's needs change;* *(3-20-04)*~~

~~***g.*** *Documentation using the Department-required form justifying the provision of community crisis supports to the participant; and* *(3-20-04)*~~

~~***h.*** *An informed consent form clearly explaining the purpose of the TSC and signed by the participant or legal guardian.* *(3-20-04)*~~

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Personal Assistance Agency (PAA). A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-

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

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; (3-20-04)

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; (3-20-04)

c. Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; (3-20-04)

d. Provision of a licensed professional nurse (RN) or, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; (3-20-04)

e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (3-20-04)

f. Assuring that all personal assistants meet the qualifications in Subsection 146.09 of these rules; (3-20-04)

g. Billing Medicaid for services approved and authorized by the RMS; (3-20-04)

h. Making referrals for PCS-eligible participants for ~~*case management*~~ service~~s~~ coordination as described in IDAPA 16.03.17, "Service Coordination," when a need for these services is identified; and ~~*(3-20-04)*~~( )

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

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

a. Financial Eligibility. The participant must be financially eligible for Medical Assistance (MA) under IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families

and Children" or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled". (3-20-04)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Basic personal care and grooming to include bathing, care of the hair, assistance

with clothing, and basic skin care; (3-20-04)

b. Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines; (3-20-04)

c. Assisting the participant with physician-ordered medications that are ordinarily self-administered, such as opening the packaging or reminding the participant to take medications; (3-20-04)

d. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (3-20-04)

e. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the developmentally disabled participant; (3-20-04)

f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met: (3-20-04)

i. The task is not complex and can be safely performed in the given participant care situation; (3-20-04)

ii. A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs; (3-20-04)

iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly; (3-20-04)

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN; (3-20-04)

v. The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN and must be readily available for review, preferably with the participant's record; and (3-20-04)

vi. Routine medication may be given by the personal assistant through the non-nasogastric tube if authorized by the supervising RN. (3-20-04)

g. The provider is excluded from delivering the following services: (3-20-04)

i. Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; (3-20-04)

ii. Insertion or sterile irrigation of catheters; (3-20-04)

iii. Injecting fluids into the veins, muscles or skin; and (3-20-04)

iv. Administering medication. (3-20-04)

05. Non-Medical Care and Services Provided. PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 146.04.a. through 146.04.f. of this rule, the provider may also perform the following services: (3-20-04)

a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded. (3-20-04)

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

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

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

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

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

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

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

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

i. The physician's or authorized provider's information, including their orders for

service; (3-20-04)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the

service coordinator or the participant. (3-20-04)

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

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

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

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

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

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

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

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

ii. The provider is enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary provider status; and (3-20-04)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. A copy of the information required in Subsections 146.13.a. through 146.13.d. of this rule must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. (3-20-04)

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

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

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

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

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

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

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

147. ~~*TARGETED CASE MANAGEMENT*~~ SERVICE COORDINATION FOR PERSONAL CARE SERVICE RECIPIENTS.
The Department will purchase ~~*case management (CM)*~~ service coordination services, as described

in IDAPA 16.03.17, "Service Coordination," for Medicaid-eligible recipients who have been approved for personal care services (PCS). Services will be provided by an organized ~~*case management*~~ service coordination provider agency who has entered into a written provider agreement with the Department. Services will be authorized in amount, scope and duration by regional Medicaid ~~*unit*~~ services (RM~~*U*~~S) staff. ~~*(10-28-90)*~~(____)

~~***01. Eligible Target Group****. Those recipients who are approved for PCS and who require and desire assistance to adequately access services necessary to maintain their own independence in the community are eligible for case management services. The scope and amount of services will be determined by the Regional Medicaid Unit based upon the individual community service plan.* *(10-28-90)***

~~***02. Service Definition****. For the purposes of providing case management services to PCS eligible recipients, case management is an individualized service provided by an employee of a qualified case management provider agency acting in the role of a coordinator of multiple services to ensure that the various needs of the individual are assessed and met. Components of case management are:* *(10-28-90)***

~~***a.*** *An assessment of the service needs of the client including information available regarding the client and a face-to-face interview with the client and significant others; and* *(10-28-90)***

~~***b.*** *The development of an individual community service plan; and* *(10-28-90)***

~~***c.*** *Arranging for and assisting with access to all services necessary to maintain the recipient in the community at the highest level of independence possible; and* *(10-28-90)***

~~***d.*** *Face-to-face contact at least every thirty (30) days with the recipient and others as necessary to coordinate and monitor the progress of the existing individual community service plan.* *(10-28-90)***

~~***03. Core Services****. The core services consist of the following:* *(10-28-90)***

~~***a.*** *Assessment. A comprehensive evaluation of the recipient's ability to function in the community including, but not limited to:* *(10-28-90)***

~~*i. Medical needs, physical problems and strengths; and* *(10-28-90)***

~~*ii. Mental and emotional problems and strengths; and* *(10-28-90)***

~~*iii. Physical living environment; and* *(10-28-90)***

~~*iv. Vocational and educational needs; and* *(10-28-90)***

~~*v. Financial and social needs; and* *(10-28-90)***

~~*vi. An evaluation of the community support system including the involvement of family or significant others; and* *(10-28-90)***

~~*vii. Safety and risk factors; and* (10-28-90)~~

~~*vii. Legal status.* (10-28-90)~~

~~***b.*** *Individual community service plan (ICSP) development. Based on the information obtained during the recipient assessment and input obtained from professionals involved with the recipient, the case manager will develop a written plan which will include at least the following:* (10-28-90)~~

~~*i. Problems identified during the assessment; and* (10-28-90)~~

~~*ii. Overall goals to be achieved; and* (10-28-90)~~

~~*iii. Reference to all services and contributions provided by the informal support system including the actions, if any, taken by the CM to develop the support system; and* (10-28-90)~~

~~*iv. Documentation of who has been involved in the service planning, including the client's involvement; and* (10-28-90)~~

~~*v. Schedules for CM monitoring and reassessment; and* (10-28-90)~~

~~*vi. Documentation of unmet need and service gaps; and* (10-28-90)~~

~~*vii. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery.* (10-28-90)~~

~~*viii. The ICSP will be reevaluated and updated by the case manager at least annually and approval continued, if appropriate, by the Regional Medical Unit.* (10-22-93)~~

~~*ix. A copy of the current ICSP will be provided to the recipient or their legal representative.* (10-28-90)~~

~~***c.*** *Linking/coordination of service. The case manager will actively advocate for services required by the client and coordinate such service delivery between multiple agencies, individuals and others.* (10-28-90)~~

~~***d.*** *Continuity of care. The case manager will monitor and evaluate the services required and received by the recipient at least every thirty (30) days and is responsible to assure that the services are delivered in accordance with the individual community service plan. If new needs are identified, then the individual community service plan will be revised and the new needs addressed.* (10-28-90)~~

~~***e.*** *The case manager will encourage the independence of the recipient by demonstrating to the individual how to best access service delivery systems such as energy assistance, legal assistance, financial assistance, etc. Such encouragement will be conducted on an ongoing basis.* (10-22-93)~~

~~***04. Record Requirements**. In addition to the development and maintenance of the individual community service plan, the following documentation must be maintained by the case management provider: (10-28-90)***~~

~~***a.** Name of recipient; and (10-28-90)***~~

~~***b.** Name of provider agency and person providing the service; and (10-28-90)***~~

~~***c.** Date and time of service; and (10-28-90)***~~

~~***d.** Place of service; and (10-28-90)***~~

~~***e.** Activity record describing the recipient and community contact; and (10-28-90)***~~

~~***f.** Signature of the recipient on the ICSP; and (10-28-90)***~~

~~***g.** Written consent and acceptance of case management services and release of information forms. (10-28-90)***~~

~~***05. Case Manager Provider Qualifications/Limitations**. All individual case managers must be employees of an organized entity that has a valid provider agreement with the Department's Bureau of Medicaid Policy and Reimbursement. (10-22-93)***~~

~~***a.** The case management agency cannot provide personal care services and case management services to the same recipient. (10-28-90)***~~

~~***b.** The employing entity will supervise individual case management providers and assure that the following qualifications are met. (10-28-90)***~~

~~*i. The individual case manager must be a licensed social worker; or licensed professional nurse (R.N.); or have at least a BA or BS in a human services field and at least one (1) year's experience in service delivery to the service population. (10-22-93)*~~

~~*ii. The individual case manager must be supervised by an individual who has at least a BA or BS degree and is a licensed social worker, psychologist or licensed professional nurse (registered nurse/RN) with at least two (2) years experience in service delivery to the service population. The supervisor will oversee the service delivery and have the authority and responsibility to remove the individual CM if the client's needs are not met. (10-28-90)*~~

~~*iii. Individual case managers will not be assigned case management responsibility for more than thirty (30) active CM clients. (10-28-90)*~~

~~*iv. The Bureau may grant a waiver of the caseload limit when requested by the agency when the following critera are met: (10-22-93)*~~

~~*(1) The availability of case management providers is not sufficient to meet the needs of the service area. (10-22-93)*~~

~~*(2) The recipient that has chosen the particular provider that has reached their limit, has just cause to need that particular manager over other available managers. (10-22-93)*~~

~~*(3) The individual case manager's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of CM service) clients. (10-22-93)*~~

~~*v. The request for waiver must include: (10-22-93)*~~

~~*(1) The time period for which the waiver is requested; and (10-22-93)*~~

~~*(2) The alternative caseload limit requested; and (10-22-93)*~~

~~*(3) Documentation that the granting of the waiver would not diminish the effectiveness of the case manager's services, violate the purposes of the program, or adversely affect the health and welfare of any of the case managers' clients. (10-22-93)*~~

~~*vi. The Bureau may impose any conditions, including limiting the duration of a waiver, which it deems necessary to ensure the quality of case management services provided. (10-22-93)*~~

~~***06. CM Agency Responsibilities**. The CM agency must demonstrate prior to approval of provider status by the Department: (10-28-90)*~~

~~***a.** The capacity to provide all case services as required in Subsection 147.03; and (12-31-91)*~~

~~***b.** Experience with the target population. If a limited segment of the population will be served, such specialization must be indicated; and (10-28-90)*~~

~~***c.** Appropriate personnel practices including, but not limited to: (10-28-90)*~~

~~*i. Conduct an orientation program for all new employees which covers at least the local resources available, case management service delivery, confidentiality of information and client rights. (10-28-90)*~~

~~*ii. Sufficient staff to meet the CM service needs of the target population; and (10-28-90)*~~

~~*iii. Provider screening and hiring practices which assure provider qualifications in accordance with Subsection 147.05; and (12-31-91)*~~

~~*iv. Qualified supervision of individual CM staff; and (10-28-90)*~~

~~*v. An administration system which will assume adequate documentation of cases and services. (10-28-90)*~~

~~***07. Recipient's Choice**. The eligible recipient will have free choice of case*~~

~~*management providers as well as the providers of medical and other services under the case management program.* *(10-28-90)*~~

~~***08.*** ***Payment for Services****. The scope, duration and total hours of case management services to be reimbursed by the Medicaid Program will be authorized by the Department's regional Medicaid program staff.* *(10-28-90)*~~

~~***a.*** *Payment for case management services will not duplicate payment made by any other private or public reimbursement source to the provider for the same purpose.* *(10-28-90)*~~

~~***b.*** *The initial evaluation and ICSP development will be authorized by the RMU and paid using a fee-for-service established by the Department's Bureau of Medicaid Policy and Reimbursement. The RMU may also authorize up to eight (8) hours of service delivery at the time that the evaluation and care plan is authorized.* *(10-28-90)*~~

~~***c.*** *Ongoing CM services will be authorized by the RMU and paid utilizing an hourly rate for service delivery. The amount to be paid will be established by the Department's Bureau of Medicaid Policy and Reimbursement. This rate will include travel costs.* *(10-28-90)*~~

~~***d.*** *Medicaid program reimbursement for CM services is limited to eight (8) hours of service delivery per client per month. Additional hours may be authorized in writing by the RMU based on documentation of client need by the provider or client.* *(10-28-90)*~~

~~***e.*** *Failure to provide services for which reimbursement has been received or to maintain records as required in Subsection 147.04 will be cause for recoupment of payments for the services.* *(12-31-91)*~~

~~***f.*** *Individuals requiring and desiring case management services will be identified by the regional Medicaid program personnel during the approval process for personal care services based on referrals from individual supervising nurses and/or PCS provider agencies. Individuals will be identified based on their medical, social and family situation. The scope, duration and total hours of case management services to be provided will be based upon the needs as determined in the ICSP. Case management services will not be provided to individuals who choose to direct and obtain their own services within the community.* *(10-28-90)*~~

~~***g.*** *Individuals who are identified by the RMU as not meeting the criteria for inclusion in the target population and are therefore not eligible for CM services may appeal such action utilizing procedures contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Section 301, et seq., "Rules Governing Contested Case Proceedings and Declaratory Rulings".* *(7-1-94)*~~

(BREAK IN CONTINUITY OF SECTIONS)

476. ~~*TARGETED CASE MANAGEMENT*~~ <u>SERVICE COORDINATION</u> FOR THE MENTALLY ILL.

The Department will purchase ~~*case management (CM)*~~ service coordination services, as described in IDAPA 16.03.17, "Service Coordination," for adult Medicaid recipients with severe disabling mental illness. Services will be provided by an organized provider agency that has entered into a provider agreement with the Department. The purpose of these services is to assist eligible individuals to gain access to needed medical, social, educational, mental health and other services. ~~*(3-20-04)*~~( )

~~***477. ELIGIBLE TARGET GROUP.***~~
~~*Only those individuals who are mentally ill and eighteen (18) years of age or older who are using or have a history of using high-cost medical services associated with exacerbations of mental illness are eligible for CM services.*~~ ~~*(3-20-04)*~~

~~***01. Diagnostic and Functional Criteria****. The following diagnostic and functional criteria will be applied to determine membership in this target population:*~~ ~~*(3-30-01)*~~

~~***a.*** *Diagnosis: A condition of severe and persistent mental illness determined by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under state law, and be a diagnosis listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) within one (1) of the following classification codes for:*~~ ~~*(3-30-01)*~~

~~*i. Schizophrenia and Other Psychotic Disorders;*~~ ~~*(3-30-01)*~~

~~*ii. Organic mental disorders associated with Axis III physical disorders or conditions, or whose etiology is unknown;*~~ ~~*(3-30-01)*~~

~~*iii. Mood disorders - bipolar and depressive;*~~ ~~*(3-30-01)*~~

~~*iv. Schizoid, Schizotypal, Paranoid, and Borderline Personality disorders.*~~ ~~*(3-20-04)*~~

~~*v. If the only diagnosis is one (1) or more of the following, the person is not included in the target population for CM services:*~~ ~~*(8-1-92)*~~

~~*(1) Mental retardation; or*~~ ~~*(8-1-92)*~~

~~*(2) Alcoholism; or*~~ ~~*(8-1-92)*~~

~~*(3) Drug abuse.*~~ ~~*(8-1-92)*~~

~~***b.*** *Functional limitations: The psychiatric disorder must be of sufficient severity to cause a disturbance in the role performance or coping skills in at least two (2) of the following areas, on either a continuous (more than once per year) or an intermittent (at least once per year) basis:*~~ ~~*(8-1-92)*~~

~~*i. Vocational or academic: Is unemployed, unable to work or attend school, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history.*~~ ~~*(8-1-92)*~~

~~*ii. Financial: Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help, or the person is unable to support him or manage his finances without assistance. (8-1-92)*~~

~~*iii. Social/interpersonal: Has difficulty in establishing or maintaining a personal social support system, has become isolated, has no friends or peer group and may have lost or failed to acquire the capacity to pursue recreational or social interests. (8-1-92)*~~

~~*iv. Family: Is unable to carry out usual roles and functions in a family, such as spouse, parent, or child, or faces gross familial disruption or imminent exclusion from the family. (8-1-92)*~~

~~*v. Basic living skills: Requires help in basic living skills, such as hygiene, food preparation, or other activities of daily living, or is gravely disabled and unable to meet daily living requirements. (8-1-92)*~~

~~*vi. Housing: Has lost or is at risk of losing his current residence. (8-1-92)*~~

~~*vii. Community: Exhibits inappropriate social behavior or otherwise causes a public disturbance due to poor judgment, bizarre, or intrusive behavior which results in intervention by law enforcement and/or the judicial system. (8-1-92)*~~

~~*viii. Health: Requires substantial assistance in maintaining physical health or in adhering to medically rigid prescribed treatment regimens, e.g. brittle diabetic. (3-30-01)*~~

~~***02. Recipient's Residence**. Recipients may reside in adult foster care, residential care, semi-independent living, room and board or their own homes. (3-30-01)*~~

~~***03. Other Services**. Recipients may be receiving homemaker, personal care, home health, respite or other services. (3-30-01)*~~

~~***04. Hospice Services**. Recipients who elect hospice services as found in Section 104, or are receiving case management services through another program are excluded from CM services. (3-30-01)*~~

~~***478. CASE MANAGEMENT SERVICES.***~~
~~*CM services shall be designed to foster independence and be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational and social services in the least restrictive, most appropriate and most cost-effective setting. CM services shall consist of the following core functions: (3-20-04)*~~

~~***01. Assessment**. A CM provider must have the capacity to perform written comprehensive assessments of a person's assets, deficits and needs. Assessment is an interactive process with the maximum feasible involvement of the recipient. Should the assessments reveal that the person does not need CM services, appropriate referrals will be made to meet other needs of the participant. All the following areas must be evaluated and addressed: (3-30-01)*~~

~~***a.** Psychiatric history and current mental status: Includes but is not limited to age of*~~

~~*onset, childhood history of physical or sexual abuse, number of hospitalizations, precursors of hospitalizations, symptoms of decompensation that the client manifests, is the client able to identify his symptoms, medication history; substance abuse history, history of mental illness in the family, current mental status observation, any other information that contributes to their current psychiatric status; and* (10-22-93)~~

~~***b.*** *Medical history and current medical status: Includes but is not limited to history of any major non-psychiatric illnesses, surgeries, hospitalizations, dates of last physical, dental, or eye examinations, pertinent family history of medical illness, current health problems/needs, current medications; name of current physician; and* (10-22-93)~~

~~***c.*** *Vocational status: Includes but is not limited to current and past job status, level of satisfaction with the vocation, educational level, military status, strengths and barriers to employment; and* (10-22-93)~~

~~***d.*** *Financial status: Includes but is not limited to adequacy and stability of the client's financial status, what difficulties they perceive with it, what resources may be available, client's ability to manage personal finances; and* (10-22-93)~~

~~***e.*** *Social relationships/support: Includes but is not limited to client's ability to establish/maintain personal support systems or relationships, client's ability to acquire leisure, recreational, or social interests; and* (10-22-93)~~

~~***f.*** *Family status: Includes but is not limited to: client's ability or desire to carry out family roles, client's perception of the support he receives from their family, what role does the family play in the client's mental illness; and* (10-22-93)~~

~~***g.*** *Basic living skills: Includes but is not limited to client's ability to meet their basic living needs, what does the client want to accomplish in this area; and* (10-22-93)~~

~~***h.*** *Housing: Includes but is not limited to: current living situation and level of satisfaction with the arrangement, is present situation appropriate to the client's needs; and* (8-1-92)~~

~~***i.*** *Community/Legal status: Includes but is not limited to legal history with law enforcement, transportation needs, supports the client has in the community, daily living skills necessary for community living.* (8-1-92)~~

~~***02.*** **Service Plan Development and Implementation**. *Following the assessment(s) and determination of need for CM, a written service plan shall be developed and implemented as a vehicle to address the case management needs of the recipient. To the maximum extent possible, the development of a service plan shall be a collaborative process involving the recipient, his family or other support system, and the CM provider. The written service plan shall be developed within thirty (30) calendar days of when the recipient chooses the agency as his provider and must be signed by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under State law according to Title 54, Chapter 18, Idaho Code, indicating the services are medically necessary, and must include, at a minimum:* (3-20-04)~~

~~***a.*** *A list of focus problems identified during the assessments; and* *(8-1-92)*~~

~~***b.*** *Concrete, measurable goals to be achieved, including time frames for achievement; and* *(8-1-92)*~~

~~***c.*** *Specific plans directed toward the achievement of each one of the goals; and* *(8-1-92)*~~

~~***d.*** *Documentation of who has been involved in the service planning; the recipient, if possible, must be involved. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided as to why this was not possible. A copy of the plan must be given to the recipient; and* *(8-1-92)*~~

~~***e.*** *Reference to any formal services arranged, including specific providers where applicable; and* *(8-1-92)*~~

~~***f.*** *Planned frequency of services initiated.* *(8-1-92)*~~

~~***03.*** ***Crisis Case Management****. Crisis case management services are linking, coordinating and advocacy services provided to assist a recipient with accessing emergency community resources in order to resolve a crisis. Crisis case management services do not include crisis counseling, transportation to emergency service providers, direct skills building services, or encouragement of independence as identified in Subsection 478.05 of these rules. The crisis must be precipitated by an unanticipated event, circumstance, or life situation that places a recipient at risk of:* *(3-20-04)*~~

~~***a.*** *Hospitalization; or* *(3-20-04)*~~

~~***b.*** *Incarceration; or* *(3-20-04)*~~

~~***c.*** *Becoming homeless; or* *(3-20-04)*~~

~~***d.*** *Losing employment or major source of income; or* *(3-20-04)*~~

~~***e.*** *Physical harm to self or others, including family altercation or psychiatric relapse.* *(3-20-04)*~~

~~***04.*** ***Linking/Coordination of Services****. Through negotiation and referrals, the case manager links the recipient to various providers of services/care and coordinates service delivery. Coordination of service delivery includes activities such as: assuring that needed services have been delivered, consulting with service providers to ascertain whether they are adequate for the needs of the recipient, and consulting with the client to identify the need for changes in a specific service or the need for additional services. The case manager may refer to his own agency for services but may not restrict the recipient's choice of service providers. It may be necessary to mobilize more than one set of resources to make adequate services available. The case manager may be needed to act as an advocate for the recipient. There must be a minimum of one face-to-face contact with the recipient at least every thirty (30) days.* *(10-22-93)*~~

~~***05. Case Manager**. The case manager will encourage independence of the recipient by demonstrating to the individual how to best access service delivery systems such as transportation and Meals on Wheels, etc. Such assistance must be directed toward reducing the number of case management hours needed. Such assistance is limited to thirty (30) days per service delivery system. (3-30-01)*~~

~~***479. (RESERVED).***~~

~~***480. CM PROVIDER AGENCY QUALIFICATIONS.***~~
~~*Case management provider agencies must meet the following criteria: (8-1-92)*~~

~~***01. Intake/Pre-Screening**. Utilization of a standardized intake and prescreening process for determining whether or not Medicaid eligible individuals are included in the target group for case management services. Prescreening must be effective in sorting out who does and who does not need a full assessment of needs for CM. (3-30-01)*~~

~~***02. Core Elements**. Demonstrated capacity in providing all core elements of case management services to the target population including: (3-30-01)*~~

~~***a.** Comprehensive assessment; and (8-1-92)*~~

~~***b.** Comprehensive service plan development and implementation; and (8-1-92)*~~

~~***c.** Crisis case management services which include arranging access to emergency community resources; and (3-20-04)*~~

~~***d.** Linking/coordination of services; and (8-1-92)*~~

~~***e.** Encouragement of independence. (10-22-93)*~~

~~***481. PROVIDER QUALIFICATIONS.***~~
~~*All individual CM providers must be employees of an organized provider agency that has a valid CM provider agreement with the Department. The employing entity will supervise individual CM providers and assure that the following qualifications are met for each individual CM provider. A provider must be a(n): (3-20-04)*~~

~~***01. Psychiatrist**. Psychiatrist, M.D., D.O.; or (3-20-04)*~~

~~***02. Physician**. Physician, M.D., D.O.; or (3-20-04)*~~

~~***03. Licensed Psychologist**. Licensed Psychologist; or (3-20-04)*~~

~~***04. Psychologist Extender**. Psychologist Extender who is registered with the Bureau of Occupational Licenses; or (3-20-04)*~~

~~***05. Social Worker**. Social worker with a valid Idaho social work license issued by the Board of Social Work Examiners; or (3-20-04)*~~

~~***06.*** ***Nurse****. Nurse, R.N.; or* ***(3-20-04)***~~

~~***07.*** ***Licensed Clinical Professional Counselor****. Licensed Clinical Professional Counselor; or* ***(3-20-04)***~~

~~***08.*** ***Licensed Marriage and Family Therapist****. Licensed Marriage and Family Therapist; or* ***(3-20-04)***~~

~~***09.*** ***Clinician****. Clinician employed by a state agency and who meets the requirements of the Division of Human Resources and the Personnel Commission; or* ***(3-20-04)***~~

~~***10.*** ***Holder of a Bachelor's Degree in a Human Services Field****. Individual having a B.A. or B.S. in a human services field and at least one (1) year experience with the target population. Individuals without the one (1) year of experience may gain this experience by working for one (1) year under the supervision of a fully-qualified case manager.* ***(3-20-04)***~~

~~***482. RECIPIENT'S CHOICE.***~~
~~*The eligible recipient will be allowed to choose whether or not he desires to receive CM services. All recipients who choose to receive CM services will have free choice of CM providers as well as the providers of medical and other services under the Medicaid program.* ***(8-1-92)***~~

~~***483. PAYMENT FOR SERVICES.***~~
~~*When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as CM services, however, the actual provision of the service does not constitute CM. Medicaid will reimburse only for core services (Section 480 of these rules) provided to members of the eligible target group by qualified staff.* ***(3-20-04)***~~

~~***01.*** ***Duplication****. Payment for CM will not duplicate payment made to public or private entities under other program authorities for the same purpose.* ***(3-30-01)***~~

~~***02.*** ***Inpatients****. Payment will not be made for CM services provided to individuals who are inpatients in nursing homes or hospitals.* ***(3-30-01)***~~

~~***03.*** ***Evaluation/Service Plan Development****. Reimbursement for the initial evaluation and individual service plan development shall be paid based on an hourly rate, not to exceed six (6) hours. The rate will be established by the Department.* ***(3-20-04)***~~

~~***04.*** ***Case Management****. Reimbursement for on-going case management services shall be at a rate established by the Department.* ***(3-20-04)***~~

~~***05.*** ***Reimbursement****. Medicaid reimbursement shall be provided only for the following case management services:* ***(3-30-01)***~~

~~***a.*** *Face-to-face contact between the case manager and the recipient, no less than every thirty days;* ***(3-30-01)***~~

~~***b.*** *Telephone contact between the case manager and the recipient, the recipient's*~~

~~*mental health and other service providers, a recipient's family members, primary caregivers, legal representative, or other interested persons;* (8-1-92)~~

~~***c.*** *Face-to-face contacts between the case manager and the recipient's family members, legal representative, primary caregivers, mental health providers or other service providers, or other interested persons;* (8-1-92)~~

~~***d.*** *Development, review, and revision of the recipient's individual service plan, including the case manager's functional assessment of the recipient.* (8-1-92)~~

~~***06.*** ***Services Delivered Prior to Assessment****. The Department will not provide Medicaid reimbursement for on-going non-crisis case management services delivered prior to the completion of the assessments and individual service plan.* (3-20-04)~~

~~***07.*** ***Crisis Case Management****. The Department will provide Medicaid reimbursement for crisis case management services identified under Subsection 478.03 of these rules. Crisis case management services may be delivered prior to, or after, the completion of the assessment and individual service plan. Without authorization by the Department or its designee, crisis case management services are limited to a total of three (3) hours per calendar month. The Department or its designee may authorize additional crisis case management services beyond the three (3) hour limit if a recipient still has severe or prolonged crisis case management needs that meet all of the following criteria:* (3-20-04)~~

~~***a.*** *The service recipient is at imminent risk (within fourteen (14) days) of hospitalization or institutionalization, including jail or nursing home; and* (3-20-04)~~

~~***b.*** *The service recipient is experiencing symptoms of psychiatric decompensation; and* (3-20-04)~~

~~***c.*** *The service recipient has already received the maximum number of monthly hours of ongoing case management and crisis case management services; and* (3-20-04)~~

~~***d.*** *No other crisis assistance services are available to the recipient under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR).* (3-20-04)~~

~~***08.*** ***Audit Reviews****. Audit reviews will be conducted at least once a calendar year by the Department or its designee. Review findings may be referred to the Department's Surveillance and Utilization Review Section for appropriate action.* (3-20-04)~~

~~***09.*** ***Recoupment****. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both.* (3-30-01)~~

~~***10.*** ***Information****. The provider will provide the Department with access to all information required to review compliance with these rules.* (3-30-01)~~

~~***11. Group Case Management**. The Department will not provide Medicaid reimbursement for case management services provided to a group of recipients. (3-30-01)***~~

~~***12. Case Management in a Facility**. Medicaid will reimburse for case management services on the same date a recipient is admitted or discharged from a hospital, nursing facility, or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of service delivery. Services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those included in the responsibilities of the facility. (3-30-01)***~~

~~***13. On-Going Non-Crisis Case Management**. On-going non-crisis case management services are limited to a total of five (5) hours per calendar month. (3-20-04)***~~

~~***484. RECORD REQUIREMENTS.***~~
~~*In addition to the development and maintenance of the service plan, the following documentation must be maintained by the provider: (8-1-92)*~~

~~***01. Name**. Name of recipient. (3-30-01)***~~

~~***02. Provider**. Name of the provider agency and person providing the service.(3-30-01)***~~

~~***03. Diagnosis**. Diagnosis, contained in Subsection 477.01.a. of these rules, documented by a qualified physician or other licensed practitioner of the healing arts within the scope of his practice under state law, prior to assessment. (3-20-04)***~~

~~***04. Date**. Date, time, and duration of service. (3-30-01)***~~

~~***05. Place of Service**. Place of service. (3-30-01)***~~

~~***06. Activity Record**. Activity record describing the recipient and the service provided. The activity record must also include the dated signature and credential(s), including professional license(s), of the service provider. (3-20-04)***~~

~~***07. Documentation**. Documented review of progress toward each CM service plan goal, and assessment of the recipient's need for CM and other services at least every one hundred eighty (180) days. Documentation to support authorization of crisis case management services beyond the monthly limitation must be submitted to the Department or its designee before such authorization may be granted. Documentation to support delivery of crisis case management services must also be maintained in the recipient's agency record and must include: (3-20-04)***~~

~~***a.** A description of the crisis including identification of unanticipated event(s) that precipitate the need for crisis case management services; and (3-20-04)***~~

~~***b.** A brief review of case management and other services or supports available to, or already provided to, the recipient to resolve the crisis; and (3-20-04)***~~

~~***c.** A crisis resolution plan; and (3-20-04)***~~

~~***d.*** *Outcomes of crisis case management service provision.* *(3-20-04)*~~

~~***08.*** ***Informed Consent****. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of case management.* *(3-30-01)*~~

4~~85~~77. -- 499. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

530. EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICE COORDINATION.
The Department will purchase ~~*case management services hereafter referred to as* S~~service ~~C~~coordination ~~*(SC)*~~ services as described in IDAPA 16.03.17, "Service Coordination," for Medicaid eligible children age birth to twenty-one (21) years of age who meet medical necessity criteria. ~~*(10-1-94)*~~(____)

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

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

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

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

~~*iii. Children who have been diagnosed with a severe emotional/behavioral disorder under DSM-IV or subsequent revisions or another classification system used by the Department; and expected duration of the condition is at least one (1) year or more.* *(5-24-95)*~~

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

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

~~*ii. The condition has resulted in a level of functioning below age norm in one (1) or*~~

~~*more life areas, such as school, family, or community; or* *(10-1-94)*~~

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

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

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

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

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

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

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

~~***c.** Evaluation, which is the process of determining whether outcomes have been reached on the service plan, the need for additional revised outcomes, the need for a new plan, or if services are no longer needed. Evaluation is accomplished through periodic in-person reassessment of the child, consultation with the child's family, and consultation and updated assessment from other providers. The addition of new services to the plan or increase in the amount of an authorized service on the existing plan must be authorized by the Department prior to implementation.* *(5-24-95)*~~

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

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

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

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

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

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

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

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

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

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

~~***e.** At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any children served by the service coordinator. (3-20-04)***

~~***05. Recipient's Choice**. The eligible child's family, custodian, or legal guardian will be allowed to choose whether or not they desire to receive SC services. All eligible children and their families who choose to receive SC services will have free choice of qualified SC providers as well as the qualified providers of medical and other services under the Medicaid program. (10-1-94)***

~~***06. Payment for Services**. When a recipient is enrolled in managed care/Healthy Connections, the referral for assessment and services must be authorized by primary care providers. When an assessment indicates the need for medical, advocacy, psychiatric, social, educational, early intervention or other services, referral or arrangement for such services may***

~~*be included as SC services; however, the actual provision of the service does not constitute SC. Medicaid will reimburse for SC services only when ordered by a physician/nurse practitioner/ physician assistant and provided by qualified staff of an approved provider agency or their contractor to eligible children who meet the medical necessity criteria.* (5-24-95)~~

~~***a.*** *Payment for SC will not duplicate payment made to public or private entities under other program authorities for the same purpose.* (10-1-94)~~

~~***b.*** *Payment will not be made for SC services provided to children who are inpatients in nursing facilities or hospitals, other than activities performed within the last thirty (30) days of residence which are directed toward discharge and do not duplicate services included in the facility's content of care.* (10-1-94)~~

~~***c.*** *Reimbursement for ongoing SC services shall be paid at rates established by the Department or its designee.* (3-20-04)~~

~~***d.*** *Medicaid reimbursement shall be provided only for the following SC services:* (10-1-94)~~

~~*i.* *Face to face contact between the service coordinator and the eligible child, the child's family members, custodian, legal representative, primary care givers, service providers, or other interested groups or persons;* (10-1-94)~~

~~*ii.* *Telephone contact between the service coordinator and the child, the child's service providers, the child's family members, custodian or legal guardian, primary caregivers, legal representative, or other interested persons.* (10-1-94)~~

~~***e.*** *Except for crisis assistance the Department will not provide Medicaid reimbursement for ongoing SC services delivered prior to development of the plan by the Department.* (10-1-94)~~

~~***f.*** *Audit reviews will be completed by the Department.* (10-1-94)~~

~~***g.*** *Plans must be reviewed, updated as needed and re-authorized by the Department/ Contractor at least annually. Documentation of provision of services will be reviewed and progress toward expected outcomes will be evaluated. Documentation of satisfaction with services and supports will be obtained from parents, family and guardians.* (10-1-94)~~

~~***h.*** *Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both.* (10-1-94)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

669. DEFINITIONS <u>FOR WAIVER SERVICES FOR AGED OR DISABLED ADULTS</u>. The following definitions apply to Sections 664 through 704 of the rules: ~~*(4-5-00)*~~(____)

01. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. (4-5-00)

02. Personal Assistance Agency That Provides Fiscal Intermediary (FI) Services. A personal assistance agency that focuses on fostering participant independence and personal control of services delivered. The core tasks are: (3-30-01)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-30-01)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-30-01)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-30-01)

d. To collect any participant participation due; (3-30-01)

e. To pay personal assistants and other waiver service providers for service; (3-30-01)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-30-01)

g. To offer a full range of services and perform all services contained in a written agreement between the participant and the provider; (3-30-01)

h. Make referrals for PCS eligible participant for ~~*case management*~~ service~~s~~ coordination when a need for such services is identified; and ~~*(3-30-01)*~~( )

i. Obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (3-30-01)

03. Fiscal Intermediary Services. Services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (3-30-01)

04. Individual Service (IS) Plan. A document which outlines all services including, but not limited to, personal assistance services and IADLs, required to maintain the individual in his home and community. The plan is initially developed by the RM~~*U*~~S or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the RM~~*U*~~S and all Medicaid reimbursable services must be contained in the plan. ~~*(3-30-01)*~~( )

05. Personal Assistance Agency or Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for the care given, and provides payroll, including all required withholding for federal and state tax purposes, and benefits for care providers working for them. They also bill Medicaid for services provided by employees, and collect participant contribution. (3-30-01)

06. Employer of Record. An entity which bills for services, withholds required taxes, and conducts other administrative activities for a waiver program participant. Such an entity is also called a personal assistance agency functioning as a fiscal intermediary. (3-30-01)

07. Employer of Fact. A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver program provider. This individual may be a family member. (4-5-00)

08. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program. (4-5-00)

670. SERVICES PROVIDED.

01. Services Provided Under Waiver. Services that may be provided under the waiver are: (4-5-00)

a. Adult day care; (3-30-01)

b. Assistive technology; (4-5-00)

c. Assisted transportation; (4-5-00)

d. Attendant care; (4-5-00)

e. ~~*Case management*~~ Service coordination; ~~*(3-30-01)*~~(____)

f. Chore services; (4-5-00)

g. Adult companion; (4-5-00)

h. Adult residential care; (4-5-00)

i. Consultation; (4-5-00)

j. Home delivered meals; (4-5-00)

k. Homemaker; (4-5-00)

l. Home modifications; (4-5-00)

m. Personal emergency response system; (4-5-00)

n. Psychiatric consultation; (4-5-00)

o. Respite care; and (4-5-00)

p. Skilled nursing. (4-5-00)

02. Administrative Case Management. The Department will also provide administrative case management. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

672. PROVIDER QUALIFICATIONS.
Each provider must have a signed provider agreement with the Department for each of the services it provides. (4-5-00)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations where no agency exists, or no FI is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by an agency or FI is still not available. (3-30-01)

02. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks/activities in the Department's approved Aged and Disabled waiver as approved by the Health Care Financing Administration (HCFA). (3-30-01)

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (3-30-01)

b. For the purposes of Section 672, a relative is defined as a spouse or parent of a minor child. (3-30-01)

03. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (4-5-00)

04. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (4-5-00)

05. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (4-5-00)

a. A master's degree in a behavioral science; (4-5-00)

b. Be licensed in accordance with state law and regulations; or (4-5-00)

c. Have a bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (4-5-00)

06. ~~***Case Management***~~ **Service Coordination**. ~~*Case managers*~~ Service coordinators

and ~~*case management*~~ service coordination agencies will meet the same requirements as PCS ~~*case managers*~~ service coordinators specified in ~~*Section 147*~~ IDAPA 16.03.17, "Service Coordination," unless specifically modified by another section of these rules. ~~*(3-30-01)*~~( )

07. Consultation Services. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (3-30-01)

08. Adult Residential Care Providers. The facility will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. (4-5-00)

09. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (4-5-00)

a. Supervising the direct service; (4-5-00)

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (4-5-00)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (4-5-00)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (4-5-00)

e. Being inspected and licensed as a food establishment by the district health department. (4-5-00)

10. Personal Emergency Response Systems. Providers must have a Land Mobile License from the Federal Communications Commission (FCC). (3-30-01)

(BREAK IN CONTINUITY OF SECTIONS)

692. ~~*CASE MANAGEMENT*~~ SERVICE COORDINATION.
~~*Case management*~~ Service coordination includes all of the activities contained in ~~*Subsection 147.03 of these rules*~~ IDAPA 16.03.17, "Service Coordination," Sections 250, 300 and 400. Such services are designed to foster independence of the participant, and will be time limited.
~~*(3-30-01)*~~( )

01. Service Care. All services will be provided in accordance with an Individual Service Plan, which will take the place of the Individual Community Service Plan found in ~~*Subsection 147.03.b*~~ IDAPA 16.03.17, "Service Coordination," Section 400. All services will be incorporated into the Individual Service plan and authorized by the RM~~*U*~~S. ~~*(3-30-01)*~~( )

02. Requirements for an FI. Participants of PCS will have one (1) year from the date which services begin in their geographic region, as described in Section 667 of these rules, to obtain the services of an FI and become an employee in fact or to use the services of an agency unless the provisions of Subsection 670.01 are met. Provider qualifications are in accordance with Subsections 147.05 and 147.06. (3-30-01)

03. Notification by ~~*Case Manager*~~ Service Coordinator. The ~~*case manager*~~ service coordinator will notify the RM~~*U*~~S, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. ~~*(3-30-01)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

796. PROVIDER QUALIFICATIONS.
All providers of waiver services must have a valid provider agreement/performance contract with the Department. Performance under this agreement/contract will be monitored by the Regional Medicaid Services in each region. (3-20-04)

01. Residential Habilitation Service Providers. Providers of residential habilitation services must meet the following requirements: (3-20-04)

a. Direct service staff must meet the following minimum qualifications: be at least eighteen (18) years of age; be a high school graduate or have a GED or demonstrate the ability to provide services according to a Plan of Care; have current CPR and First Aid certifications; be free from communicable diseases; pass a criminal background check (when residential habilitation services are provided in a certified family home, all adults living in the home must pass a criminal background check); participate in an orientation program, including the purpose and philosophy of services, service rules, policies and procedures, proper conduct in relating to waiver participants, and handling of confidential and emergency situations that involve the waiver participant, provided by the agency prior to performing services; and have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-20-04)

b. The provider agency will be responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator, if no agency is available in their geographic area as outlined in Subsection 796.01.c. of this rule, who has demonstrated experience in writing skill training programs. Additional training requirements may also include: instructional technology; behavior technology; feeding; communication/sign language; mobility; assistance with medications (training in assistance with medications must be provided by a licensed nurse); activities of daily living; body mechanics and lifting techniques; housekeeping techniques and maintenance of a clean, safe, and healthy environment. (3-20-04)

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a Program Coordinator who has a valid ~~*case management, service coordination, or targeted*~~ service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. ~~*(3-20-04)*~~(____)

d. When residential habilitation services are provided in the provider's home, the agency must meet the environmental sanitation standards; fire and life safety standards; and building, construction and physical home standards for certification as a certified family home. Non-compliance with the above standards will be cause for termination of the provider's provider agreement/contract. (3-20-04)

02. Chore Service Providers. Providers of chore services must meet the following minimum qualifications: (7-1-99)

a. Be skilled in the type of service to be provided; and (7-1-99)

b. Demonstrate the ability to provide services according to a Plan of Care. (3-20-04)

03. Respite Care Service Providers. Providers of respite care services must meet the following minimum qualifications: (7-1-99)

a. Meet the qualifications prescribed for the type of services to be rendered, for instance. Residential Habilitation providers must be an employee of an agency selected by the waiver participant and/or the family or guardian; and (7-1-99)

b. Have received caregiving instructions in the needs of the person who will be provided the service; and (7-1-99)

c. Demonstrate the ability to provide services according to a Plan of Care; and (3-20-04)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; and (7-1-99)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (7-1-99)

f. Be free of communicable diseases; and (3-20-04)

g. Have successfully completed a traumatic brain injury training course approved by the Department. (3-20-04)

04. Supported Employment Service Providers. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury

training course approved by the Department. (3-20-04)

05. Transportation Service Providers Must: (7-1-99)

a. Possess a valid driver's license; and (7-1-99)

b. Possess valid vehicle insurance. (7-1-99)

06. Environmental Modifications Service Providers. Environmental Modifications services must: (7-1-99)

a. Be done under a permit, if required; and (7-1-99)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (7-1-99)

07. Specialized Medical Equipment and Supplies. Specialized Medical Equipment and Supplies purchased under this service must: (7-1-99)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (7-1-99)

b. Be obtained or provided by authorized dealers of the specific product where applicable. For instance, medical supply businesses or organizations that specialize in the design of the equipment. (7-1-99)

08. Personal Emergency Response Systems. Personal Emergency Response Systems must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (7-1-99)

09. Home Delivered Meal Services. Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (7-1-99)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; and (7-1-99)

b. Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; and (7-1-99)

c. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; and (7-1-99)

d. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; and (7-1-99)

e. Provide documentation of current driver's license for each driver; and (7-1-99)

f. Must be inspected and licensed as a food establishment by the District Health Department. (7-1-99)

10. Extended State Plan Service Providers. All therapy services, with the exception of physical therapy, must be provided by a provider agency capable of supervising the direct service. Providers of services must meet the provider qualifications listed in the State Plan and have taken a traumatic brain injury training course approved by the Department. (3-20-04)

11. Nursing Service Providers. Nursing Service Providers must provide documentation of current Idaho licensure as a RN or LPN in good standing and have taken a traumatic brain injury training course approved by the Department. (3-20-04)

12. Behavior Consultation/Crisis Management Service Providers. Behavior Consultation/Crisis Management Providers must meet the following: (7-1-99)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; or (3-20-04)

b. Be a licensed pharmacist; or (7-1-99)

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (7-1-99)

d. Take a traumatic brain injury training course approved by the Department. (3-20-04)

e. Emergency back-up providers must also meet the minimum provider qualifications under Residential Habilitation services. (3-20-04)

13. Day Rehabilitation Providers. Day Rehabilitation Providers must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. (3-20-04)

14. Personal Care Service Providers. Personal Care Service providers must meet the requirements outlined in IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Subsections 146.06.a. through 146.06.~~h~~c. - PCS Provider Qualifications. Providers must take a traumatic brain injury training course approved by the Department. ~~(3-20-04)~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0404

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the October 6, 2004 Idaho Administrative Bulletin, Volume 04-10, pages 354 and 355.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Chris Baylis at (208) 364-1891.

DATED this 15th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed regular rulemaking procedures. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0309-0404***
Rules Governing the Medical Assistance Program ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rulemaking:

The Department is revising Section 521 of this chapter to change the frequency of utilization control reviews of certain medicaid participants in nursing facilities from quarterly to annual. A change in Federal code allows the Department to no longer perform quarterly reviews. The term "participant" is added for consistency.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking is based on a change in Federal code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chris Baylis at (208) 364-1891.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 27, 2004.

DATED this 25th day of August, 2004.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

301. -- 3~~0~~4<u>9</u>. (RESERVED).

~~310. UTILIZATION CONTROL – NURSING FACILITIES.~~
~~The policy, rules and regulations to be followed must be those cited in 42 CFR 456.250 through 42 CFR 456.281.~~ *~~(7-1-94)~~*

~~311. – 349. (RESERVED).~~

(BREAK IN CONTINUITY OF SECTIONS)

508. -- 5~~19~~20. (RESERVED).

~~***520. ANNUAL UTILIZATION CONTROL REVIEW.***~~
~~*Title XIX recipients in a NF are subject to an on-site review by Regional Nurse Reviewers within ninety (90) days of the date of medical entitlement, and in one (1) year after medical entitlement to determine the need for continued NF care. Reviews will be conducted each calendar quarter on selected Title XIX recipients and other residents mandated by PASARR.* *(7-1-99)*~~

521. ~~*QUARTERLY*~~ UTILIZATION CONTROL REVIEWS.
Selection of ~~*recipients/residents*~~ participants to be reviewed ~~*each quarter*~~ at least annually:
~~*(7-1-99)*~~(____)

~~***01. Ninety-Day Review****. Recipients to be reviewed within ninety (90) days of date of initial medical entitlement; and* *(7-1-99)*~~

~~***02. Annual Review****. Recipients whose medical entitlement one (1) year anniversary date falls within the quarter; and* *(7-1-99)*~~

0~~3~~1. Level II ~~*Residents*~~ Participants. ~~*Recipients/residents*~~ Participants who have a Level II evaluation, with ~~*an*~~ the review completed within the quarter of the admission anniversary date ~~*that falls within the quarter*~~; and ~~*(7-1-99)*~~(____)

0~~4~~2. Special Medicaid Rate. ~~*Recipients*~~ Participants who are receiving services that require a special Medicaid rate; and ~~*(7-1-99)*~~(____)

0~~5~~3. Selected Recertification. ~~*Recipients*~~ Participants identified during previous reviews whose improvement may remove the need for continuing NF care. ~~*(7-1-99)*~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0405

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2004, Idaho Administrative Bulletin, Vol. 04-10, pages 356 through 361.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Paul Leary at (208) 364-1833.

DATED this 17th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), 56-1004(l)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Date: **Tuesday, October 12, 2004**
Time: **3:00 p.m. - 5:00 p.m.**
Place: **Region IV Office**
1720 Westgate Drive, Suite D - Room 119
Boise, Idaho

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0309-0405***
Rules Governing the Medical Assistance Program ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

The proposed amendments change the reimbursement methodology and rates used by Medicaid for ground and air ambulance services. The new reimbursement methodology will be based on a fee-for-service system that reimburses at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service on a common fee schedule used by the Department for all ambulance providers. In addition, the base rate is being adjusted to cover ancillary items and supplies that previously could be billed separately.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted prior to the publication of the proposed rule because the rule changes are being made to align the Department's rules with Medicare's reimbursement levels.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Arla Farmer at (208) 364-1833.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 27, 2004.

DATED this 25th day of August, 2004.

Sherri Kovach - Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

060. FEES AND UPPER LIMITS.

01. Inpatient Hospital Fees. In reimbursing licensed hospitals, the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for inpatient

hospital care in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho". Inpatient payments ~~*shall*~~ must not exceed the Upper Payment limit set forth in the Code of Federal Regulations. ~~*(7-1-97)*~~(____)

02. Outpatient Hospital Fees. The Department will not pay more than the combined payments the provider is allowed to receive from the beneficiaries and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year end cost settlement. (7-1-97)

a. Maximum payment for hospital outpatient diagnostic laboratory services will be limited to the Department's established fee schedule. (5-25-93)

b. Maximum payment for outpatient hospital diagnostic radiology procedures will be limited to the blended rate of costs and the Department's established fee schedule specified in IDAPA 16, Title 03, Chapter 10, Subsection 457.02, at the time of cost settlement. (7-1-97)

c. Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule. (5-5-93)

d. Maximum payment for hospital out-patient surgical procedures will be limited to the blended rate of costs and the Department's fee schedule for ambulatory surgical centers specified in IDAPA 16.03.10, Subsection 457.01, at the time of cost settlement. (7-1-97)

e. Hospital-based ambulance services will be reimbursed ~~*according to Medicare cost reimbursement principles. All other ambulance providers will be reimbursed according to*~~ 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~~*'s established fee schedule for medical transportation*~~ in its pricing file. ~~*(7-1-97)*~~(____)

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

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

a. The provider's actual charge for service; or (11-10-81)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-30-01)

c. The Medicaid upper limitation of payment on those services, minus the Medicare

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

150. <u>EMERGENCY</u> TRANSPORTATION.

01. Scope of Coverage and General Requirements for Ambulance Services. Medically necessary ambulance services are reimbursable in emergency situations or when prior authorization has been obtained from the Department or its designee. Ambulance services are subject to review by the Department or its designee prior to the service being rendered, and on a retrospective basis. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that an ambulance service is not covered, then no Medicaid payment will be made for the ambulance service. Reimbursement for ambulance services originally denied by the Department or its designee will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". Payment for ambulance services is subject to the following limitations: (3-15-02)

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

b. If Medicare does not pay the entire bill for ambulance service, the provider is to secure a Medicare Summary Notice (MSN) from Medicare, attach it to the appropriate claim form and submit it to the Department. (5-3-03)

c. For Medicare recipients, the Department will reimburse providers for services up to the Medicaid allowable amount minus the Medicare payment. (5-3-03)

d. Before payment is made by the Department, a Medicaid recipient must utilize any available insurance benefits to pay for ambulance services. (7-1-98)

e. Ambulance services are medically necessary when an emergency condition exists.

For purposes of reimbursement, an emergency condition exists when a recipient manifests acute symptoms and/or signs which, by reasonable medical judgement of the Department or its designee, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the recipient. If such condition exists, and treatment is required at the recipient's location, or transport of the recipient for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department or its designee. For purposes of reimbursement, in non-emergency situations, the provider must provide justification to the Department or its designee that travel by ambulance is medically necessary due to the medical condition of the recipient, and that any other mode of travel would, by reasonable medical judgement of the Department or its designee, result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the recipient. (7-1-98)

~~***f.*** *Each billing invoice for ambulance service must have prior authorization attached, if appropriate, and be submitted to the Department for payment. Ambulance units that are not hospital-based must bill on a HCFA 1500 claim form and are reimbursed on a fee for service schedule. Hospital- based ambulance units must bill on a UB-92 claim form and are reimbursed at the hospital's outpatient reimbursement rate. If no attachments to the claim are required, the provider may bill electronically.*~~ ~~*(7-1-98)*~~

~~***g.***~~ **f.** All Emergency Medical Services (EMS) Providers that provide services to Medicaid recipients in Idaho must hold a current license issued by the Emergency Medical Services Bureau of the Department, and must be governed by IDAPA 16.02.03, "Rules Governing Emergency Medical Services". Ambulances based outside the state of Idaho must hold a current license issued by their states' EMS licensing authority when the transport is initiated outside the state of Idaho. Payment will not be made to ambulances that do not hold a current license. (7-1-98)

~~***h.***~~ **g.** Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the recipient was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department or its designee. (7-1-98)

~~***i.***~~ **h.** Ambulance services providers cannot charge Medicaid recipients more than is charged to the general public for the same service. (7-1-98)

02. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (7-1-98)

a. The point of pickup is inaccessible by land vehicle; or (11-10-81)

b. Great distances or other obstacles are involved in getting the recipient to the nearest appropriate facility and speedy admission is essential; and (11-10-81)

c. Air ambulance service will be covered where the recipient's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (11-10-81)

d. Air ambulance services must be approved in advance by the Department or its designee except in emergency situations. Emergency air ambulance services ~~*shall*~~ will be authorized by the Department or its designee on a retrospective basis. ~~*(3-15-02)*~~( )

e. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the recipient. (7-1-98)

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

a. The ~~*B*~~base rate for ambulance services includes customary patient care equipment ~~*including such*~~ and items such as stretchers, clean linens, reusable devices~~,~~ and ~~*reusable*~~ equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the recipient during transport. In addition to the base rate, the Department will reimburse mileage. ~~*(11-10-81)*~~( )

~~***b.*** *Not to be included as a base rate and to be billed separately are charges for each nonreusable item and disposable supply, such as oxygen, triangular bandage and dressing, which may be required for the care of the recipient during transport. Oxygen will be reimbursed according to volume used by the recipient during transport. The volume must appear in the appropriate field on the claim.* *(7-1-98)*~~

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

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

~~***e***~~**d.** Reimbursement for waiting time will not be considered unless documentation submitted to the Department or its designee identifies the length of the waiting time and establishes its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips. (7-1-98)

~~***f***~~**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~~*s*~~. At least~~,~~ this level of personnel ~~*are*~~ 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 ~~*level of ambulance license the unit has been issued*~~ following: ( )

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

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

iii. The level of life support authorized by the Department. ( )

f. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed ~~*at*~~ 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 ~~*at*~~ up to the ~~*Intermediate Life Support (ILS)*~~ 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 ~~*at*~~ up to the Advanced Life Support, Level II (ALSII) rate. ~~*In addition to the base rate, the Department will reimburse mileage. These rates are set by the Department.*~~ When a recipient's condition requires hospital-to-hospital transport with ongoing care that must be furnished by one (1) or more health care professionals in an appropriate specialty area, including emergency or critical care nursing, emergency medicine, or a paramedic with additional training, Specialty Care Transport (SCT) may be authorized by the Department. ~~*(7-1-98)*~~( )

g. If multiple licensed EMS providers are involved in the transport of a recipient, only the ambulance provider which actually transports the recipient will be reimbursed for the services. In situations where personnel and equipment from a licensed ALSII provider boards an ~~*ILS*~~ ALSI or BLS ambulance, the transporting ambulance may bill for ALSII services as authorized by the Department or its designee. In situations where personnel and equipment from a licensed ~~*ILS*~~ ALSI provider boards an ALSII or BLS ambulance, the transporting ambulance may bill for ~~*ILS*~~ ALSI services as authorized by the Department or its designee. In situations where medical personnel and equipment from a medical facility are present during the transport of the recipient, the transporting ambulance may bill at the ALSI or ALSII level of service. The transporting provider must arrange to pay the other provider for their services. The only exception to the preceding policy is in situations where medical personnel employed by a licensed air ambulance provider boards an ALSI, ~~*ILS*~~ ALSII, or BLS ground ambulance at some point, and the air ambulance medical personnel also accompany and treat the recipient during the air ambulance trip. In this situation, the air ambulance provider may bill the appropriate base rate for the air ambulance trip, and may also bill the charges associated with their medical personnel and equipment as authorized by the Department or its designee. The ground ambulance provider may also bill for their part of the trip as authorized by the Department or its designee. ~~*(7-1-98)*~~( )

h. If multiple licensed EMS providers transport a recipient for different legs of a trip, each provider must bill ~~*their*~~ his base rate~~,~~ and mileage, ~~*and for nonreusable supplies and oxygen used,*~~ as authorized by the Department or its designee. ~~*(7-1-98)*~~( )

i. If a licensed transporting EMS provider responds to an emergency situation and treats the recipient, but does not transport the recipient, the Department may reimburse for the treat and release service. The Department will reimburse the appropriate base rate ~~*and will pay for nonreusable supplies and oxygen used at the scene*~~. This service requires authorization from the Department or its designee, usually on a retrospective basis. ~~*(7-1-98)*~~( )

j. If an ambulance vehicle and crew have returned to a base station after having transported a recipient to a facility and the recipient's physician orders the recipient to be

transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. (7-1-98)

k. Round trip charges will be allowed only in circumstances when a facility in-patient is transported to another facility to obtain specialized services not available in the facility in which the recipient is an in-patient. The transport must be to and from a facility that is the nearest one with the specialized services. (7-1-98)

l. If a licensed transporting EMS provider responds to a recipient's location and upon examination and evaluation of the recipient, finds that his condition is such that no treatment or transport is necessary, the Department will pay for the response and evaluation service. This service requires authorization by the Department or its designee, usually on a retrospective basis. No payment will be made if the EMS provider responds and no evaluation is done, or the recipient has left the scene. No payment will be made ~~*for mileage, supplies or oxygen, nor will payment be made*~~ to an EMS provider who is licensed as a non-transporting provider. ~~*(3-15-02)*~~(____)

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - RULES GOVERNING MEDICAID PROVIDER REIMBURSEMENT IN IDAHO

DOCKET NO. 16-0310-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2005, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 56-202 and 56-117, Idaho Code.

DESCRIPTIVE SUMMARY: The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice.

Only sections that have changes different from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the October Administrative Bulletin, Volume 04-10, pages 367 through 377. The Department is amending the text of the pending rules because of comments received during the comment period from both providers and staff. Section 005, Incorporation by Reference is added to correctly place the incorporation of the Resource Utilization Groups Grouper document which was noted in the definition section into Section 005. Several definitions have had minor grammar changes. The term for "Case Mix Component" has been deleted and the term "Case Mix Adjustment Factor" has been added. Under the Direct Care costs the term registered nurse was amended to professional nurse with (RN) to help clarify the type of certification. Also, medical waste disposal was added as a direct care cost beginning July 1, 2005.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 17th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-102, 56-202, and 56-117, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an

agency, not later than October 20, 2004.

The hearing site will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

These rules are being amended to add substantive sections into this chapter from IDAPA 16.05.02, "Rules Governing Audit of Providers," that the Department has proposed to repeal under Docket No. 16-0502-0301, published in the Idaho Administrative Bulletin, on September 3, 2003, Vol. 03-9, page 187. The rules have also been amended for plain language and sections have been moved for clarity.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because these rule amendments are for clarification and to help eliminate rules that are redundant.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sheila Pugatch at (208) 364-1817.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 27, 2004.

DATED this 25th day of August, 2004.

Sherri Kovach, Program Supervisor
Administrative Procedures Section
Department of Health and Welfare
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

001. TITLE AND SCOPE.

01. Title. The rules in this chapter are to be cited ~~*in full*~~ as ~~*Idaho Department of Health and Welfare Rules,*~~ IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho". ~~*(12-31-91)*~~( )

02. Scope of Provider Reimbursement. These rules establish reimbursement principles and rates for FQHCs, RHCs, and facilities defined in Subsection 011.02 of these rules that provide services to Medicaid participants. ( )

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

a. Cost verification of actual costs for providing goods and services; ( )

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

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

d. Reimbursement rates or settlement calculated under this chapter. ( )

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Sections 200-224. ( )

(BREAK IN CONTINUITY OF SECTIONS)

005. INCORPORATION BY REFERENCE.
Unless provided otherwise, any reference in these rules to any document identified in Section 005 shall constitute the full incorporation into these rules of that document for the purposes of the reference, including any notes and appendices therein. The term "documents" includes codes, standards, or rules which have been adopted by an agency of the state or of the United States or by any nationally recognized organization or association. The following documents are hereby incorporated by reference: (3-20-04)

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from HCFA (CMS), 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations internet site at http://www.access.gpo.gov/nara/cfr/cfr-table-search.html. (3-20-04)

02. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual

(PRM), Part I and Part II (HCFA Publication 15-1 and 15-2), is available on the CMS internet site at http://cms.hhs.gov/manuals/pub151/PUB_15_1.asp and http://cms.hhs.gov/manuals/pub152/PUB_15_2.asp. (3-20-04)

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

006. -- 009. (RESERVED).

0~~04~~10. DEFINITIONS A THROUGH D.

01. Accrual Basis. An accounting system based on the ~~*matching*~~ principle~~.~~ that ~~*R*~~revenues are recorded when they are earned; expenses are recorded in the period incurred. ~~*(1-16-80)*~~(____)

02. Allowable Cost. Costs ~~*which*~~ that are reimbursable, and sufficiently documented to meet the requirements of audit. ~~*(1-16-80)*~~(____)

03. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (1-16-80)

04. Appraisal. The method of determining the value of property as determined by a*n* MAI appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. ~~*(9-15-84)*~~(____)

05. Assets. Economic resources of the ~~*contractor,*~~ provider recognized and measured in conformity with generally accepted accounting principles. ~~*(1-1-82)*~~(____)

06. Audit. An examination of facility records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements with Medicaid law, regulations, and rules. (____)

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

08. Audit Reports. (____)

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

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. (____)

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. (____)

0~~6~~9. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (1-16-80)

***~~07~~*10. Bed-Weighted Median**. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (4-5-00)

***~~08~~*11. Beneficiaries**. Persons who are eligible for and receive benefits under federal health insurance programs such as Title XVIII and Title XIX. (1-16-80)

***~~09~~*12. Betterments**. Improvements to assets which increase their utility or alter their use. (1-16-80)

1~~0~~3. Capitalize. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (1-16-80)

~~11.~~ ~~Case Mix Component~~. *~~The portion of the facility's rate, direct care component, that is determined from quarterly case mix indices. The case mix component of a facility's rate is established at the beginning of each calendar quarter, based on the case mix indices calculated on the picture date of the preceding quarter.~~* *~~(4-5-00)~~*

***14. Case Mix Adjustment Factor**. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average facility-wide acuity is the average of the indexes that correspond to the cost reporting period.* *( )*

1~~2~~5. Case Mix Index (CMI). A numeric score assigned to each facility resident, based on the resident's physical and mental condition, ~~*which*~~ that projects the amount of relative resources needed to provide care to the resident. ~~*(4-5-00)*~~( )

a. Facility Wide Case Mix Index. The average of the entire facility's case mix ~~*indices*~~ *indexes* identified at each picture date during the cost reporting period. If case mix ~~*indices*~~ *indexes* are not available for applicable quarters due to lack of data, case mix ~~*indices*~~ *indexes* from available quarters will be used. ~~*(4-5-00)*~~( )

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG~~*'s*~~ classification. Medicaid or non-Medicaid status ~~*will be*~~ is based upon information contained in ~~*claims and*~~ the MDS databases. To the extent that Medicaid identifiers are found to be incorrect ~~*at the time of the audit*~~, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. ~~*(4-5-00)*~~( )

c. State-Wide Average Case Mix Index. The simple average of all facilities "facility wide" case mix ~~*indices*~~ *indexes* used in establishing the reimbursement limitation July 1 of each year. The state-wide case mix index will be calculated annually during each July 1 rate setting.

~~*(4-5-00)*~~(____)

l6. **Chain Organization**. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (____)

1~~3~~7. **Common Ownership**. An individual, individuals, or other entities ~~*which*~~ who have equity~~,~~ or ~~*evidence*~~ ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. ~~*(4-5-00)*~~(____)

1~~4~~8. **Compensation**. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (1-16-80)

1~~5~~9. **Control**. Control exists where an individual or an organization has the power, directly or indirectly, *to* significantly ~~*to*~~ influence or direct the actions or policies of an organization or institution. ~~*(4-5-00)*~~(____)

~~16~~20. **Cost Center**. A "collection point" for expenses incurred in the rendering of services, supplies, or materials ~~*which*~~ *that* are related or so considered for cost-accounting purposes. ~~*(1-16-80)*~~(____)

~~17~~21. **Cost Component**. The portion of the facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a facility's rate is established annually at July 1 of each year. (4-5-00)

~~18~~22. **Cost Reimbursement System**. A method of fiscal administration of Title XIX which compensates the provider on the basis of expenses incurred. (1-16-80)

~~19~~23. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (4-5-00)

2~~0~~4. **Cost Statements**. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (1-16-80)

2~~1~~5. **Costs Related to Patient Care**. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include, but are not limited to, costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs~~*, and others*~~. ~~*(4-5-00)*~~(____)

2~~2~~6. **Costs Not Related to Patient Care**. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are ~~*not*~~ *non*allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are ~~*not*~~ *non*allowable unless it

can be specifically shown that they relate to patient care and for the operation of the nursing facility. ~~(4-5-00)~~(____)

2~~3~~7. Customary Charges. Customary charges are the ~~regular~~ rates ~~for various services which are recorded for~~ charged to Medicare beneficiaries and ~~charges~~ to patients liable for such charges, as reflected in the facility's records. Those charges are ~~to be~~ adjusted downward, ~~where~~ 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 (see Chapter 3, Sections 310 and 312, PRM). ~~(4-5-00)~~(____)

2~~4~~8. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the provider. However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (7-1-97)

2~~5~~9. Department. The Idaho Department of Health and Welfare ~~of the state of Idaho~~. ~~(1-16-80)~~(____)

~~26~~30. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (1-1-82)

~~27~~31. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (4-5-00)

a. Direct nursing salaries ~~which~~ that include the salaries of ~~registered~~ *professional* nurses *(RN)*, licensed professional nurses, certified nurse's aides, and unit clerks; ~~and~~ ~~(4-5-00)~~(____)

b. Routine nursing supplies; ~~and~~ ~~(4-5-00)~~(____)

c. Nursing administration; ~~and~~ ~~(4-5-00)~~(____)

d. Direct portion of Medicaid related ancillary services; ~~and~~ ~~(4-5-00)~~(____)

e. Social services; ~~and~~ ~~(4-5-00)~~(____)

f. Raw food; ~~and~~ ~~(4-5-00)~~(____)

g. Employee benefits associated with the direct salaries~~.~~*: and* ~~(4-5-00)~~(____)

h. *Medical waste disposal, for rates with effective dates beginning July 1, 2005.* *(____)*

~~28~~32. Director. The Director of the Department of Health and Welfare or his designee.

(1-1-82)

011. DEFINITIONS E THROUGH J.

~~29~~01. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (9-15-84)

~~3~~02. Facility. ~~*An entity which contracts with the Director to provide services to recipients in a structure owned, controlled, or otherwise operated by such an entity, and which entity is responsible for operational decisions in conjunction with the use of the term "facility":*~~ Facility refers to a nursing facility or an intermediate care facility for persons with mental retardation. ~~*(1-1-82)*~~(____)

~~b~~a. "Free-standing Nursing Facility" means a ~~*skilled*~~ nursing facility~~*, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which*~~ that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital~~,~~. ~~*as defined in Section 39-1301(a), Idaho Code; or*~~ ~~*(9-28-90)*~~(____)

~~c~~b. "Hospital-based facility" means a nursing facility~~*, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which*~~ that is owned, managed, or operated by, or is otherwise a part of a licensed hospital~~*, as defined in Section 39-1301(a), Idaho Code*~~. ~~*(7-1-97)*~~(____)

c. "Intermediate Care Facility For Persons With Mental Retardation (ICF/MR)" means a facility licensed as an ICF/MR and federally certified to provide care to Medicaid and Medicare patients. (____)

~~a~~d. ~~*The term*~~ "Nursing Facility~~*" or "*~~(NF) ~~*is used to describe all non-ICF/MR facilities*~~ means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients~~;~~. ~~*(2-1-91)*~~(____)

~~d~~e. "Rural Hospital-Based Nursing Facilities~~.~~" ~~*Those*~~ means hospital-based nursing facilities not located within *a* metropolitan statistical area (MSA) as defined by the United States Bureau of Census. ~~*(4-5-00)*~~(____)

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

~~e~~g. "Urban Hospital-Based Nursing Facilities~~.~~" ~~*Those*~~ means hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. ~~*(4-5-00)*~~(____)

03. Federally Qualified Health Center (FQHC). An entity that meets the requirements of 42 USC 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. (____)

~~*31*~~**04.** **Fiscal Year**. ~~*The business year of an organization*~~ An accounting period that consists of twelve (12) consecutive months. ~~*(1-16-80)*~~( )

~~*32*~~**05.** **Forced Sale**. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (11-4-85)

~~*33*~~**06.** **Funded Depreciation**. Amounts deposited or held which represent recognized depreciation. (1-16-80)

~~*34.* **GAAP**. Generally accepted accounting principles, pronounced "gap". (1-16-80)~~

~~*35*~~**07.** **Generally Accepted Accounting Principles** ***(GAAP)***. ~~*Those concepts, postulates, axioms, etc., which are considered standards for accounting measurement.*~~ A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. ~~*(1-16-80)*~~( )

~~*36*~~**08.** **Goodwill**. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is *a* nonallowable, nonreimbursable expense. ~~*(9-15-84)*~~( )

~~*37*~~**09.** **Historical Cost**. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (1-1-82)

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

~~*38*~~**11.** **ICF/MR**. An intermediate care facility for ~~*the mentally retarded*~~ persons with mental retardation. ~~*(9-15-84)*~~( )

~~*39*~~**12.** **ICF/MR Living Unit**. The ~~*specific property or portion thereof*~~ physical structure that an ICF/MR uses to house patients. ~~*(7-1-97)*~~( )

~~*40*~~**13.** **Improvements**. Improvements to assets which increase their utility or alter their use. (1-16-80)

~~*41*~~**14.** **Indirect Care Costs**. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (4-5-00)

~~*b*~~**a.** Activities; ~~*and*~~ ~~*(4-5-00)*~~( )

~~*a*~~**b.** Administrative and general care costs~~*: and*~~; ~~*(4-5-00)*~~( )

c. Central service and supplies; ~~*and*~~ ~~*(4-5-00)*~~(____)

~~*e*~~**d.** Dietary (non-"raw food" costs); ~~*and*~~ ~~*(4-5-00)*~~(____)

~~*h*~~**e.** Employee benefits associated with the indirect salaries; ~~*and*~~ ~~*(4-5-00)*~~(____)

~~*i*~~**f.** Housekeeping; ~~*and*~~ ~~*(4-5-00)*~~(____)

~~*d*~~**g.** Laundry and linen; ~~*and*~~ ~~*(4-5-00)*~~(____)

~~*g*~~**h.** Medical records; ~~*and*~~ ~~*(4-5-00)*~~(____)

~~*j*~~**i.** Other costs not included in direct care costs, or costs exempt from cost limits~~.~~; and ~~*(4-5-00)*~~(____)

~~*f*~~**j.** Plant operations and maintenance (excluding utilities)~~; *and*~~. ~~*(4-5-00)*~~(____)

~~*42*~~**15. Inflation Adjustment**. *The* ~~C~~cost used in establishing a *nursing* facility's prospective reimbursement rate ~~*shall be*~~ *is* indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. ~~*(4-5-00)*~~(____)

~~*43*~~**16. Inflation Factor**. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility ~~*(SNF)*~~ Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. *The national index is used when there is no state or regional index.* ~~*(4-5-00)*~~(____)

~~*44*~~**17. Interest**. The cost incurred for the use of borrowed funds. (1-16-80)

~~*45*~~**18. Interest on Capital Indebtedness**. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are ~~*differentiated from those related to current indebtedness by the payback period of the related debt*~~ *reported under property costs*. ~~*(1-16-80)*~~(____)

~~*46*~~**19. Interest On Current Indebtedness**. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are ~~*differentiated from others by the fact that the related debt is scheduled for repayment within one (1) year*~~ *reported under administrative costs*. ~~*(1-16-80)*~~(____)

~~*47*~~**20. Interest Rate Limitation**. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (±1%) at the date the loan is made. ~~*(4-5-00)*~~(____)

~~*48*~~**21.** **Interim Reimbursement Rate (IRR)**. A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (10-22-93)

~~*49*~~**22.** **Intermediary**. Any organization ~~*which*~~ that administers the Title XIX program; in this case the Department of Health and Welfare. ~~*(1-16-80)*~~(____)

~~***50. Intermediate Care Facility For The Mentally Retarded**. A habilitative facility designed and operated to meet the educational, training, habilitative and intermittent medical needs of the developmentally disabled. (9-15-84)***

012. DEFINITIONS K THROUGH O.

~~*5*~~**01.** **Keyman Insurance**. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. (1-16-80)

~~*5*~~**02.** **Lease**. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (1-16-80)

~~*5*~~**03.** **Leasehold Improvements**. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (1-16-80)

~~*5*~~**04.** **Level of Care**. The classification in which a patient/resident is placed ~~*following a medical/social review decision*~~. ~~*(1-16-80)*~~(____)

~~*5*~~**05.** **Licensed Bed Capacity**. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (1-16-80)

~~*5*~~**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) ~~*shall be*~~ is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge ~~*shall be*~~ are reimbursed fair compensation; which is the same as reasonable cost. ~~*(4-5-00)*~~(____)

~~*5*~~**07.** **MAI Appraisal**. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (9-15-84)

~~*5*~~**08.** **Major Movable Equipment**. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (12-28-89)

a. A relatively fixed location in the building; (11-4-85)

b. Capable of being moved, as distinguished from building equipment; (11-4-85)

c. A unit cost of five thousand dollars ($5000) or more; (4-5-00)

d. Sufficient size and identity to make control feasible by means of identification tags; and (11-4-85)

e. A minimum life of three (3) years. (4-5-00)

~~6~~09. **Medicaid**. The ~~*1965 amendments to the*~~ federal and state funded medical assistance program found in Title XIX of the Social Security Act ~~*(P.L. 89-97), as amended*~~. ~~*(1-1-82)*~~(____)

~~6~~10. **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 residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (4-5-00)

~~59~~11. **Minimum Data Set (MDS)**. A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the document initially used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (4-5-00)

~~6~~12. **Minor Movable Equipment**. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen ~~*shall*~~ may, at the facility's option, be considered minor movable equipment with the cost ~~*thereof*~~ reported as a medical supply. The general characteristics of this equipment are: ~~*(12-28-89)*~~(____)

a. ~~*In general, n*~~No fixed location and subject to use by various departments of the provider's facility; ~~*(11-4-85)*~~(____)

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (4-5-00)

c. Subject to inventory control; (11-4-85)

d. Fairly large quantity in use; and (11-4-85)

e. ~~*Generally, a*~~A useful life of less than three (3) years. ~~*(4-5-00)*~~(____)

~~6~~13. **Necessary**. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (4-5-00)

~~6~~14. **Net Book Value**. The historical cost of an asset, less accumulated depreciation.

(1-1-82)

~~*6*~~**15.** **New Bed**. ~~*A*~~ Subject to specific exceptions stated in these rules, a bed is considered new if it ~~*is an additional nursing facility*~~ adds to the number of beds ~~*that is*~~ for which a facility is licensed ~~*subsequent to*~~ on or after July 1, 1999. ~~*(4-5-00)*~~(____)

~~*6*~~**16.** **Nominal Charges**. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (4-5-00)

~~*6*~~**17.** **Nonambulatory**. Unable to walk without assistance. (11-4-85)

~~*6*~~**18.** **Nonprofit Organization**. An organization whose purpose is to render services without regard to gains. (1-1-82)

~~*6*~~**19.** **Normalized Per Diem Cost**. Refers to direct care costs that have been adjusted based on the facility's case mix index for purposes of making the per diem cost comparable among facilities. Normalized per diem costs are calculated by dividing the facility's direct care per diem costs by its facility-wide case mix index, and multiplying the result by the statewide average case mix index. (4-5-00)

~~*70.* **Nursing Home Facility**. A "Nursing Facility" or "NF". See facility. (9-28-90)~~

~~*71*~~**20.** **Nursing Facility Inflation Rate**. ~~*The most specific skilled nursing facility inflation rate applicable to Idaho established by Data Resources, Inc. or its successor. If a state or regional index has not been implemented, the national index will be used*~~ See Subsection 011.17, Inflation Factor. ~~*(4-5-00)*~~(____)

~~*7*~~**21.** **Ordinary**. Ordinary means that the costs incurred are customary for the normal operation of the business. (4-5-00)

013. DEFINITIONS P THROUGH Z.

~~*73*~~**01.** **Patient Day**. A calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care shall be deemed to exist. (1-1-82)

~~*74*~~**02.** **Picture Date**. A point in time when case mix ~~*indices*~~ *indexes* are calculated for every facility based on the residents in the facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the facility's rate for the next quarter. ~~*(4-5-00)*~~(____)

~~*75*~~**03.** **Private Rate**. Rate most frequently charged to private patients for a service or item. (1-16-80)

~~*76*~~**04.** **PRM**. The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, HCFA Publications 15-1 and 15-2, which are incorporated by reference in~~*to*~~ Section 005 of these rules. ~~*(4-5-00)*~~(____)

~~77~~**05.** **Property Costs**. *Property costs are* ~~T~~the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish ~~those~~ *which* components *are an integral part* of property costs ~~which are identified as an integral part of an appraisal~~. ~~(9-15-84)~~(____)

~~78~~**06.** **Property Rental Rate**. A rate paid per Medicaid patient day to other than hospital based nursing ~~homes~~ *facilities* in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/MR facilities. (7-1-97)(____)

~~79. **Proprietary**. An organization operated for the purpose of monetary gains. (1-16-80)~~

~~8~~**07.** **Provider**. ~~A licensed and certified skilled nursing or intermediate care facility which renders care to Title XIX recipients.~~ Any individual, organization or business entity furnishing medical goods or services in compliance with this chapter who has *a Medicaid provider number and has* entered into a written provider agreement with the Department under IDAPA 16.03.09, "Rules Governing the Medical Assistance Program". ~~(1-16-80)~~(____)

~~81~~**08.** **Prudent Buyer**. A prudent buyer is one who seeks to minimize cost when purchasing an item of standard quality or specification, ~~(~~PRM, Chapter 2100~~)~~. ~~(4-5-00)~~(____)

~~82~~**09.** **Public Provider**. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (4-5-00)

~~84~~**10.** **Raw Food**. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (4-5-00)

~~85~~**11.** **Reasonable Property Insurance**. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year shall not be considered reasonable. (11-4-85)

~~86~~**12.** **Recipient**. An individual determined eligible by the ~~Director~~ *Department* for the services provided in the state plan for Medicaid. ~~(1-1-82)~~(____)

~~87~~**13.** **Related Entities**. The provider, to a significant extent, is associated or affiliated with, or is controlled by, or has control of another entity. (1-16-80)

~~83~~**14.** **Related To Provider**. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (4-5-00)

~~88~~**15.** **Resource Utilization Groups (RUG~~'s~~)**. A process of grouping residents according

to the clinical and functional status identified by the responses to key elements of the MDS. *The RUG Grouper is used* ~~F~~for *the* purposes of ~~*initial*~~ rate setting~~*, RUG's III, version 5.12, 34 Grouper, nursing weights only, with index maximization will be used for grouping residents and is hereby incorporated into these rules. The RUG's Grouper is available from HCFA, 7500 Security Blvd., Baltimore, MD, 21244-1850. Subsequent versions of RUG's, or its successor, will be evaluated and may be incorporated into the rate setting process as necessary*~~. ~~*(4-5-00)*~~*(____)*

16. **Rural Health Clinic (RHC)**. An entity that meets the requirements of 42 USC Section 1395x(aa)(2) as an outpatient facility that 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. (____)

~~*89*~~**17.** **Skilled Nursing Care**. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (1-16-80)

~~***90.*** ***Skilled Nursing Facility****. A nursing care facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and certified as a "Nursing Facility" under Title XVIII.*~~ ~~*(9-28-90)*~~

~~*9*~~**18.** **Title XVIII**. The Medicare program administered by the federal Social Security Administration. (1-16-80)

~~*92*~~**19.** **Title XIX**. The medical assistance program known as Medicaid administered by the state of Idaho, Department of Health and Welfare. (1-16-80)

~~*93*~~**20.** **Utilities**. All expenses for heat, electricity, water and sewer. (9-15-84)

0~~*06*~~14. -- 0~~*4*~~29.(RESERVED).

030. PROVIDER'S RESPONSIBILITY TO MAINTAIN RECORDS.
The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Subsection 001.03 of these rules. (____)

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

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. (____)

03. **Revenue Documentation**. Documentation of revenues must include the amount, date, purpose, and source of the revenue. (____)

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. (____)

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

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

05. **Retention of Records**. Records required in Subsections 030.01 through 030.03 of these rules must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services. ( )

031. -- 039. **(RESERVED).**

040. **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. ( )

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: ( )

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

b. Clearly demonstrates the need for additional time to properly respond. ( )

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. ( )

041. **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 ( )

042. -- 049. **(RESERVED).**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - RULES GOVERNING MEDICAID PROVIDER REIMBURSEMENT IN IDAHO

DOCKET NO. 16-0310-0402

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2005, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 56-202 and 56-117, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice.

Only sections that have changes different from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the October Administrative Bulletin, Volume 04-10, pages 378 through 394. The Department is amending the text of the pending rules because of comments received during the comment period from both providers and staff. Those changes include the following:

Section 110 - Allowable Costs has had clarifications made to entertainment costs, food costs, and home office costs.

Section 302 - Development Of The Rate was amended to provide clearer directions on the applicable case mix index and how it is calculated Typographical and grammar changes were made which included changing the abbreviations of NF to nursing facilities throughout the docket.

Section 304 - Treatment of New Beds was amended to clarify exceptions to new bed rates when beds are added for under served area.

Section 311- Special Rates was amended to clarify the special rate add on amount and when those additional cost apply. The ventilator dependent resident rate was also amended for clarification.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 17th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-102, 56-202, and 56-117, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

These rules are being amended to clarify the current prospective payment methodology used in reimbursement to nursing home providers and to remove obsolete language applying to the previous payment methodology. The rules have also been amended for plain language and sections have been moved for clarity.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because these rule amendments are for clarification.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sheila Pugatch at (208) 364-1817.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 27, 2004.

DATED this 25th day of August, 2004.

Sherri Kovach, Program Supervisor
Administrative Procedures Section
Department of Health and Welfare
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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

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

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

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

04. Telephone. (208) 334-5500. ( )

05. Internet Website Address. The website address is: "http://www.healthandwelfare.idaho.gov". ( )

00~~6~~7. -- 0~~4~~19. (RESERVED).

020. 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. ( )

(BREAK IN CONTINUITY OF SECTIONS)

110. ALLOWABLE COSTS.
~~*Below is a list of the normally allowable costs, and t*~~The ~~*related*~~ following definitions and explanations~~*, which includes, but is not limited to, the following items*~~ apply to allowable costs:
~~*(7-1-97)*~~( )

01. **Accounts Collection**. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable. ( )

0~~1~~2. Auto and Travel Expense. ~~*Expense of m*~~Maintenance and ~~*operation*~~ operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement ~~*will*~~ can not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported~~ *on*~~. Meal reimbursement ~~*will be*~~ is limited to the amount that would be allowed by the state for a ~~*Department*~~ state employee. ~~*Entertainment expense is allowable only if documentation is provided naming the individuals and stating the purpose of the meeting. Entertainment expense is allowable only for patient care related purposes.*~~ ~~*(7-1-97)*~~( )

0~~2~~3. Bad Debts. Payments for efforts to collect past due Title XIX accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX coinsurance amounts are one hundred percent (100%) reimbursable (PRM, Section 300). (4-5-00)

0~~3~~4. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (1-16-80)

~~17~~05. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation ~~*shall*~~ cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation ~~*shall*~~ cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Section~~s~~ 402 ~~*and 403*~~ of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: ~~*(7-1-97)*~~( )

a. Salaries wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (7-1-97)

b. Supplies and services provided for the owner's personal use. (1-16-80)

c. Compensation paid by the facility to employees for the sole benefit of the owner. (1-16-80)

d. Fees for consultants, directors, or any other fees paid regardless of the label. (1-16-80)

e. Keyman life insurance. (1-16-80)

f. Living expenses, including those paid for related persons. (1-16-80)

0~~4~~6. Contracted Service. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (1-16-80)

0~~5~~7. Depreciation. Depreciation on buildings and equipment is an allowable property expense ~~*for hospital-based facilities*~~ subject to Section 060 of these rules. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. ~~*(10-22-93)*~~(____)

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

0~~6~~9. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (4-5-00)

10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable. (____)

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

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

13. Home Office Costs. *Reasonable c*osts allocated by related entities for home office services are allowable *in their applicable cost centers*. (____)

~~07~~14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (1-16-80)

~~08~~15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (7-1-97)

~~09~~16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, shall be reimbursed in the same manner as an owned

asset. The cost of leases related to home offices and ICF/MR day treatment services shall not be reported as property costs and shall be allowable based on reasonable cost principles subject to other limitations contained herein. (7-1-97)

17. **Malpractice/Public Liability Insurance**. Premiums for malpractice and public liability insurance must be reported as administrative costs. ( )

1~~0~~8. **Payroll Taxes**. The employer's portion of payroll taxes is reimbursable. (1-6-80)

1~~1~~9. **Property Costs**. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. ~~*A*~~ For free-standing *nursing facilitie*s and ICF/MRs, the property rental rate ~~*will be*~~ is paid ~~*in lieu of costs in some circumstances according to other provisions*~~ as described in Section 060 of these rules. Hospital-based *nursing facilitie*s are paid based on property costs. ~~*(7-1-97)*~~( )

a. Amortization of leasehold improvements will be included in property costs. ( )

i. Straight line depreciation on fixed assets is included in property costs. ( )

ii. Depreciation of moveable equipment is an allowable property cost. ( )

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

~~1~~20. **Property Insurance**. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (11-4-85)

~~13~~21. **Repairs and Maintenance**. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (1-16-80)

~~14~~22. **Salaries**. Salaries and wages of all employees engaged in patient care activities or ~~*overall*~~ operation and maintenance ~~*of the facility, including support activities of home offices, shall be*~~ are allowable costs. However, non-nursing home wages are not an allowable cost. ~~*(1-16-80)*~~( )

~~15~~23. **Supplies**. Cost of supplies used in patient care or providing services related to patient care ~~*are*~~ is allowable. ~~*(1-16-80)*~~( )

~~16~~24. **Taxes**. The cost of ~~*P*~~property taxes on assets used in ~~*rendering*~~ providing patient care are allowable. Other taxes ~~*may be*~~ are allowable~~*. Specifics are covered*~~ costs as provided in the ~~*Provider Reimbursement Manual,*~~ PRM, Chapter 21. Tax penalties are ~~*not*~~ nonallowable costs. ~~*(4-5-00)*~~( )

111. -- 114. (RESERVED).

115. NONALLOWABLE COSTS.
~~*In the absence of convincing evidence to the contrary, expenses listed below will be considered nonreimbursable.*~~ The following definitions and explanations apply to nonallowable costs: ~~*(1-16-80)*~~(____)

0~~3~~1. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided ~~*(see Subsection 354.04.c.ii.)*~~ is nonallowable. ~~*(12-31-91)*~~(____)

0~~6~~2. Acquisitions. Costs of corporate acquisitions, ~~*e.g.*~~, such as purchase of corporate stock as an investment, are nonallowable. ~~*(1-16-80)*~~(____)

03. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable. (____)

0~~1~~4. Charity Allowances. Cost of free care or discounted services are nonallowable. ~~*(1-16-80)*~~(____)

~~1~~05. Consultant Fees. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility are nonallowable. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants and/or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. ~~*Information obtained from consultants will be provided to facilities.*~~ Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified ~~*pursuant to Subsection 115.15.b.*~~, unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This Subsection in no way limits the Department's ability to disallow excessive consultant costs under other Sections of this chapter, such as Section 100 or 121, when applicable. ~~*(7-1-97)*~~(____)

~~12~~06. Fees. Franchise fees are nonallowable, see ~~(~~PRM, Section 2133.1~~)~~. ~~*(4-5-00)*~~(____)

0~~9~~7. Fund Raising. Certain fund raising expenses are nonallowable, see ~~(~~PRM, Section 2136.2~~)~~. ~~*(4-5-00)*~~(____)

~~16~~08. Goodwill. Costs associated with goodwill as defined in S~~*ubs*~~ection ~~*003.27*~~ 011 of these rules are nonallowable. ~~*(7-1-97)*~~(____)

0~~7~~9. Holding Companies. All home office costs associated with holding companies are ~~*not*~~ nonallowable ~~(~~see PRM, Section 2150.2A~~)~~. ~~*(4-5-00)*~~(____)

1~~7~~0. Interest. Interest to finance nonallowable costs are nonallowable. ~~*(7-1-97)*~~(____)

1~~3~~1. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable. ~~*(7-1-98)*~~(____)

~~*0*~~**12.** **Nonpatient Care Related Activities**. All activities not related to patient care are nonallowable. ~~*(1-16-80)*~~(____)

~~**1**~~**13.** **Organization**. Organization costs are nonallowable, ~~(~~see PRM, Section 2134 ~~*and subsections of Section 2134 for specifics)*~~. ~~*(4-5-00)*~~(____)

14. **Pharmacist Salaries**. Salaries and wages of pharmacists are nonallowable. (____)

15. **Prescription Drugs**. Prescription drug costs are nonallowable. (____)

~~***18.*** ***Property Costs****. Costs reimbursed based on a property rental rate according to other provisions of these rules.* *(7-1-97)*~~

~~*04*~~**16.** **Related Party Interest**. Interest on related party loans are nonallowable, ~~(~~see PRM, Sections 218.1 and 218.2~~)~~. ~~*(4-5-00)*~~(____)

~~*05*~~**17.** **Related Party Nonallowable Costs**. All costs ~~*not*~~ nonallowable to providers are ~~*not*~~ nonallowable to a related party, whether or not they are allocated. ~~*(1-16-80)*~~(____)

~~*0*~~**18.** **Related Party Refunds**. All refunds, allowances, and terms, ~~*etc., shall*~~ will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. ~~*(1-16-80)*~~(____)

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

~~*14*~~**20.** ~~***Yellow Pages***~~ **Telephone Book Advertising**. Telephone book ~~*yellow page*~~ advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable. ~~*(1-1-82)*~~(____)

~~*10*~~**21.** **Vending Machines**. Costs of vending machines and cost of the product to stock the machine are nonallowable costs. ~~*Barber and beauty shops.*~~ ~~*(1-16-80)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

~~***208. REPORTING FORMS.***~~
~~*Unless prior approval is granted, only state forms will be acceptable. Requests for approval of alternate forms must be in writing accompanied by samples. Such requests will not be considered adequate reason for late filing, or granting of a waiver, except in extraordinary circumstances as determined by the intermediary. Following is a partial listing of the account titles used on the state forms. Included also is an explanation of the classification and reporting standards applicable to that account. The report form may be revised periodically to meet changing Department and provider needs and may be in electronic format at the discretion of the Department. Reported costs shall only include allowable costs unless the Department structures the report to remove*~~

~~nonallowable costs by cost groupings, in which case, reported total and subtotal costs shall reflect net allowable costs except for the nonreimbursable section of the report. (7-1-97)~~

~~**01. Revenues**. The categories are self-explanatory. They are intended to give sufficient breakdown of revenues to effect the reasonable cost principles embodied in the cost reporting system. Facilities may also use the cost center approach of the statement to evaluate the expense of certain cost centers in respect to their revenue. (1-16-80)~~

~~**02. Expenses**. (7-1-93)~~

~~**a.** Administrative. (12-31-91)~~

~~i. Salaries: Administrator. Included in this category are salaries paid for administrators and assistant administrators of the facility. Any compensation in excess of the amount allowable under other provisions of this chapter shall be entered in the nonreimbursable Section of the cost statement (see Subsection 110.17 of these rules). (7-1-97)~~

~~ii. Salaries: Office and Clerical. Salaries and wages paid to clerks, bookkeepers, and others whose duties relate to overall operation of the facility, should be included in this account. (1-16-80)~~

~~iii. Payroll Taxes. The provider's portion of payroll taxes for all employees except those taxes related to the payroll for persons providing day treatment services to ICF/MR patients shall be included in the report categories provided for such costs. Payroll taxes for employees providing day treatment services to ICF/MR patients shall be reported in categories provided for these expenses. Self employment taxes related to owners are nonallowable and should not be included. (7-1-97)~~

~~iv. Employee Benefits. Expenses incurred such as sick pay and vacation pay should be included in this account except for those expenses relating to persons providing day treatment services for ICF/MR patients. Employee benefits for these employees should be reported in cost categories provided for those expenses. (7-1-97)~~

~~v. Accounts Collections. The expenses related to collection of past due program accounts such as legal fees, bill collectors, etc., are allowable. Allowances for bad debts and bad debt write-off are not allowable, and should be included in the Section titled Nonreimbursable Expenses. (4-28-89)~~

~~vi. Auto and Travel. These expenses shall be those incurred in the operation of vehicles and other travel expense related to patient care. Normally, entertainment shall not be involved, but shall be recorded in the Section under Nonreimbursable Expenses (see PRM, Chapter 21). (4-5-00)~~

~~vii. Bank and Finance Charges. Normally recurring minor charges for handling of accounts shall be included here. (1-16-80)~~

~~viii. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care or for general patient use, license fees (not including franchises), and dues to professional~~

~~*health care organizations are to be included. Dues, tuitions and educational fees to facilitate quality health care services are includable where the provisions of PRM, Section 400, are met.* *(4-5-00)*~~

~~*ix. Employee Recruitment. Costs of advertising for new employees shall be recorded in this account including applicable entertainment costs.* *(1-16-80)*~~

~~*x. Home Office Costs. Costs allocated by related entities for various services shall be included in this account.* *(1-16-80)*~~

~~*xi. Malpractice/Public Liability Insurance. Premiums for malpractice and public liability insurance shall be included in this account.* *(1-16-80)*~~

~~*xii. Purchased Services. Costs of legal, accounting, and management services (not including related entities) for overall operations shall be included in this account.* *(1-16-80)*~~

~~*xiii. Supplies and Rentals. Cost of supplies, postage, ledger sheets, and rental of minor office equipment shall be included in this account.* *(1-16-80)*~~

~~*xiv. Telephone and Communications. Cost of telephone and related communications shall be included in this account.* *(1-16-80)*~~

~~*xv. Interest, Working Capital. Allowable interest expense for loans not related specifically to the purchase of the real or personal property of the provider shall be reported here.* *(1-1-82)*~~

~~*xvi. Miscellaneous. Any expense not properly allocable to other cost centers and not properly classified in other classification of administration expenses shall be included here.* *(1-16-80)*~~

~~***b.*** *Property. Property costs shall be reported by all facilities including those facilities which are reimbursed a property rental rate.* *(11-4-85)*~~

~~*i. Amortization. Amortization of leasehold improvements shall be included here. Certain others may be included here also.* *(1-16-80)*~~

~~*ii. Depreciation on Fixed Assets. Depreciation expenses for buildings and fixtures should be included here. Any depreciation in excess of straight line AHA lives shall not be included unless otherwise waived by the Department. Such excess shall be included in the Section of Nonreimbursable Expenses.* *(7-1-97)*~~

~~*iii. Depreciation of Equipment. Depreciation expense for moveable equipment shall be included here. Excess depreciation as defined above shall be included in the Nonreimbursable Section (see Subsection 354.04.c.).* *(12-31-91)*~~

~~*iv. Interest Expense. Interest expense related to purchase of land, buildings and equipment related to patient care shall be included here only if it is payable to unrelated entities. Generally, interest payable to related entities shall be included in the Nonreimbursable Section*~~

~~*(PRM, Section 202.3).* *(4-5-00)*~~

~~*v. Insurance. Insurance premiums for property insurance such as fire and glass shall be includable here.* *(1-16-80)*~~

~~*vi. Lease and Rental Payments. Payments for lease or rental of buildings, land and for equipment shall be includable here.* *(1-16-80)*~~

~~*vii. Taxes. Taxes on property related to patient care shall be recorded in this account.* *(1-16-80)*~~

~~***e.*** *Patient Care Service.* *(1-16-80)*~~

~~*i. Nursing Care.* *(1-16-80)*~~

~~*(1) Salaries. Director of Nursing. Salaries or wages of the Director of Nursing shall be included here.* *(1-16-80)*~~

~~*(2) Registered Nurse. Salaries and wages of registered nurses shall be included in this account. Payroll taxes shall not be included but overtime shall be.* *(1-16-80)*~~

~~*(3) Licensed Professional Nurses. Wages for licensed professional nurses shall be included in this account including overtime, but not including payroll taxes.* *(1-16-80)*~~

~~*(4) Aides/Orderlies. Normal overtime and wages for aides and orderlies, not to include payroll taxes, shall be included in this account.* *(1-16-80)*~~

~~*(5) Contracted Services. Payments for patient health care services under contract shall be entered here.* *(1-16-80)*~~

~~*ii. Therapy Services.* *(1-16-80)*~~

~~*(1) Salaries. Salaries for all therapy personnel shall be recorded here.* *(1-16-80)*~~

~~*(2) Professional Services. Payments for contracted therapy services shall be recorded here.* *(1-16-80)*~~

~~*(3) Supplies and Miscellaneous. Expenses for supplies and miscellaneous expenses related to therapy and recreational therapy services shall be recorded here.* *(1-16-80)*~~

~~*iii. Social Services.* *(1-16-80)*~~

~~*(1) Salaries. Wages and salaries for activity directors and social services personnel shall be recorded here.* *(1-16-80)*~~

~~*(2) Contracted Services. Payments under contract arrangement for activities director or other social services personnel shall be included here.* *(1-16-80)*~~

~~*iv. Payroll Taxes and Employee Benefits. The payroll taxes and cost of employee benefits related to the salaries reported in Section 208 of these rules should be reported here.* (7-1-97)~~

~~*v. Costs Not Subject to the Percentile Cap.* (12-31-91)~~

~~*(1) Special Needs. Those costs determined by the Department and authorized under Section 56-117, Idaho Code, will be excluded from other reported costs and will be reported here (see Subsection 254.08).* (12-31-91)~~

~~*(2) Excluded Costs. Increases in costs otherwise subject to a cap incurred by facilities as a result of changes in legislation or regulations will be excluded from costs reported in categories subject to the cap and will be reported here (see Subsection 254.09).* (7-1-97)~~

~~***d.*** *Facility Operations and Services.* (1-16-80)~~

~~*i. Central Supply.* (1-16-80)~~

~~*(1) Salaries: Pharmacist. Salaries and wages of pharmacists who are regular employees of the facility shall be included here, but are not reimbursable.* (1-16-80)~~

~~*(2) Salaries. Salaries and wages of others, such as stock clerks, shall be recorded here.* (1-16-80)~~

~~*(3) Contracted Services. Payments for services under contract will be recorded in this category, not including pharmaceutical services.* (1-16-80)~~

~~*(4) Supplies and Miscellaneous. Miscellaneous expenses and routine nursing supplies such as laxatives, aspirin, and dressings shall be recorded here; the cost of oxygen concentrators may also be recorded here. Cost of prescription drugs must not be included.* (12-28-89)~~

~~*ii. Laundry and Linen.* (1-16-80)~~

~~*(1) Salaries. Salaries and wages for personnel involved in laundry operations shall be recorded here.* (1-16-80)~~

~~*(2) Purchased Services. Costs of contracted linen services shall be recorded here.* (1-16-80)~~

~~*(3) Linens and Bedding. Purchase of sheets, mattress pads, blankets, towels, etc., shall be entered here. Costs of beds and mattresses are capitalizable and should be treated accordingly.* (1-16-80)~~

~~*(4) Miscellaneous Expenses. Miscellaneous expenses not properly classified in other areas of Section 208 should be included in this account.* (12-31-91)~~

~~***e.*** *Dietary.* (1-16-80)~~

~~*i. Salaries: Dietitian. Wages of a dietitian who is a regular employee shall be included here. (1-16-80)*~~

~~*ii. Salaries: Other. Salaries of cooks and other dietary personnel should be recorded here. (1-16-80)*~~

~~*iii. Purchased Services. Payments for contracted dietary services, or dietitians, shall be included here. (1-16-80)*~~

~~*iv. Food. Cost of food used for the period will be included here not including vending machine items. For purposes of reasonable cost evaluation, revenues from meals sold to nonpatients will reduce food costs and should be reported in the revenue Section. (1-16-80)*~~

~~*v. Supplies. Cost of dietary supplies other than food should be recorded here. Do not include vending machine items. (1-16-80)*~~

~~***f.** Plant Operations and Maintenance. (1-16-80)*~~

~~*i. Salaries. Wages of all housekeeping and maintenance employees shall be included in this account. (1-16-80)*~~

~~*ii. Repairs and Maintenance. Cost of minor repairs to buildings and equipment shall be recorded here. (1-16-80)*~~

~~*iii. Purchased Services. Costs of maintenance and repair services purchased under contract arrangements shall be recorded here. (1-16-80)*~~

~~*iv. Utilities. Expenses for heat, electricity, water and sewer shall be included in this account. (9-15-84)*~~

~~*v. Supplies and Miscellaneous. Expense of supplies and other unclassified expenses should be included here. (1-16-80)*~~

~~***g.** Nonreimbursable Expenses. This classification of expenses is provided to reconcile your cost statement to books of record. It will also help the facility to determine its reasonable costs and anticipate its revenues. Routine business expenses not includable in the reasonable cost formula are to be recorded in Section 208. The account titles are indicative of these costs which are commonly found. (12-31-91)*~~

~~***03. Home Office Reporting**. The purpose of the provisions of Section 208, is to support the costs allocated to the provider facility. A report is required for each level of organization which allocates costs to the provider, directly or indirectly. (7-1-97)*~~

20~~9~~8. -- 239. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

251. ~~*PRINCIPLE*~~ (RESERVED).
~~*Providers of nursing home services will be paid at the allowed amount determined in accordance with Section 56-101 to 56-131, Idaho Code. Total payment will be made up of the total of the following components:* (4-5-00)~~

~~***01. Property And Utility Costs**. All allowable property and utility costs. (9-15-84)*~~

~~***02. Nonproperty, Nonutility Costs**. Nonproperty nonutility costs as determined in accordance with the above mentioned Sections of the Idaho Code. (9-15-84)*~~

~~***03. Efficiency Increment**. An efficiency increment determined in accordance with the above mentioned Sections of the Idaho Code. (1-1-82)*~~

~~***04. Exempt Costs**. Other allowable costs exempt from the percentile cap under Sections 56-110(b) and 56-117, Idaho Code, as specified in Subsection 254.08 and 254.09. (12-31-91)*~~

(BREAK IN CONTINUITY OF SECTIONS)

302. DEVELOPMENT OF THE RATE.
Nursing facility ~~*R*~~rates ~~*shall be*~~ are prospective, with new rates effective July 1 of each year, and rebased annually. ~~*Rate setting shall be prospective with new rates effective July 1 of each year. There will be no settlement between actual costs incurred during the rate year and the rate itself. Rates for skilled care nursing facilities with unaudited cost reports will be interim rates established by the Department until a rate is calculated based on an audited cost report. The draft audit of a cost report submitted by a facility shall be issued by the Department no later than five (5) months from the date all information required for completion of the audit is filed with the Department. Data used to develop the reimbursement rate for nursing facilities will be made up of the following components:*~~ The rate for a *nursing facility* is the sum of the cost components described in Subsection 302.04 through 302.09 of this rule. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. ~~*(4-5-00)*~~( )

0~~*8*~~1. Applicable Case Mix ~~*Component*~~ Index (CMI). The Medicaid ~~*case mix indices*~~ CMI used in establishing each facility's rate ~~*will be recalculated quarterly and each facility's rate will be adjusted accordingly. The case mix indices will be*~~ *is* calculated based on the most recent assessment for each *Medicaid* resident in the *nursing* facility on the first day of the ~~*first*~~ month of the preceding quarter (~~*i.e.*~~ for example, assessments as of April 1~~*, 1999 would be*~~ are used to establish the ~~*case mix indices*~~ CMI needed to establish rates for the quarter beginning July 1~~*, 1999*~~). *Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility.* The CMI *is* recalculated quarterly and each *nursing facility*'s rate *is* adjusted accordingly. *A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting*

period (for example, an October 1 CMI would represent the fiscal quarter ended September 30). ~~*(4-5-00)*~~(____)

~~***02.***~~ ~~***Utility Costs***~~. ~~*Projected utility costs for the facility's upcoming fiscal year may be submitted to the Department not less than ninety (90) days prior to the beginning date of the facility's upcoming fiscal year. In the absence of such submission the Department will project the facility's utility costs utilizing the methodologies found in Subsection 254.06.*~~ ~~*(12-31-91)*~~

0~~7~~2. Applicable Cost ~~Component~~ Data. ~~*The cost component of each facility's rate shall be established effective July 1 of each year and remain in effect through the following June 30.*~~ The cost data used in establishing the cost components of the rate calculation ~~*will be*~~ are from the audited or unaudited cost report which ended during the previous calendar year (~~*i.e.*~~ for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 ~~*will be*~~ are used in setting rates effective July 1, 1999). ~~*If unaudited data is used, the rate will be considered an interim rate until the audited data is available, at which time a retroactive adjustment to the payment rate will be made.*~~ The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department. ~~*(4-5-00)*~~(____)

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

0~~3~~4. Direct Care Cost Component. The direct care cost component of a *nursing* facility's rate is ~~*the lesser of the facility's inflated direct care per diem costs, or the case mix adjusted per diem cost limit for that type of provider (free-standing nursing facility and urban hospital-based facilities, or rural hospital-based facilities). The lesser of the cost or limitation is then case mix adjusted, based on the facility's Medicaid case mix index.*~~ determined as follows: ~~*(4-5-00)*~~(____)

a. ~~*All costs included in the direct care component will be adjusted based on the facility's case mix indices, with the exception of raw food and Medicaid related ancillary costs.*~~ The direct care per diem cost limit applicable to the rate period for *a nursing facility* type (free-standing and urban hospital-based *nursing facility* or rural hospital-based *nursing facility*) is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the *nursing facility*'s facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit. ~~*(4-5-00)*~~(____)

b. ~~*The direct care limitation will be adjusted based on each facility's case mix index. The calculated direct care limit will be divided by the statewide average facility-wide case mix index, and then multiplied by the individual facility-wide case mix index.*~~ The adjusted direct care per diem cost limit is compared to the *nursing facility*'s inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted. ~~*(4-5-00)*~~(____)

~~***c***~~*ii*. ~~*The lesser of the cost or limit will be divided by the facility-wide case mix index, and then multiplied by the most recent quarterly Medicaid case mix index to arrive at the direct care component.*~~ If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by

the *nursing facility*'s facility-wide CMI for the cost reporting period, and then multiplied by the *nursing facility*'s most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component. ~~*(4-5-00)*~~(____)

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

0~~4~~5. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider ~~(~~ -- free-standing ~~*nursing facilities*~~ and urban hospital-based *nursing* facilities, or rural hospital-based *nursing* facilities~~)~~. ~~*(4-5-00)*~~(____)

~~***06. Calculated Reimbursement Rate****. The reimbursement rate for a facility will be the sum of the Direct Care Component, Indirect Care Component, Efficiency Incentive, Cost Exempt from Limitation, and Property Reimbursement. In no case will the interim reimbursement rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is being made as computed by the lower of costs or customary charges.*~~ ~~*(4-5-00)*~~

0~~5~~6. Efficiency Incentive. The efficiency incentive is available to those providers, both free-standing and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by seventy percent (70%). There is no incentive available to those facilities with per diem costs in excess of the indirect care cost limit, or to any facility based on the direct care cost component. ~~*(4-5-00)*~~(____)

07. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 309 of these rules. (____)

0~~1~~8. Property Reimbursement. ~~*Per diem property costs as shown on the latest twelve (12) month cost report or audit report whichever is to be used in accordance with the cost reporting standards specified in Subsections 254.03.a. and 254.03.b. and the property rental rate as determined by Section 060, for facilities which receive this rate in lieu of property costs. No inflationary increase will be considered for property costs for the purpose of developing the interim rate.*~~ The property reimbursement component ~~*will be*~~ is calculated in accordance with Section 060 and Subsection 110.19 of these rules. ~~*(4-5-00)*~~(____)

09. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 302 of these rules. (____)

(BREAK IN CONTINUITY OF SECTIONS)

304. TREATMENT OF NEW BEDS.
Facilities ~~*which*~~ that add beds ~~*subsequent to the effective date of these rules (*~~ after July 1, 1999~~)~~, will have their reimbursement rate subjected to an additional limitation for the next three (3) ~~*full*~~ years. This limitation will apply beginning with the first rate setting period which utilizes a cost report that includes the date when the beds were added. ~~*The facility's rate will be limited to the bed-weighted average of two (2) rates. Those two (2) rates are:*~~ ~~*(4-5-00)*~~(____)

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

a. ~~*t*~~The facility's current prospective rate calculated in accordance with Section 302~~,~~ of these rules; and (____)

b. ~~*t*~~The current median rate for ~~*skilled care*~~ *nursing* facilities of that type, ~~*(*~~free-standing, rural hospital-based, or urban hospital-based~~*)*~~, established each July 1. ~~*(4-5-00)*~~(____)

02. Calculation of ~~*New*~~ the Bed-Weighted ~~*Rate*~~ Average. The current calculated facility rate ~~*will be*~~ is multiplied by the number of beds in existence prior to the addition. The median rate ~~*will be*~~ is multiplied by the number of added beds, ~~*(*~~weighted for the number of days in the cost reporting period for which they were in service~~*)*~~. These two (2) amounts ~~*will be*~~ are added together and divided by the total number of beds, ~~*(*~~with the new beds being weighted if they were only in service for a portion of the year~~*)*~~. The resulting per diem ~~*will*~~ amount represents an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation ~~*will*~~ receive their calculated rate. ~~*(4-5-00)*~~(____)

03. Exception to New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes: (4-5-00)

a. Any beds converted from nursing facility beds to assisted living beds, ~~*may not be reclassified to new*~~ can be converted back to nursing facility beds ~~*until*~~ within three (3) years ~~*have elapsed from the date the beds were reclassified to assisted living beds*~~ and not be classified as new nursing facility beds. When a *nursing facility* bed has been converted to an assisted living bed for three (3) or more concurrent years and the bed is converted back to a *nursing facility* bed, it must be treated as a new *nursing facility* bed. ~~*(4-5-00)*~~(____)

b. Beds ~~*which are*~~ added as a result of expansion plans, which the Department was ~~*made*~~ aware of ~~*in writing*~~ prior to July 1, 1999, will not be treated as new beds. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning, and~~*/or*~~ development. ~~*Simply t*~~The existence of adequate land ~~*and/*~~or space ~~*will*~~ *at the nursing facility does* not *by itself* constitute ~~*having expended*~~ a significant *expenditure of* resources for the purposes of expansion. A written request with adequate supporting documentation for an exception under this provision must ~~*be*~~ have been received by the Department no later than December 31, 1999. In no case will beds added ~~*subsequent to*~~ after July 1, 2003, qualify for ~~*the*~~ *this* exception to the new bed criteria. ~~*(4-5-00)*~~(____)

c. Beds which are decertified as a requirement of survey and certification due to deficiencies at the facility ~~*may*~~ can be re-certified as existing beds with the approval of the Department. ~~*(4-5-00)*~~(____)

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

(BREAK IN CONTINUITY OF SECTIONS)

311. SPECIAL RATES.
A special rate consists of a *facility's* daily *reimbursement* rate for *a patient* plus a*n* add-on amount. Section 56-117, Idaho Code, provides authority for the ~~*Director*~~ *Department* to pay facilities ~~*a special*~~ an amount in addition to the daily rate ~~*for care given to*~~ *when a* patient~~*s who have long term care*~~ *has* needs *that are* beyond the ~~*normal*~~ scope of facility services~~*. These patients must have needs which are*~~ and *when the cost of providing for those additional needs is* not adequately reflected in the rates calculated pursuant to the principles ~~*set forth*~~ found in Section 56-102, Idaho Code. ~~*The payment*~~ This special rate add-on amount for such specialized care ~~*will be*~~ is in addition to any payments made in accordance with other provisions of this chapter~~*. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of this section will be*~~ and is excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. ~~*(4-5-00)*~~(____)

01. Determination~~*s*~~. ~~*A determination*~~ The Department determines to approve ~~*or not approve*~~ a special rate ~~*will be made*~~ on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request ~~*will*~~ must be ~~*for*~~ based on an ~~*expected*~~ identified condition that will ~~*be on-going*~~ continue for a period ~~*of*~~ greater than two (2) weeks. ~~*(4-5-00)*~~(____)

~~***02.***~~ ~~***Application***~~~~*. Until the facility applies for a special rate, patients with such needs will be included in the computation of the facility's rates following the principles described in Section 56-102, Idaho Code.*~~ ~~*(4-5-00)*~~

0~~*3*~~2. **Effective Date**. Upon approval, a special rate~~*s will become*~~ is effective on the date the application ~~*is*~~ was received, unless the provider requests a retroactive effective date. Special rates may be retroactive for up to thirty (30) days prior to receipt of the application. ~~*(3-20-04)*~~(____)

0~~*4*~~3. **Reporting**. Costs equivalent to payments ~~*at the*~~ for special rate ~~*will*~~ add-on amounts must be removed from the cost components subject to limits, and ~~*will*~~ be reported separately by the provider. ~~*(4-5-00)*~~(____)

0~~*5*~~4. **Limitation**. ~~*The reimbursement rate paid will*~~ A special rate cannot exceed the

provider's charges to other patients for similar services. ~~*(4-5-00)*~~(____)

0~~*6*~~5. Prospective Rate Treatment. Prospective treatment of special rates became effective July 1, 2000. Subsections 311.0~~*7*~~6 ~~*through*~~ and 311.0~~*9*~~7 of these rules provide clarification of how special rates ~~*will be handled*~~ are paid under the prospective payment system. ~~*(3-20-04)*~~(____)

~~***07. Residents Qualifying****. Special rates are intended for residents who have long term care needs beyond the normal scope of facility services, and whose needs are not adequately reflected in the rates set pursuant to Section 56-102, Idaho Code.*~~ ~~*(3-15-02)*~~

0~~*8*~~6. Determination of Payment for Qualifying Residents. Special rate~~*s shall be reimbursed in*~~ add-on amounts are calculated using one (1) of the methods described in Subsections 311.0~~*8*~~6.a. through 311.0~~*8*~~6.~~*d*~~e. of these rules. ~~*(3-20-04)*~~(____)

a. Special ~~*Rate*~~ Care Units. If a facility operates a special ~~*rate*~~ care unit~~*; i.e.*~~, such as a behavioral unit~~,~~ or a Traumatic Brain Injury (TBI) unit, ~~*etc., the following*~~ reimbursement ~~*methods will apply under the circumstances*~~ is determined as described in Subsections 311.0~~*8*~~6.a.i. through 311.0~~*8*~~6.a.v~~*i*~~. of these rules. ~~*(3-20-04)*~~(____)

i. ~~*Facility is Under the Direct Care Limit -*~~ If the facility ~~*operates a special rate unit, the*~~ is below the direct care cost~~*s of which do not exceed the direct care*~~ limit~~,~~ with ~~*all direct*~~ special care unit costs included~~*in the rate calculation*~~, no special rate ~~*shall be*~~ is paid for the unit. ~~*(3-15-02)*~~(____)

ii. ~~*Facility is Over the Direct Care Limit - If the facility operates a special rate unit, the costs of which exceed the direct care limit, with all direct care costs included in the rate calculation, the special rate for the unit will be equal to the lesser of the per diem amount by which direct care costs exceed the limit, or the special rate add-on calculated as follows: each Medicaid resident approved for a special rate is classified using Medicare's grouper (currently RUG's III v.5.12 44 Group) and is assigned a total rate equal to the applicable Medicare price that would be paid if the resident were Medicare eligible. The special rate "add-on" to the facility rate is calculated by subtracting the resident-specific Medicaid rate (based on each resident's Medicaid CMI) from the Medicare price. The average of the special rate add-on amounts calculated using this methodology shall be compared to the amount the provider is over the limit. The lesser amount is allowed as a special rate.*~~ If the facility is over the direct care cost limit with special care unit costs included, a special rate add-on amount will be calculated. The special rate add-on amount for the unit is the lesser of the per diem amount by which direct care costs exceed the limit or a calculated add-on amount. The calculated special rate add-on is derived as follows: each Medicaid resident is assigned a total rate equal to the Medicare rate that would be paid if the resident were Medicare eligible. The resident's acuity adjusted Medicaid rate, based on each resident's individual Medicaid CMI, is subtracted from the Medicare rate. The average difference between the Medicaid and the Medicare rates for all special care unit residents is the calculated special rate add-on amount. The calculated special rate add-on amount is compared to the per diem amount by which the provider exceeds the direct care limit. The lesser of these two amounts is allowed as the special rate add-on amount for the unit. ~~*(3-15-02)*~~(____)

~~*iii. New Unit Added Before July 1, 2000 - A unit added before July 1, 2000 that does*~~

~~*not have sufficient historical cost data in the cost report used to set the rate shall receive the same rate that would have been set under the retrospective system until a cost report with sufficient cost detail is filed.*~~ ~~*(3-15-02)*~~

i~~v~~ii. New Unit Added ~~*a*~~After July 1, 2000. ~~*- To qualify for special rates,*~~ The Department must approve special rates for new special care units~~,~~ or increases to the number of licensed beds in an existing special care unit ~~*must first receive Departmental approval*~~. Since a new unit will not have the cost history of an existing unit, the provider's relationship to the cap will not be considered in qualifying for a special rate. ~~*Those residents who are*~~ New units approved for special rates will have their special ~~*rate*~~ add-on amount calculated as the difference between the applicable Medicare price under PPS, and the acuity adjusted Medicaid rate for ~~*that individual*~~ all unit residents as explained in Section 311.0~~*8*~~6.a.ii. of these rules. However, the average of these amounts ~~*would*~~ is not ~~*be*~~ limited to the amount the provider is over the direct care cost limit, as the costs of the unit are not in the rate calculation. ~~*(3-20-04)*~~(____)

iv. One Hundred Percent (100%) Special Care Facility ~~*in Existence as of*~~ Existing July 1, 2000. ~~-~~ If ~~*at*~~ *on* July 1, 2000, an entire facility ~~*is devoted to caring for "special rate" residents, including*~~ *was* a special care unit which included Medicaid residents ~~*approved for special rates as well as private pay and other residents who would qualify for special rates if they were Medicaid eligible*~~, the facility's ~~*allowable reimbursement will be calculated as follows. The costs of the*~~ direct care ~~*component*~~ cost per diem will not be subject to the direct care cost limit. However, ~~*those*~~ the direct care costs ~~*will still be*~~ are case-mix adjusted based on the ratio of the facility's Medicaid ~~*case-mix*~~ CMI for the rate period to the facility-wide ~~*case-mix index*~~ CMI for the *cost reporting* period. ~~*(3-15-02)*~~(____)

vi. Unit Routine Customary Charge. ~~-~~ If the cost to operate a special ~~*rate*~~ care unit is being included in a facility's rate calculation process, the facility must report its usual and customary charge for ~~*that*~~ a semi-private room in the unit on the quarterly reporting form, in addition to the semi-private daily room rate for the general nursing home population. A weighted average routine customary charge ~~*shall be*~~ is computed ~~*by taking the number of Medicaid days approved for special rates times the usual and customary charge for private pay individuals in that unit, plus the Medicaid days not in the special rate unit times the usual and customary charge for that portion of the facility*~~ to represent the composite of all Medicaid residents in the facility based on the type of rooms they occupy, including the unit. ~~*(3-15-02)*~~(____)

b. Equipment~~/~~ and Non-Therapy Supplies. Equipment and non-therapy supplies not adequately addressed in the current RUG~~'s~~ system, as determined by the Department, ~~*shall be*~~ *are* reimbursed at invoice cost as an add-on ~~*to the facility's rate for the resident receiving the equipment or supplies*~~ *amount*. ~~*The facility need not exceed the direct care limit to receive a special rate for such services. Items that qualify for such treatment include but are not limited to the following: air fluidized beds, overlay mattresses, TPN supplies and VAC wound care.*~~ ~~*(3-15-02)*~~(____)

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. *The facility need not exceed the direct care limit to receive a special rate for ventilator care and tracheostomy care.* In the case of ventilator dependent and tracheostomy residents, a two (2) step approach ~~*shall be*~~ is taken to establish ~~*the special rate*~~ an add-on amount. ~~*The facility need not exceed the direct care limit to receive a special rate for ventilator care and tracheotomy care.*~~ The

first step is the calculation of a staffing add-on for the cost, if any, of additional direct care staff required to meet the exceptional needs of these residents. The add-on ~~*shall be*~~ is calculated following the provisions ~~*set forth*~~ in Subsection 311.0~~8~~6.d. of these rules, adjusted for the appropriate skill level of care staff. The second step ~~*shall be*~~ is the calculation of an add-on for equipment, ~~*supply*~~ supplies, or both ~~*add-on to be added to the rate*~~ up to the invoice cost or rental amount. The combined amount of these two (2) components ~~*shall be*~~ is considered the special ~~*rate*~~ add-on amount to the facility's rate for approved residents receiving this care. ~~*(3-20-04)*~~(____)

d. Residents ~~*Who Do*~~ Not ~~*Reside*~~ Residing in a Special ~~*Rate*~~ Care Unit Requiring One-to-One Staffing Ratios. Facilities ~~*that do not have established units with a cost history built into their cost reports and rates*~~ may at times have residents who require unusual levels of staffing~~;~~, such as~~,~~ one-to-one staffing ratios. If the resident qualifies for a special rate, ~~*the additional reimbursement will be allowed as follows:*~~ an hourly add-on rate is computed for reimbursement of approved one-to-one (1 to 1) hours in excess of the minimum staffing requirements in effect for the period. The hourly add-on rate is equal to the current WAHR CNA wage rate plus a benefits allowance of thirty percent (30%), then weighted to remove the CNA Minimum daily staffing time.

~~*Example Using Sixteen (16) Hours of One-To-One Care*~~	
~~*Total hours per day:*~~	~~*24.0*~~
~~*Less minimum staff level required:*~~	~~*(2.0)*~~
~~*Net special rate hours allowed:*~~	~~*22.0*~~
~~*Average wage rate of CNA's per WAHR survey:*~~	~~*$7.53*~~
~~*Plus Benefits at Thirty percent (30%):*~~	~~*$2.26*~~
~~*Allowed wages and Benefits*~~	~~*$9.79*~~
~~*Allowable daily special rate add-on:*~~	~~*$215.38*~~
~~*Divided by total hours:*~~	~~*24.0*~~
~~*Calculated hourly rate:*~~	~~*$8.97*~~
~~*One to one hours approved:*~~	~~*16.0*~~
~~*Sixteen (16) hours of one to one add-on:*~~	~~*$143.53*~~

~~*(3-15-02)*~~(____)

e. Varying Levels of One-to-One Care. For ~~*differing*~~ varying levels of one-to-one care~~; *i.e.*~~, such as eight (8) hours or twenty-four (24) hours, ~~*only*~~ the total special rate add-on amount is calculated as the number of hours ~~*of*~~ approved for one-to-one care ~~*approved would be changed*~~ times the hourly add-on rate as described in Subsection 311.0~~8~~6.d. The WAHR CNA wage rate as described in IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 148 will be updated prior to the July 1st rate setting each year. Should the WAHR~~*S*~~ survey be discontinued, the Department may index prior amounts ~~*may be indexed*~~ forward, or conduct a comparable survey~~ *may be conducted*~~. ~~*(3-20-04)*~~(____)

0~~9~~7. Treatment of the Special Rate Cost for Future Rate Setting Periods. Special rates ~~*shall be*~~ are established on a prospective basis similar to the overall facility rate. When ~~*a*~~ the cost report ~~*is*~~ used to set a prospective rate contains non-unit special rate cost, an adjustment ~~*shall be*~~ is made to "offset," or ~~*remove, the amount received for the special rates from the calculation of costs*~~ reduce costs by an amount equal to total incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received ~~*shall be*~~ is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. ~~*The case-mix index for each resident shall be left in the facility-wide average and the Medicaid average for rate setting purposes, as the offset would only be for the incremental portion of the rate, above what Medicaid would have paid.*~~ No related adjustment is made to the facility's CMIs. ~~*(3-15-02)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

407. COSTS FOR THE COMPLETION OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPS) IN NURSING FACILITIES ~~*(NFS)*~~ (EXCLUDING ICF/MR FACILITIES) AND FOR COMPLYING WITH CERTAIN OTHER REQUIREMENTS.
Provisions of federal law require the state to give special treatment to costs related to the completion of training and competency evaluation of nurse aides and to increase rates related to other new requirements. Treatment will be as follows: ~~*(9-28-90)*~~(____)

01. Cost Reimbursement. Effective for cost reports filed and for payments made after April 1, 1990, ~~*such*~~ NATCEP costs ~~*shall*~~ will be outside the content of nursing facility care and ~~*shall*~~ will be ~~*reimbursed*~~ reported separately as ~~*an ancillary*~~ exempt costs. ~~*(9-28-90)*~~(____)

02. Costs Subject to Audit. Such NATCEP costs ~~*shall remain*~~ are subject to audit, ~~*shall be reported separate from other costs, shall*~~ and must be reported by all ~~*NFs*~~ *nursing facilities*, including those ~~*which*~~ that are hospital-based, and ~~*will*~~ are not ~~*be*~~ included in the percentile cap. ~~*(9-28-90)*~~(____)

~~***03. Payment Adjustments**. Beginning April 1, 1990, interim NF payments will be adjusted to exclude NATCEP costs from the content of NF care, separate payments covering such costs will be made, and payment rates will be revised to cover certain other costs. (9-28-90)*~~

~~***a.** NATCEP's costs are not part of the content of nursing home care, are to be reported separately on cost reports by all NF's and are reimbursed separate from NF interim rates. Such costs incurred from July 1, 1988 through September 30, 1990 will be reimbursed at one hundred percent (100%) of reasonable cost; NATCEP costs incurred thereafter will be separately reimbursed based on the Medicaid share of reasonable costs. (9-28-90)*~~

~~***b.** Reimbursement for new costs, other than NATCEP related costs, which result from Public Law 100-203 (OBRA 1987) will be incorporated in interim NF payments effective October 1, 1990 for those providers who document such costs by October 1, 1990. Acceptable*~~

~~*documentation will include estimated wages and benefits for new employees or net increases in scheduled working hours for specific current employees in order to comply with new requirements under OBRA 1987. The Department will provide forms for listing items related to the added costs including:* *(9-28-90)*~~

~~*i. New employees;* *(9-28-90)*~~

~~*ii. Related new responsibilities;* *(9-28-90)*~~

~~*iii. Products and services added;* *(9-28-90)*~~

~~*iv. Products and services no longer required;* *(9-28-90)*~~

~~*v. Added hours required;* *(9-28-90)*~~

~~*vi. Wage rates and other costs related to the net added products and services; and* *(9-28-90)*~~

~~*vii. The benefits rate for the facility.* *(9-28-90)*~~

~~***c.*** *Interim rate increases will be based on total estimated added annual costs divided by the number of annual patient days used in determining the remainder of the interim rate. These rate increases are subject to reevaluation and revision based on actual costs. Interim payments are intended to approximate as closely as possible the final settlement amount. The final settlement for increases related to new costs resulting from OBRAs will be no more or less than audited actual cost. There will be no percentile cap or efficiency increment applied to these new costs.* *(9-28-90)*~~

~~***d.*** *A rate change for new costs related to OBRA 1987 will not count toward the limit of two (2) adjustments per year as addressed in Subsection 303.03.* *(12-31-91)*~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.17 - SERVICE COORDINATION

DOCKET NO. 16-0317-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202(b), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The proposed rule was amended to better reflect that the mode and frequency of contact between service coordinator and participant must be based on the needs of the participant and that face-to-face contact must occur at least monthly for mental health service coordination and at least every ninety (90) days for all other service coordination. This rule change is being made based on comment.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Vol. 04-10, pages 395 through 400.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Leslie Clement at (208) 364-1804.

DATED this 17th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed regular rulemaking procedures. The action is authorized pursuant to Section 56-202(b), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public

hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rulemaking:

This docket changes the time line from thirty (30) to sixty (60) days for development of a service plan by service coordinators. The service plan time line for mental health service coordination remains at thirty (30) days. The rule is being promulgated at the request of service coordinators who testified before the 2004 House Health and Welfare committee. This change will benefit the providers and participants receiving service coordination by ensuring enough time is allowed to develop the service coordination plan. Also, based on a petition for rulemaking from the Case Management Association of Idaho, Inc. (CMAID), three (3) additional changes will be made to clarify the face to face contact requirements, participant's right to choose a provider, and individual service coordinator caseloads. In addition to these requested changes the Department is adding a new section that will be required in all chapters to clarify mandatory criminal history check requirements

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule is based on requested changes from service providers that the Department has agreed to make.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Paul Leary at (208) 364-1840.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 27, 2004.

DATED this 5th day of August, 2004.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036

(208) 334-5564 phone, (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following documents: (3-20-04)

01. State Medicaid Manual. Centers for Medicare and Medical Services, Publication No. 45, ~~*Part Four (4) - Services,*~~ Sections 1115, 2114, 4302, ~~*"Optional Targeted Case Management Services - Basis, Scope and Purpose,"*~~ and 4442.3. (August 28, 2002). This document is available online at http://www.cms.gov/manuals/cmstoc.asp or requested by mail at the Centers for Medicare and Medical Services, 7500 Security Boulevard, Baltimore, Maryland 21244. ~~*(3-20-04)*~~( )

02. DSM-IV-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83720-0036. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

008.~~*009.*~~ (RESERVED).

009. MANDATORY CRIMINAL HISTORY CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ( )

02. When Employee May Begin Work. Once a service coordinator or paraprofessional has completed a self-declaration form and has been fingerprinted, he may begin working for the service coordination agency on a provisional basis, except if he discloses a designated crime listed in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks," while awaiting the results of the criminal history check. ( )

03. Additional Criminal Convictions. Once a service coordinator or paraprofessional has received a criminal history clearance, any additional criminal convictions must be reported by the service coordination agency to the Department or its designee when the agency learns of the conviction. ( )

010. DEFINITIONS.

01. Agency. An agency is a business entity that provides service coordination and includes at least a supervisor and a service coordinator. (3-20-04)

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (3-20-04)

03. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (3-20-04)

a. Hospitalization; (3-20-04)

b. Loss of housing; (3-20-04)

c. Loss of employment or major source of income; (3-20-04)

d. Incarceration; or (3-20-04)

e. Physical harm to self or others, including family altercation or psychiatric relapse. (3-20-04)

04. Crisis Service Coordination. Crisis service coordination services are linking, coordinating and advocacy services provided to assist a participant to access emergency community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. (3-20-04)

05. Current Assessment. An assessment that accurately reflects the status of the participant. (3-20-04)

06. Department. The Idaho Department of Health and Welfare or its designee. (3-20-04)

07. High Cost Services. As used in Subsection 203.01 of these rules, high cost services are medical services that result in expensive claims payment or significant state general fund expenditure that may include: (3-20-04)

a. Emergency room visits or procedures; (3-20-04)

b. Inpatient medical and psychiatric services; (3-20-04)

c. Nursing home admission and treatment; (3-20-04)

d. Institutional care in jail or prison; (3-20-04)

e. State, local, or county hospital treatment for acute or chronic illness; and (3-20-04)

f. Outpatient hospital services. (3-20-04)

08. Human Services Field. A particular area of academic study in health, social services, education, behavioral science or counseling. (3-20-04)

09. Paraprofessional. An adult who has a minimum of a bachelor's degree in a human services field but no experience with participants, or a person without a degree but with a high school diploma or equivalency who has at least twelve (12) months' experience with the population to whom they will be providing services. (3-20-04)

10. Practitioner Of The Healing Arts. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (3-20-04)

11. Provider. Any individual, organization or business entity furnishing medical goods or services in compliance with this chapter and who has applied for and received a provider number and entered into a written provider agreement, under IDAPA 16.03.09 "Rules Governing the Medical Assistance Program," Sections 020 and 040. ( )

1~~1~~2. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Service coordination is a brokerage model of case management as defined in the State Medicaid Manual referenced in Subsection 004.01 of these rules. ~~(3-20-04)~~( )

1~~2~~3. Service Coordinator. An individual who provides service coordination to a Medicaid eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements in Section 700 of these rules. (3-20-04)

1~~3~~4. Supports. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of his choice. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

400. SERVICE PLAN DEVELOPMENT.
A written service coordination plan must be developed and implemented within ~~*thirty*~~ sixty (~~3~~60) days after the participant chooses a service coordination agency except in the case of adults with severe and persistent mental illness; in which case the time limit is thirty (30) days. The plan must be updated at least annually. The plan must address the service coordination needs of the participant as identified in the assessment. ~~(3-20-04)~~( )

01. Service Plan Content For Individuals With Developmental Disabilities. The service coordination plan for individuals with developmental disabilities is incorporated into the participant's plan of service. The content is identified in IDAPA 16.03.13, "Prior Authorization For Behavioral Health Services," Section 310. (3-20-04)

02. Service Plan Content For Individuals Receiving Personal Assistance Services. The individual's service plan must contain at least the following: (3-20-04)

a. Problems identified during the assessment; (3-20-04)

b. Overall goals to be achieved; (3-20-04)

c. Reference to all services and contributions provided by the informal support system including the actions, if any, taken by the service coordinator to develop the support system; (3-20-04)

d. Documentation of who has been involved in the service planning, including the participant's involvement; (3-20-04)

e. Schedules for service coordination monitoring and reassessment; (3-20-04)

f. Documentation of unmet needs and service gaps; and (3-20-04)

g. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery. (3-20-04)

03. Service Plan Content For Individuals With Severe And Persistent Mental Illness. The service coordination plan must include the following: (3-20-04)

a. A list of problems and needs identified during the assessment; (3-20-04)

b. Concrete measurable goals and objectives to be achieved by the service coordinator; (3-20-04)

c. Time frames for achievement of the goals and objectives; (3-20-04)

d. Reference to any formal services arranged including specific providers; (3-20-04)

e. Frequency of services initiated; and (3-20-04)

f. Documentation of who was involved in the service planning. (3-20-04)

04. Service Plan Development For EPSDT Service Coordination. The initial plan for EPSDT service coordination is completed by the Department or designee. An EPSDT service coordination agency selected by the family develops an annual service coordination plan and submits it to the Department for prior authorization of continued service coordination. (3-20-04)

401. -- 499. (RESERVED).

500. SERVICE COORDINATOR CONTACT AND AVAILABILITY.

01. Contact With Participant. At least every thirty (30) days, service coordinators

must have contact with the participant, legal guardian or provider who can verify the participant's well being and whether services are being provided according to the written plan. The frequency, mode of contact, and person being contacted must be identified in the plan. (3-20-04)

a. *The mode and frequency of contact for developmental disability service coordination must be identified in the plan and must meet the needs of the participant.* ~~*Developmental disabilities s*~~Service coordinators must have face-to-face contact with each participant at least every ninety (90) days. ~~*(3-20-04)*~~(____)

b. *The mode and frequency of contact for mental health service coordination must be identified in the plan and must meet the needs of the participant.* Mental health service coordinators must have ~~*a*~~ face-to-face contact every month with each participant. ~~*(3-20-04)*~~(____)

c. *The mode and frequency of contact for Early and Periodic Screening and Diagnosis and Treatment (EPSDT) service coordination must be identified in the plan and must meet the needs of the child.* EPSDT service coordinators must have face to face contact with the child and the child's family at least every ninety (90) days. (____)

d. *The mode and frequency of contact for Personal Care Service (PCS) service coordination must be identified in the plan and must meet the needs of the participant.* PCS service coordinators must have face to face contact with the participant and others *at least every ninety (90) days* as necessary to coordinate and monitor the progress of the existing individual service plan. (____)

02. Hours Of Availability. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include on the plan what the participant, families, and providers should do in an emergency situation.

(3-20-04)

501. -- 549. (RESERVED).

550. PARTICIPANT CHOICE OF SERVICE ~~*COORDINATORS AND*~~ COORDINATION PROVIDERS.

Eligible participants have the option to select service coordinators. A participant must have free choice of a service ~~*coordinators as well as providers of Medicaid services*~~ coordination provider. ~~*(3-20-04)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

700. SERVICE COORDINATOR QUALIFICATIONS.

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (3-20-04)

02. Work Experience And Supervision. All service coordinators must have at least

twelve (12) months' experience working with the population they will be serving or be supervised by a qualified service coordinator. (3-20-04)

03. Minimum Education Requirements. All service coordinators must have a minimum of a bachelor's degree in a human services field from a nationally accredited university or college; or be a licensed professional nurse, also referred to as a registered nurse (RN). (3-20-04)

~~***04. Criminal History Check**. All service coordinators must pass the Department's criminal history check in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". (3-20-04)*~~

701. -- 724. (RESERVED).

725. PARAPROFESSIONALS.
Under the supervision of a qualified service coordinator, paraprofessionals may be used to assist in the implementation of a service coordination plan except for plans of participants with a mental illness. Paraprofessionals must be able to read and write at a level equal with the paperwork and forms involved in the provision of service. ~~*All paraprofessionals must pass the Department's criminal history check as described in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". (3-20-04)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

751. ~~*AGENCY*~~ <u>INDIVIDUAL SERVICE COORDINATOR</u> CASE LOADS.
The total caseload of a service coordinator must assure quality service delivery and client satisfaction. ~~*(3-20-04)*~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.18 - CHIP B AND CHILDREN'S ACCESS CARD RULES

DOCKET NO. 16-0318-0401 (NEW CHAPTER)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is July 1, 2004. This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-239 and 56-240, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change. Since this rule was published in July, the Department has obtained a new internet website address, therefore it was added to Section 005.05 in order to provide accurate public access to this website. After the public comment period the following amendments were made to the proposed text of this rule: the words "or employer" were deleted from Section 010.15 because the premium referred to in this subsection is only paid to an insurance company; in Section 605 a sentence was added to clarify Access Card payments and, two terms were changed for clarity and a subsection was added to clarify data reporting requirements in Section 620.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the July 7, 2004 Administrative Bulletin, Volume 04-07, pages 73 through 80.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Robin Pewtress at (208) 364-1892.

DATED this 17th day of November, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0318-0401***
CHIP B and Children's Access Card Rules ***PENDING RULE (New Chapter)***

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2004.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-239 and 56-240, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

Date:	**Wednesday, July 14, 2004**	**Wednesday, July 14, 2004**	**Thursday, July 15, 2003**
Time:	**7:00 - 9:00 p.m.**	**7:00 - 9:00 p.m.**	**7:00 - 9:00 p.m.**
Place:	**Dept. of Health & Welfare** **1120 Ironwood Dr., Suite 102** **Coeur d'Alene, ID**	**Dept. of Health & Welfare** **1720 Westgate Dr., Suite D** **Boise, ID**	**Dept. of Health & Welfare** **2nd Floor Conf. Room** **150 Shoup Ave** **Idaho Falls, ID**

The hearing sites will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

This new chapter of rule supports the implementation of the Idaho Health Insurance Access Card Act passed during the 2003 Idaho Legislative session. It describes the payment of services and covered services for eligible children under the Children's Health Insurance Program B (CHIP B) and provides guidelines for the insurance premium subsidy program for eligible children under the Children's Access Card.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code, and are necessary in order to comply with deadlines in governing law and confer a benefit to Idahoans.

NEGOTIATED RULEMAKING: Informal negotiated rulemaking was conducted. The Department, through the formation of the "CHIP B Access Card Project" team, conducted many meetings within the Department reviewing options for the implementation of the CHIP B program and researched other similar programs to design a workable program for Idahoans.

The Department also met with and discussed options for the Children's Access Card program with the "Access Card Insurer Group" made up of several major insurance companies and a broker representative. Also, the Idaho High Risk Reinsurance Pool Board reviewed the rules and made recommendations to the Department.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rules, contact Robin Pewtress, Idaho SCHIP Director, at 208-364-1892.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before July 28, 2004.

DATED this 29th day of June, 2004.

Sherri Kovach, Program Supervisor
DHW - Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 03
CHAPTER 18

16.03.18 - CHIP B AND CHILDREN'S ACCESS CARD RULES

000. LEGAL AUTHORITY.
Under Section 56-202(b), Idaho Code, the Legislature has delegated to the Department of Health and Welfare the responsibility to establish and enforce such rules as may be necessary or proper to administer public assistance programs within the state of Idaho. Under Sections 56-239 and 56-240, Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to define program requirements and eligibility conditions for federal financial assistance in payments for the CHIP B and Children's Access Card program. Furthermore, the Idaho Department of Health and Welfare is the designated agency to administer programs under Title XXI of the Social Security Act. (7-1-04)T

001. TITLE AND SCOPE.

01. Title. The title of this chapter is IDAPA 16.03.18, "CHIP B and Children's Access Card Rules".
(7-1-04)T

02. Scope. Under Sections 56-239 and 56-240, Idaho Code, these rules describe the general provisions regarding the administration of the Idaho CHIP B (Children's Health Insurance Program B) and Children's Access Card programs. These rules identify the amount, duration, and scope of care and services to be purchased on behalf of eligible individuals. All goods and services not specifically included in this chapter are excluded from coverage. (7-1-04)T

03. Policy. It is the policy of the Department, under Section 56-209(b), Idaho Code, that CHIP B and the Children's Access Card Programs are available to individuals who are eligible as set forth in IDAPA 16.03.01, "Eligibility For Health Care Assistance for Families and Children". (7-1-04)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of this chapter. These documents are available for public inspection as described in Sections 005 and 006 of these rules. (7-1-04)T

003. ADMINISTRATIVE APPEALS.
All administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (7-1-04)T

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference into these rules. (7-1-04)T

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

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (7-1-04)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (7-1-04)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (7-1-04)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (7-1-04)T

05. Internet Website. The Department's internet website is found at "http://~~*www2.state.id.us/dhw/*~~ www.healthandwelfare.idaho.gov". ~~*(7-1-04)T*~~(7-1-04)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.
Any use or disclosure of Department records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records". (7-1-04)T

007. -- 009. (RESERVED).

010. DEFINITIONS.

01. Children's Access Card. The insurance premium assistance program for children in families who qualify for CHIP A or CHIP B. (7-1-04)T

02. CHIP A (Children's Health Insurance Program A). The health insurance

program for children whose income exceeds the Title XIX Medicaid threshold, but is less than or equal to one hundred fifty percent (150%) of the Federal Poverty Guidelines (FPG). (7-1-04)T

03. CHIP B (Children's Health Insurance Program B). A limited health insurance program for children in families whose income is greater than one hundred fifty percent (150%), but is less than or equal to one hundred and eighty-five percent (185%) of the current FPG. (7-1-04)T

04. Co-Payment (Co-pay). The amount a participant is required to pay for specified services. (7-1-04)T

05. Cost-Sharing. A payment the participant is required to make toward the cost of his health care. (7-1-04)T

06. Department. The Idaho Department of Health and Welfare. (7-1-04)T

07. Director. The Director of the Department of Health and Welfare. (7-1-04)T

08. Family. One (1) or two (2) natural or adoptive parents and their child(ren) who live in the same dwelling. (7-1-04)T

09. Field Office. An office of the Idaho Department of Health and Welfare authorized to accept and process applications for benefits. (7-1-04)T

10. Insurance Vendor. An insurance company regulated by the Idaho Department of Insurance. (7-1-04)T

11. Medically Necessary. A service is medically necessary if it can reasonably prevent, diagnose or treat a condition that endangers life, causes pain or causes functionally significant deformity or malfunction. In addition, no other effective treatment is available or suitable for the participant that is more conservative or substantially less costly. (7-1-04)T

12. Mid-Level Practitioner. A certified registered nurse anesthetist (CRNA), nurse practitioner (NP), nurse midwife (NM), or physician assistant (PA). (7-1-04)T

13. Participant. A person who is applying for or receiving CHIP B or Children's Access Card benefits. (7-1-04)T

14. Premium. A regular and periodic charge or payment for health coverage. (7-1-04)T

15. Premium Assistance. The partial or total premium paid to an insurance company ~~*or employer*~~ by the State to supplement the cost of enrolling an eligible individual in a health insurance plan. ~~*(7-1-04)T*~~(7-1-04)T

16. Provider. Any individual, organization or business entity furnishing medical goods or services. (7-1-04)T

17. Social Security Act. 42 U.S.C. 101 et seq., authorizing, in part, federal grants to the states for CHIP B assistance to eligible low-income individuals. (7-1-04)T

18. State. The state of Idaho. (7-1-04)T

19. Third Party. A person, institution, corporation, or public or private agency that is liable to pay all or part of a participant's medical cost for his injury, disease or disability. (7-1-04)T

011. -- 099. (RESERVED).

CHIP B Payment Of Services
(Sections 100 through 170)

100. CHOICE OF PROVIDERS.

01. Service Selection. Each participant may obtain any CHIP B services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in a coordinated care plan. (7-1-04)T

02. Medical Care Provided Outside The State Of Idaho. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Out-of-state medical care is covered if the participant has a medical emergency or if the service is included in the scope of CHIP B but not available from an Idaho provider. Out-of-state medical care is subject to the same utilization review and other medical care coverage requirements and restrictions as medical care received within the state of Idaho. (7-1-04)T

101. -- 019. (RESERVED).

120. PROVIDER AGREEMENT.
Payment for services to CHIP B participants will be made only to providers that have an effective Medicaid provider agreement. All Medicaid provider agreement terms and conditions apply to CHIP B services. Where the Department purchases CHIP B services through an insurance vendor, the vendor must execute an agreement with each CHIP B provider that contains the minimum requirements of Medicaid providers. Vendors must also take steps to assure that no provider suspended or barred from providing Medicaid or Medicare services will be paid for providing services to CHIP B participants. (7-1-04)T

121. -- 129. (RESERVED).

130. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will provide for reimbursement to providers of medical care and services, regardless of the current eligibility status of the participant in the month of billing, if each of the following conditions is met: (7-1-04)T

a. The participant was found eligible for CHIP B for the month, day, and year the medical care and services were provided; (7-1-04)T

b. Not more than twelve (12) months have elapsed since the month the latest participant services were billed; and (7-1-04)T

c. A Children's Access Card program payment is not made for the same month as a CHIP B reimbursement request. (7-1-04)T

02. Payment In Full. By participating in the CHIP B program, providers agree to accept the Department's payment for services to eligible participants as payment in full. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. (7-1-04)T

131. -- 139. (RESERVED).

140. THIRD PARTY LIABILITY.
Third party liability and recovery will apply in accordance with IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 030. CHIP B reimbursement is considered the payment of last resort. (7-1-04)T

141. -- 149. (RESERVED).

150. IDENTIFICATION (ID) CARD.
The Department or its designee will issue an identification (ID) card to an individual eligible for CHIP B or the Children's Access Card. The service provider or insurance vendor is responsible to request the ID card before providing services. (7-1-04)T

151. -- 154. (RESERVED).

155. INFORMATION AVAILABLE FOR PARTICIPANTS.
The following information will be available at each Department Field Office for use by participants: (7-1-04)T

01. Scope. The amount, duration, and scope of the available care and services. (7-1-04)T

02. Obtaining Services. The manner in which the care and services may be secured. (7-1-04)T

03. ID Card. How to use the ID card to obtain services. (7-1-04)T

156. -- 159. (RESERVED).

160. REVIEW OF RECORDS.
The Department or its designee, and the U.S. Department of Health and Human Services have the right to review pertinent records of providers and insurance vendors receiving CHIP B or Children's Access Card payments in accordance with IDAPA 16.03.09, "Rules Governing the

Medical Assistance Program". (7-1-04)T

161. -- 169. (RESERVED).

170. FEES AND UPPER LIMITS.
Reimbursement to providers will be as provided in IDAPA 16.03.09, "Rules Governing the Medical Assistance Program" or IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho," or as stated in the agreement between the provider and the Department's designated insurance vendor, as appropriate. (7-1-04)T

171. -- 199. (RESERVED).

CHIP B Covered Services
(Sections 200 through 310)

200. INPATIENT SERVICES.
Inpatient services are limited to a semi-private room, intensive and coronary care unit, general nursing, rehabilitation, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat and inhalation therapy, operating, recovery, birthing and delivery room, routine and intensive care for newborns, and other medically necessary benefits and prescribed supplies for treatment of injury or illness. (7-1-04)T

201. -- 224. (RESERVED).

225. PHYSICIAN SERVICES.
Office, clinic, outpatient surgery center and hospital treatment by a physician, mid-level practitioner for a medical condition, injury or illness are covered. (7-1-04)T

01. Wellness Services. Well child, well baby and immunization services to the extent recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices are covered. Examinations for school activities are covered. (7-1-04)T

02. Anesthesia. Anesthesia services rendered by a anesthesiologist who is a physician, other than the attending physician or assistant, or by a certified nurse anesthetist are covered, provided that the related surgical and hospital services are also covered. (7-1-04)T

03. Second Opinion. Medically appropriate second opinions are covered. (7-1-04)T

226. -- 229. (RESERVED).

230. OUTPATIENT HOSPITAL.
All benefits described in these rules provided on an outpatient basis in a hospital are covered including: (7-1-04)T

01. An Observation Bed And Partial Hospitalization Benefits; (7-1-04)T

02. Ambulatory Surgical Center; (7-1-04)T

03. Chemotherapy; (7-1-04)T

04. Emergency Room Benefits For Surgery; (7-1-04)T

05. Injury Or Medical Emergency; and (7-1-04)T

06. Diagnostic Or Outpatient Treatment Of A Medical Condition, Injury Or Illness. (7-1-04)T

231. -- 234. (RESERVED).

235. DRUGS.
Drugs prescribed by a practitioner acting within the scope of his practice, chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines and prenatal vitamins are covered. The provisions of IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Sections 805 through 813 apply. (7-1-04)T

236. -- 244. (RESERVED).

245. OUTPATIENT MENTAL HEALTH.
Outpatient mental health clinic and rehabilitative services are covered. Inpatient mental health services are not covered. (7-1-04)T

246. -- 249. (RESERVED).

250. LABORATORY AND RADIOLOGY SERVICES.
Imaging and laboratory services are covered for diagnostic and therapeutic purposes as a result of accident, illness or medical conditions. X-ray, radium, or radioactive isotope therapy are covered. (7-1-04)T

251. -- 254. (RESERVED).

255. TRANSPORTATION.
Medically necessary ground and air ambulance emergency transportation is covered. (7-1-04)T

256. -- 259. (RESERVED).

260. PRENATAL CARE.
Prenatal care is covered. (7-1-04)T

261. -- 264. (RESERVED).

265. FAMILY PLANNING.
Pre-pregnancy family planning services and prescribed supplies, including birth control contraceptives are covered. (7-1-04)T

266. -- 269. (RESERVED).

270. SURGICAL SERVICES.
Surgical services are covered as described in Sections 200, 225, and 230 of these rules. Professional services rendered by a physician, surgeon or doctor of dental surgery for treatment of a fractured jaw or other injury to sound natural teeth and gums are covered. (7-1-04)T

271. -- 279. (RESERVED).

280. VISION SERVICES.

01. Medical Treatment. Medical treatment of diseases or injury to the eye is included in vision services. Medical treatment must be provided by a licensed physician or optometrist working within the scope of his license. Tonometry services are not covered unless the participant is receiving continuing treatment for glaucoma. (7-1-04)T

02. Vision Examination. One (1) vision examination is covered per year. (7-1-04)T

03. Eyeglasses. One (1) pair of lenses and one set of frames every twelve (12) months are covered. (7-1-04)T

281. -- 284. (RESERVED).

285. ABORTION SERVICES.
Abortions are not covered under CHIP B unless the abortion is necessary to save the life of the woman, or to terminate a pregnancy 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. (7-1-04)T

286. -- 299. (RESERVED).

300. HEARING EXAMS AND HEARING AIDS.
Hearing exams, including newborn hearing screening in a hospital or outpatient setting are covered. Coverage includes assessment and diagnosis. Hearing aids are covered when billed by the audiologist. (7-1-04)T

301. -- 309. (RESERVED).

310. OTHER CLINICS.
Services provided by Rural Health Clinics, Federally Qualified Health Centers, and Indian Health Services are covered. (7-1-04)T

311. -- 399. (RESERVED).

400. SERVICES NOT COVERED BY CHIP B.
Services excluded from reimbursement under IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 065 are excluded from reimbursement under CHIP B. (7-1-04)T

401. -- 599. (RESERVED).

Children's Access Card
(Sections 600 Through 620)

600. CHILDREN'S ACCESS CARD.
The Children's Access Card program pays a premium subsidy toward a private health insurance plan for a participant. The rules governing payment and benefits are found in Sections 130, 150, 605, 615, and 620, of these rules. (7-1-04)T

601. -- 604. (RESERVED).

605. INSURANCE PREMIUM SUBSIDY.
The Department or its designee will pay an insurance premium subsidy to an approved insurance vendor in full or partial payment of a premium for a ~~*qualifying*~~ conforming health benefit plan selected by an eligible participant and defined in Section 56-238(8), Idaho Code. The Department's payment will not exceed one hundred dollars ($100) each month for each participant. The total payment for eligible children in the same family will not exceed three hundred dollars ($300) each month. The Department will not pay more than one Access Card payment for the same month for the same participant. ~~*(7-1-04)T*~~(7-1-04)T

606. -- 614. (RESERVED).

615. BENEFITS AND COST-SHARING.
Participating private health insurers must define the covered benefits and amounts of cost-sharing provided by the plan, subject to the minimum requirements set forth in Section 56-238(8), Idaho Code. Cost-sharing may include co-insurance, co-payments, deductibles, and excess premium costs above the Department's premium subsidy. Childhood immunizations are provided by the State if not covered by private insurance coverage. (7-1-04)T

616. -- 619. (RESERVED).

620. VENDOR ~~*APPLICATION*~~ AGREEMENT.
An insurance company that wants to participate in the Children's Access Card Program must apply to the Department and be approved for participation. The Department will confirm that the ~~*vendor*~~ applicant is an insurance company ~~*recognized*~~ regulated by the Department of Insurance. ~~*(7-1-04)T*~~(7-1-04)T

01. Agreement. The applicant must submit a signed Access Card Program Vendor Participation Agreement to the Department. (7-1-04)T

0~~1~~2. Conforming Benefit Plan. The vendor must certify to the Department that the benefit plan meets the definition of a health benefit plan ~~*that includes inpatient and outpatient hospital services and physician medical and surgical services*~~ as set forth in Section 56-238(8), Idaho Code. The benefit plan must include inpatient and outpatient hospital services, and physician medical and surgical services. ~~*(7-1-04)T*~~(7-1-04)T

0~~2~~3. **Vendor Application Denied**. The Department will not approve the application of a vendor whose authority to sell insurance plans in the State of Idaho is suspended. (7-1-04)T

04. **Data Reporting Requirement**. The Department requires Access Card participating insurance vendors to provide data to the Department as necessary to comply with federal reporting requirements. (7-1-04)T

621. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.04 - RULES AND MINIMUM STANDARDS FOR EMPLOYMENT SERVICES

DOCKET NO. 16-0404-0401 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-4605, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule for the repeal of IDAPA 16.04.04 is being adopted as proposed and the chapter is being repealed in its entirety. The notice of the proposed rulemaking to repeal this chapter of rules was published in the August 4, 2004, Administrative Bulletin, Volume 04-8, page 162.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cameron Gilliland at (208) 334-5512.

DATED this 15th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 39-4605, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0404-0401***
Minimum Standards for Employment Services ***PENDING RULE (Chapter Repeal)***

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

This entire chapter of rule is being repealed. Under Senate Bill 1410, the 2004 Legislature moved funding for supported employment services under the administration of the Division of Vocational Rehabilitation. Administration of supported employment services is no longer a Department of Health and Welfare responsibility.

FEE SUMMARY: No fee is being imposed or increased by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the repeal of this chapter is due to legislative action.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Cameron Gilliland at (208) 334-5512.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before August 25, 2004.

DATED this 23rd day of June, 2004.

Sherri Kovach
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IDAPA 16.04.04 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.11 - RULES GOVERNING DEVELOPMENTAL DISABILITIES AGENCIES

DOCKET NO. 16-0411-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-4601 et seq., Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the September 1, 2004 Idaho Administrative Bulletin, Volume 04-9, pages 147 through 149.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Cameron Gilliland at (208) 334-0924.

DATED this 15th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Sections 39-4601 et seq., Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 15, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and

purpose of the proposed rulemaking:

This rulemaking is necessary to revise definitions for "Service Coordination" and "Service Coordinator" to conform with the definitions in the new chapter of rule IDAPA 16.03.17 "Service Coordination." The new chapter for "Service Coordination" was approved by the 2004 Legislature and this rulemaking will prevent a conflict in definitions between rules. The term "Targeted Service Coordinators" will be deleted as it no longer is used.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased. N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule is necessary to avoid a conflict in rules due to the passage of the new service coordination chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cameron Gilliland at (208) 334-0924.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before September 22, 2004.

DATED this 14th day of July, 2004.

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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

011. DEFINITIONS -- P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-20-04)

01. Paraprofessional. A person such as an aide or therapy technician who is qualified to assist DDP's in providing services. (7-1-97)

02. Participant. A person who receives health care services, has been identified as

having a developmental disability as defined in this chapter, and who is receiving services through a DDA. (3-20-04)

03. Person-Centered Planning Process. A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-20-04)

04. Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-20-04)

05. Plan Developer. A paid or nonpaid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that covers all services and supports, based on a person- centered planning process. (3-20-04)

06. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. The plan developer is the plan monitor unless there is a Service Coordinator, in which case the Service Coordinator assumes both roles. (3-20-04)

07. Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-20-04)

08. Physical Therapist. A person qualified to conduct physical therapy evaluations and therapy, who is registered to practice in Idaho, and has specialized training in developmental disabilities or one (1) year of experience working with persons with developmental disabilities. (7-1-97)

09. Physician. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Sections 54-1801 et seq., Idaho Code. (7-1-97)

10. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-20-04)

11. Provider. Any individual or organization furnishing services through the provisions of these rules. (7-1-97)

12. Provider Agreement. An agreement between a provider and third-party payor whereby the third-party payor agrees to pay the provider for furnishing developmental disabilities rehabilitative and habilitative services in accordance with these rules. (7-1-97)

13. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-20-04)

14. Provisional License. A license issued to a DDA which is found not to be in

substantial compliance with these rules but not to have deficiencies which jeopardize the health or safety of participants. A provisional license can be issued for a specific period of time, not to exceed one hundred eighty (180) days, while corrections are being completed. (3-20-04)

15. Psychologist. A person licensed by the State of Idaho in accordance with the provisions of Sections 54-2301 et seq., Idaho Code, to independently practice psychology, or who is exempt from such requirements and meets the minimum qualifications established by the Idaho Personnel Commission to perform the duties assigned in classified service as defined by the Department, and has specialized training in developmental disabilities or one (1) year of experience working with persons with developmental disabilities. (7-1-97)

16. Psychology Assistant. An individual who practices psychology under the supervision of a licensed psychologist as required by Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners". (7-1-97)

17. Rehabilitation. The process of improving skills or level of adjustment to increase the person's ability to maintain satisfactory independent or dependent functioning. (7-1-97)

18. Rehabilitative and Habilitative Services. Evaluation and diagnostic services which include medical, social, developmental, psychological/psychiatric services, occupational therapy, physical therapy, and speech and hearing therapy. Treatment services which include individual, group and family-centered psychotherapy; individual and group speech and hearing therapy; individual and group physical therapy; individual and group developmental therapy, and individual and group occupational therapy. Evaluation, diagnostic and treatment services are to be provided on an outpatient basis and may be community-based, home-based, or center-based as consistent with the requirements of this chapter. (7-1-97)

19. Service. Evaluation, diagnosis, therapy, training, assistance, or support provided to a person with a developmental disability by a DDA. (7-1-97)

20. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. See IDAPA 16.03.17, "Service Coordination," Section 010. ~~*(3-20-04)*~~( )

21. Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under IDAPA 16.03.~~*09*~~17, "~~*Rules Governing the Medical Assistance Program*~~ Service Coordination," Section ~~*118*~~700. ~~*This includes Targeted Service Coordinators.*~~ ~~*(3-20-04)*~~( )

22. Social Worker. A person licensed in accordance with the Social Work Licensing Act, Sections 54-3201 et seq., Idaho Code, and who has specialized training in developmental disabilities or one (1) year of experience working with persons with developmental disabilities. (7-1-97)

23. Speech and Language Pathologist. A person qualified to conduct speech/

language evaluation and therapy, who possesses a certificate of clinical competency in speech-language pathology or who will be eligible for certification within one (1) year of employment. Certification must be from the American Speech Language and Hearing Association (ASHA). (3-20-04)

24. State Developmental Disability Authority. The Department is the State Developmental Disability Authority which has statewide responsibility for planning, coordinating and monitoring developmental disabilities services. (3-20-04)

25. Substantial Compliance. Deficiencies identified at the time of the survey by the licensing agency that do not present a serious risk to participants' health or safety or seriously impede the agency's ability to provide habilitative or rehabilitative services. (3-20-04)

26. Supervision. Initial direction and procedural guidance by a DDP and periodic inspection of the actual work performed at the site of service delivery. (7-1-97)

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

28. Temporary Developmental Disabilities Site Approval. A location, established by a fully licensed agency, to provide additional services for ninety (90) or less consecutive days. (7-1-97)

29. U.L. Underwriters Laboratories. (7-1-97)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.11 - RULES GOVERNING DEVELOPMENTAL DISABILITIES AGENCIES

DOCKET NO. 16-0411-0402

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-4605, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

In order to better assure the quality and safety of developmental disabilities services provided to children under three years of age, the Department has revised the coursework content areas required for Developmental Specialists serving children under three. This revision follows recommendations submitted to the Idaho Infant Toddler Program by the Governor-appointed Idaho Infant Toddler Interagency Coordinating Council during the comment period and will bring the rules into alignment with the current standards for the Early Childhood/Early Childhood Special Education "blended" certificate.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 1, 2004, Idaho Administrative Bulletin, Vol. 04-9, pages 150 through 159.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mary Jones at (208) 334-5512.

DATED this 15th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), and 39-4605, Idaho Code.

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0411-0402***
Rules Governing Developmental Disabilities Agencies ***PENDING RULE***

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 15, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

In response to a recommendation from the Governor-appointed Interagency Coordinating Council (ICC) to the Idaho Infant Toddler Program, the Department has elected to increase the education requirements for Developmental Specialists serving children under three. A "grandfather clause" has also been added for practicing Developmental Specialists who serve children under three and are in compliance with the current requirements.

Currently, this chapter makes no reference to the requirements with which Developmental Disabilities Agencies (DDAs) must comply under the federal Individuals with Disabilities Education Act (IDEA), Part C, when they provide services to children under three. Reference to these requirements is being added to assure that DDAs comply with this federal act.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased. N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule change stating required compliance with IDEA, Part C, is a reference to federal law already in effect. The increase in the educational requirements for Developmental Specialists was based on a recommendation from the Governor-appointed Interagency Coordinating Council, an advisory body representing a broad spectrum of stakeholders, including parents, providers, advocates, a legislator, higher education faculty, and Department staff.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mary Jones at (208) 334-5512.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before September 22, 2004.

DATED this 14th day of July, 2004.

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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS -- A THROUGH O.
For the purposes of these rules the following terms are used as defined below: (3-20-04)

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

02. Annual. Every three hundred sixty-five (365) days except during a leap year which equals three hundred sixty-six (366) days. (7-1-97)

03. Audiologist. A person qualified to conduct hearing evaluation and therapy, who possesses a certificate of clinical competency in audiology or who will be eligible for certification within one (1) year of employment. Certification must be from the American Speech, Language and Hearing Association (ASHA). (3-20-04)

04. Baseline. Current level of ability to complete a task independently, as a basis for initiating therapeutic intervention. (7-1-97)

05. Board. The Idaho State Board of Health and Welfare. (7-1-97)

06. Department. The Idaho Department of Health and Welfare. (7-1-97)

07. Developmental Disabilities Agency (DDA). A developmental disabilities facility designated in accordance with these rules to provide (outpatient) rehabilitative or habilitative services to children or adults with developmental disabilities. (7-1-97)

08. Developmental Disabilities Facility. Any public or private organization or agency which provides developmental disabilities services on an inpatient, outpatient, residential, clinical or other programmatic basis, including community rehabilitation programs and developmental disabilities agencies. (7-1-97)

09. Developmental Disabilities Professional (DDP). A physician, psychologist, social worker, audiologist, speech and language pathologist specialist, developmental specialist, occupational therapist, physical therapist, or therapeutic recreation specialist employed by the developmental disabilities agency to provide evaluation and services as defined by the Department. (7-1-97)

10. Developmental Disability. A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age and: (3-20-04)

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; and (7-1-97)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (7-1-97)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (7-1-97)

11. Developmental Specialist. A person qualified to conduct developmental evaluation and therapy, including: (3-30-01)

a. A person who possesses a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation and who has a minimum of two hundred forty (240) hours of professionally supervised experience with individuals who have developmental disabilities; or (3-30-01)

b. A person who possesses a bachelor’s or master’s degree in an area not listed in Subsection 010.11.a. of these rules, and who: (3-20-04)

i. Has completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies which relates to the job requirements of a developmental specialist; and (3-30-01)

ii. Has passed a competency examination approved by the Department; and (3-30-01)

iii. Has a minimum of two hundred forty (240) hours of professionally supervised experience with individuals who have developmental disabilities; or (3-30-01)

c. A person who possesses a bachelor’s or master’s degree in an area not listed in Subsection 010.11.a. of these rules, and who: (3-20-04)

i. Has passed a competency examination approved by the Department; and (3-30-01)

ii. Has a minimum of two hundred forty (240) hours of professionally supervised experience with individuals who have developmental disabilities; or (3-30-01)

d. A person who is exempt from the requirements of these rules: (3-30-01)

i. Any person employed as a developmental specialist prior to October 6, 1988 will be exempt from the requirements of these rules as long as there is not a gap of more than three (3) years of employment as a developmental specialist; or (3-30-01)

ii. Any person employed as a developmental specialist prior to May 30, 1997, unless previously disallowed by the Department, will be exempt from the requirements of these rules. (3-30-01)

e. Developmental Specialists providing services to infants and toddlers, birth to three (3) years of age, must have a minimum of two hundred forty (240) hours of professionally supervised experience with young children who have developmental disabilities and one (1) of the following: (3-30-01)

i. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (3-30-01)

ii. 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, or nursing plus a minimum of twenty-four (2~~0~~4) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) ~~*from the listing of approved courses*~~ *an accredited college or university*. *( )*

(1) Courses *taken* must *appear on college or university transcripts and must* cover *the following standards in their* content~~ *in each of the following areas: normal child development, characteristics of young children with disabilities and foundations of special education, curriculum and instruction in ESCE, assessment in ESCE and families of young children with disabilities.*~~: *( )*

(a) Promotion of development and learning for children from birth to three (3) years; ( )

(b) Evaluation and observation methods for developmentally appropriate assessment of young children; ( )

(c) Building family and community relationships to support early interventions; ( )

(d) Development of appropriate curriculum for young children, including IFSP and IEP development; ( )

(e) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and ( )

(f) Demonstration of knowledge of policies, procedures, and exceptionalities in special education and early intervention. ( )

(2) Closely related electives may be ~~*accepted*~~ approved by the Department with a recommendation from an institution of higher education. Developmental Specialists who possess a bachelor's or master's degree listed in Subsection 010.11.e.ii., have completed a minimum of twenty (20) semester credits in *EC/*ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services. ~~*In circumstances where*~~ When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage in a specific geographic area of such qualified personnel to meet service needs the Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individuals's approved plan to meet the required standard within three (3) years of being hired. Satisfactory progress will be determined on an annual review by the Department. Individuals who have an approved plan for completion of twenty (20) semester credits in *EC/*ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. ~~*(3-30-01)*~~( )

f. Developmental Specialists providing services to children ages three (3) through seventeen (17) must meet one (1) of the Developmental Specialists definitions listed in Subsections 010.11.a. through 010.11.d. of these rules, and also complete a competency course regarding developmental evaluation and therapy for children and pass a competency examination that includes demonstration of learned skills within one (1) year of the availability of the Department approved competency course and examination. (3-20-04)

g. Developmental Specialists providing services to children under the provisions of an Individualized Education Plan approved by a local school district must meet the personnel requirements established by the State Department of Education, Bureau of Special Education. Services must also be delivered in accordance with local school district and state education requirements for mandatory school attendance, and coordination of services, see Section 821 of these rules. (3-20-04)

12. Director. The Director of the Idaho Department of Health and Welfare or his designee. (7-1-97)

13. Evaluation. A process by which the need for services or progress toward identified goals is determined. It may include a comprehensive assessment or a specific skill assessment for the purpose of determining baseline or the need for further intervention for the discipline area being assessed. (7-1-97)

14. Habilitation. The process of developing skills and abilities. (7-1-97)

15. Initial License. A license issued to a DDA upon application when the Department determines that all application requirements have been met. An initial license can be issued for a period not to exceed one hundred eighty (180) days from the initiation of services. This license allows the Department time to evaluate the agency's ongoing capability to provide services and to meet these rules. (7-1-97)

16. Normalization. The process of providing services which promote a life as much as possible like that of other citizens of the community, including living in the community and

access to community resources. These services are designed to enhance the social image and personal competence of those being served. (7-1-97)

17. Objective. A behavioral statement of outcome developed to address an identified need of an individual. The need is identified by the participant and guardian where applicable, and others the participant has chosen to participate on his planning team, to be incorporated into the participant's repertoire of functional behaviors. The objective is written in measurable terms which specify a target date for completion, no longer than two (2) years in duration, and criteria for successful attainment of the objective. (3-20-04)

18. Occupational Therapist. A person qualified to conduct occupational therapy evaluations and therapy, who is certified by the American Occupational Therapy Certification Board and licensed to practice in Idaho, and who has specialized training in developmental disabilities or one (1) year of experience working with persons with developmental disabilities. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

800. STANDARDS FOR DEVELOPMENTAL DISABILITIES AGENCIES (DDA) PROVIDING SERVICES TO PARTICIPANTS AGE EIGHTEEN OR OLDER AND ISSH WAIVER PARTICIPANTS.
DDA services for participants eighteen (18) years of age or older and ISSH Waiver participants must be prior authorized in accordance with IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". Each DDA providing services under the requirements of Section 800 must provide the following rehabilitative and habilitative services consistent with the needs of persons with developmental disabilities eighteen (18) years of age or older or ISSH Waiver participants based on a plan of service authorized by the Department. (3-20-04)

01. Intake. Prior to the delivery of any DDA services: (3-20-04)

a. The person must be determined by the Department to be eligible for DDA services; (3-20-04)

b. The current medical/social history, SIB-R, and the medical care evaluation form must be obtained from the Department or its designee; and (3-20-04)

c. All services must be prior authorized by the Department or its designee under IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". IBI services are authorized under Section 8~~09~~11 of these rules. ~~(3-20-04)~~(____)

02. Evaluations. Evaluations required for the development of the implementation plan administered by the DDA must: (3-20-04)

a. Be conducted by qualified professionals for the respective disciplines as defined in this chapter; (7-1-97)

b. Be identified as a service on the plan of service and be prior authorized by the Department or its designee. (3-20-04)

03. Specific Skill Assessments. Specific skill assessments which are completed by the agency must: (3-20-04)

a. Be completed by qualified professionals for the respective disciplines as defined in this chapter; and (7-1-97)

b. Be identified as a service or need on the plan of service; and (3-20-04)

c. Be conducted for the purposes of determining baselines, or the need for further interventions. (7-1-97)

04. Plan of Service. Any services provided by the DDA must be included on the plan and authorized by the Department or its designee before a participant can receive the service from the agency. (3-20-04)

05. Implementation Plan. The DDA must develop an Implementation Plan for each service or support that is included on the participant's plan of service provided by the agency as outlined in these rules. The Implementation Plan must be completed within fourteen (14) days after the initial provision of service, be revised whenever participant needs change, and must include: (3-20-04)

a. The participant's name; and (3-20-04)

b. The specific skill area; and (7-1-97)

c. A baseline statement addressing the participant's specific skills and abilities related to the specific skill to be learned; and (3-20-04)

d. Measurable, behaviorally stated objectives which are developed from an identified service or support in the plan of service; and (3-20-04)

e. Written instructions to staff such as curriculum, lesson plans, locations, activity schedules, type and frequency of reinforcement and data collection, directed at the achievement of each objective. These instructions may be standardized, however, they must be individualized and revised as necessary to promote participant progress toward the stated objective. (3-20-04)

f. Identification of the specific environment(s) where services will be provided. (3-20-04)

g. The target date for completion. (7-1-97)

06. Changes To The Implementation Plan. (3-20-04)

a. The DDA must coordinate the participant's DDA program with other service

providers to maximize learning. (3-20-04)

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

c. If there are changes to an Implementation Plan that affect the service on the plan of service, an addendum to the plan of service must be completed in accordance with IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". (3-20-04)

07. Program Documentation. Each participant's record must include documentation of the participant's involvement in and response to services provided. This documentation must include at a minimum: (3-20-04)

a. Daily entry of all activities conducted toward meeting participant objectives; and (3-20-04)

b. Sufficient progress data to accurately assess the participant's progress toward each objective; and (3-20-04)

c. A review of the data and, when indicated, changes in the daily activities or specific implementation procedures by a DDP. The review must include the DDP's dated initials; and (3-20-04)

d. Documentation of notification of the participant and when applicable, the participant's guardian. (3-20-04)

08. Records. Each DDA licensed under these rules must maintain accurate, current and complete participant and administrative records. Each participant record must contain the following information: (3-20-04)

a. Documentation which verifies that the services provided are authorized by the Department or its designee. A copy of a plan of service will suffice for compliance to this requirement; and (3-20-04)

b. When evaluations are completed or obtained by the agency the participant's record must include the evaluation forms and narrative reports, signed and dated by the respective evaluators; and (3-20-04)

c. A copy of the plan of service authorized by the Department or its designee; and (3-20-04)

d. Program documentation and monitoring records which comply with all applicable sections of these rules; and (3-20-04)

e. The case record must be divided into program/discipline areas identified by tabs,

such as, plan of service, medical, social, psychological, speech, and developmental. (3-20-04)

09. Provider Status Review. DDAs must submit semiannual and annual status reviews to the plan monitor reflecting the status of behavioral objectives or services identified on the plan of service. Semiannual status reviews must remain in the participant's file and annual status reviews must be attached to annual plan of service. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

802. SERVICES FOR CHILDREN BIRTH TO THREE YEARS OF AGE (INFANT TODDLER).
Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include: adherence to procedural safeguards and time lines, use of multi-disciplinary evaluations and Individualized Family Service Plans (IFSPs), provision of early intervention services in the natural environment, transition planning, and program enrollment and reporting requirements. For children birth to age three (3), the IFSP will be used in lieu of the Individual Program Plan (IPP). ( )

80~~2~~3. FUNDS.
Agencies which receive funds under these rules must maintain accurate records of the receipt, obligation and disbursement of funds. Reimbursement for services is contingent upon documentation in participant records which supports the need for the type and amount of each service. (3-20-04)

80~~3~~4. ACCESSIBILITY.
Records must be accessible during normal operation of the agency to the Department for the purpose of inspection, with or without prior notification, under Section 39-108, Idaho Code. (3-20-04)

80~~4~~5. REQUIRED SERVICES.
Services provided must be sufficient in quantity and quality to meet the needs of each person receiving services, and must be provided by qualified professionals for the respective disciplines defined in this chapter. The following services, individual, group, community-based and home-based must be available as recommended by the physician and based on participant needs, interests, or choices to eligible participants either by employees of the agency or through formal written agreement and must comply with all applicable rules of this chapter: (3-20-04)

01. Psychotherapy. Psychotherapy services when provided by a physician, psychiatrist, psychologist, psychology assistant, or social worker in accordance with the objectives specified. Psychotherapy services available must include the following: (3-20-04)

a. Individual psychotherapy; and (7-1-97)

b. Group psychotherapy in which there is a minimum ratio of one (1) qualified staff person for every twelve (12) individuals in group therapy; and (3-20-04)

c. Family-centered psychotherapy that includes the participant and at least one (1) other family member at any given time. (3-20-04)

02. Speech and Hearing Therapy. Speech and hearing therapy services provided in accordance with the specified objectives. (7-1-97)

03. Physical Therapy. Physical therapy services provided by a licensed physical therapist in accordance with the specified objectives. (7-1-97)

04. Developmental Therapy. Developmental therapy services: (7-1-97)

a. Must be provided by qualified developmental disabilities staff in accordance with objectives specified; and (3-20-04)

b. Therapy must be directed toward the rehabilitation/habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency. (3-20-04)

05. Occupational Therapy. Occupational therapy services provided by a licensed occupational therapist in accordance with the specified objectives. (7-1-97)

80~~5~~6. OPTIONAL SERVICES.
Optional services include medication consultation, psychiatric advice~~s~~, and Intensive Behavioral Intervention (IBI). (3-20-04)

80~~6~~7. MEDICATION CONSULTATION.
Consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or licensed nurse practitioner in direct face-to-face contact with the participant and incorporated into the individual plan with the type, amount, and duration of the service specified. (3-20-04)

80~~7~~8. PSYCHIATRIC SERVICES.
Psychiatric evaluations and services for the purpose of establishing a diagnosis, identifying participant strengths and needs, and recommending or implementing interventions to address each need. These evaluations and services must be conducted by a physician in direct face-to-face contact with the participant and incorporated into the participant's individual plan with the type, amount, and duration of service specified. (3-20-04)

80~~8~~9. INTENSIVE BEHAVIORAL INTERVENTION (IBI).

01. Individualized and Comprehensive Interventions. Individualized and comprehensive interventions used on a short term, one-to-one basis that have been shown to be effective and produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise

severely restricted range of interest. (3-20-04)

02. Service Availability. Intensive Behavioral Intervention is available only to children birth through age twenty-one (21) who have self-injurious, aggressive or severely maladaptive behavior and severe deficits in the following areas: (3-20-04)

a. Verbal and nonverbal communication; or (3-20-04)

b. Social interaction; or (3-20-04)

c. Leisure and play skills. (3-20-04)

8~~09~~10. QUALIFICATIONS TO PROVIDE INTENSIVE BEHAVIORAL INTERVENTION (IBI).
A person qualified to provide or direct the provision of Intensive Behavioral Intervention (IBI) must meet the following requirements: (5-3-03)

01. Degree. A qualified IBI professional must hold at least a bachelor's degree in a health, human services, educational, behavioral science or counseling field from a nationally accredited university or college. (5-3-03)

02. Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. The year's experience must include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. (3-20-04)

03. Training and Certification. Qualified IBI professionals and paraprofessionals must complete and pass a Department-approved training course and examination for certification. The training must include a curriculum that addresses standards of competence for the provision of intensive behavioral intervention and ethical standards. Specifically, the curriculum must include: assessment of individuals, behavioral management, services or treatment of individuals, supervised practical experience, and an observation of demonstrated competencies. An individual applying for IBI professional certification or to be certified as an IBI trainer must also be able to demonstrate their competency in the provision of IBI services by passing a certification examination. A certified IBI professional who has a break in the provision of IBI services of more than one (1) year will be required to meet any additional Department requirements implemented subsequent to the individual's certification. (3-20-04)

04. Individuals Previously Certified. Beginning July 1, 2003, an individual certified as an IBI professional prior to that date ~~*must*~~ will continue to be certified as an IBI professional as long as ~~*they*~~ he meets the requirements of Subsection 8~~09~~10.03 of these rules. ~~*(3-20-04)*~~( )

05. Use of Paraprofessionals. An aide or therapy technician who has completed Department approved training and certification may be used to provide Intensive Behavioral Intervention under the supervision of a professional who is certified by the Department to provide Intensive Behavioral Intervention. (4-5-00)

a. The agency must assure adequate professional supervision during its services hours; and (3-20-04)

b. Paraprofessionals must not conduct evaluations or establish the Implementation Plan. These activities must be conducted by a professional qualified to provide or direct the provision of Intensive Behavioral Intervention; and (3-20-04)

c. The professional must, on a weekly basis or more often if necessary, give instructions, review progress and provide training on the program(s) and procedures to be followed; and (3-20-04)

d. A professional must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional to assure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). (3-20-04)

06. Limitation to Service Provision by a Paraprofessional. Intensive Behavioral Intervention provided by a paraprofessional is limited to ninety percent (90%) of the direct intervention time. The remaining ten percent (10%) of the direct intervention time must be provided by the professional qualified to provide or direct the provision of Intensive Behavioral Intervention. (4-5-00)

81~~0~~1. INITIAL PRIOR AUTHORIZATION.
Initial Intensive Behavioral Intervention services or consultation must be prior authorized by the Department. The DDA must submit evidence of each child's eligibility for Intensive Behavioral Intervention, the Implementation Plan, the number of hours of service requested, and the measurable outcomes expected as the result of the intervention. (4-5-00)

81~~1~~2. PROGRESS REPORTS, EVALUATION, AND CONTINUED PRIOR AUTHORIZATION.
The provider must submit a report on the child's progress toward Intensive Behavioral Intervention outcomes to the Department every one hundred twenty (120) days and seek prior authorization for continuation or modification of services. On an annual basis, a multi disciplinary treatment team that includes at a minimum, the parent(s), staff psychologist and staff providing services to the child, will review current evaluations and make a recommendation for continuation or modification of the intervention. (4-5-00)

81~~2~~3. PARENT AND STAFF CONSULTATION.
Professionals may provide consultation to parents and to other staff who provide therapy or care for the child in other disciplines to assure successful integration and transition from Intensive Behavioral Intervention to other therapies. (4-5-00)

81~~3~~4. STAFFING REQUIREMENTS FOR AGENCIES.

01. Physician. For participants whose services are governed by Section 801 of these rules, the agency must have a physician available a sufficient amount of time to: (3-20-04)

a. Review medical/social history information for the purpose of ordering appropriate

evaluations; and (3-20-04)

b. Perform necessary medical assessments; and (3-20-04)

c. Review and recommend the services identified in the Individual Program Plans; and (3-20-04)

d. Participate in annual reviews of participant services to determine continued appropriateness of the plan if applicable. (3-20-04)

02. Professionals. The agency must have available, at a minimum, the qualified DDP as employees of the agency or through formal written agreement: (3-20-04)

a. Audiologist or speech and language pathologist; and (3-20-04)

b. Developmental specialist; and (3-20-04)

c. Occupational therapist; and (3-20-04)

d. Physical therapist; and (3-20-04)

e. Physician; and (3-20-04)

f. Psychologist; and (3-20-04)

g. Social worker. (3-20-04)

814~~4~~5. -- 819. (RESERVED).

820. PAYMENT PROCEDURES.
Payment for agency services must be in accordance with rates, forms, policies and procedures established by the Department. Payment for services is contingent upon documentation in each participant's record which supports the type and amount of each service based on the agency's integrated records system and compliance with the requirements specified under Section 80~~2~~3 of these rules. ~~(3-20-04)~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.17 - RULES GOVERNING RESIDENTIAL HABILITATION AGENCIES

DOCKET NO. 16-0417-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-4601 et seq., Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the September 1, 2004 Idaho Administrative Bulletin, Volume 04-9, pages 160 through 162.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mary Wells at (208) 364-1955.

DATED this 15th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Sections 39-4601 et seq., Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 15, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance

and purpose of the proposed rulemaking: This rulemaking is necessary to revise definitions for "Service Coordination" and "Service Coordinator" to conform with the definitions in the new chapter of rule IDAPA 16.03.17 "Service Coordination". The new chapter for "Service Coordination" was approved by the 2004 Legislature and this rulemaking will prevent a conflict in definitions between rules. The term "Targeted Service Coordinators" will be deleted as it no longer is used.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased. N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule is necessary to avoid a conflict in rules due to the passage of the new service coordination chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mary Wells at (208) 364-1955.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before September 22, 2004.

DATED this 7th day of July, 2004.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

011. DEFINITIONS -- M THROUGH Z.
For the purposes of these rules the following terms are used as defined below: (3-20-04)

01. Measurable Objective. A statement which specifically describes the skill to be acquired or service/support to be provided, includes quantifiable criteria for determining progress towards and attainment of the service, support or skill, and identifies a projected date of attainment. (7-1-95)

02. Mechanical Restraint. Any device that the participant cannot remove easily that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body or environment. Excluded are devices used to achieve proper body position, balance, or alignment. (3-20-04)

03. Medication. Any substance or drug used to treat a disease, condition or symptoms which may be taken orally, injected or used externally and is available through prescription or over-the-counter. (7-1-95)

04. Neglect. The negligent failure to provide those goods or services which are reasonably necessary to sustain the life and health of a person under Section 39-5302 (8), Idaho Code. (3-20-04)

05. Outcome-Based Review. An on-site review conducted by a trained reviewer authorized by the Department to determine participant satisfaction with the services received and improvement or impact upon his lifestyle following implementation of the plan of service. (3-20-04)

06. Participant. A person who receives health care services, is eligible for Medicaid, and who is receiving residential habilitation services. (3-20-04)

07. Person-Centered Planning Process. A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-20-04)

08. Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-20-04)

09. Physical Restraint. Any manual method that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body. Excluded are physical guidance and prompting techniques of brief duration. (7-1-95)

10. Physician. Any person licensed as required by Title 54, Chapter 18, Idaho Code. (7-1-95)

11. Plan Developer. A paid or nonpaid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-20-04)

12. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. The plan developer is the plan monitor unless there is a Service Coordinator, in which case the Service Coordinator assumes both roles. (3-20-04)

13. Plan of Service. An initial or annual plan that identifies all services and supports

based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-20-04)

14. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-20-04)

15. Psychosocial Information. A combined summary of psychological and social histories of a participant designed to provide the person-centered planning team with an accurate reflection of the participant's current skills, abilities, and needs. (3-20-04)

16. Progress Note. A written notation, dated and signed by a member of the person-centered planning team or service provider, that documents facts about the participant's assessment, services provided, and the participant's response during a given period of time. (3-20-04)

17. Punishment. Any procedure in which an adverse consequence is presented that is designed to produce a decrease in the rate, intensity, duration or probability of the occurrence of a behavior; or the administration of any noxious or unpleasant stimulus or deprivation of a participant's rights or freedom for the purpose of reducing the rate, intensity, duration, or probability of a particular behavior. (3-20-04)

18. QMRP. Qualified Mental Retardation Professional as defined in 42 CFR 483.430. (7-1-95)

19. Residential Habilitation. Services consisting of an integrated array of individually-tailored services and supports furnished to an eligible participant which are designed to assist them to reside successfully in their own homes, with their families, or alternate family home. (3-20-04)

20. Reviewer. A person or other entity authorized by the Department to conduct reviews to determine compliance with the program requirements and participant satisfaction with the services. (3-20-04)

21. Rule. A requirement established by state, federal, or local government under the law and having the effect of law. (3-20-04)

22. Seclusionary Time Out. The contingent removal of an individual from a setting in which reinforcement is occurring that is designed to result in a decrease in the rate, intensity, duration or probability of the occurrence of a response, and entails the removal of the individual to an isolated setting. (7-1-95)

23. Substantial Compliance. An agency is in substantial compliance with these rules when there are no deficiencies which would endanger the health, safety or welfare of the participants. (3-20-04)

24. Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity. (7-1-95)

25. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. See IDAPA 16.03.17, "Service Coordination," Section 010. ~~*(3-20-04)*~~(____)

26. Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under IDAPA 16.03.~~*09*~~17, "~~*Rules Governing the Medical Assistance Program*~~ Service Coordination," Section ~~*118*~~700. ~~*This includes Targeted Service Coordinators.*~~ ~~*(3-20-04)*~~(____)

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

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

29. Transition Plan. An interim plan developed by the residential habilitation agency defining activities to assist the participant to transition out of residential habilitation services from that agency. (3-20-04)

30. Waiver Services. Individually tailored services and supports as amended under Waiver Number 0076.90 (B) provided by an agency to an eligible recipient to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage choice, and to achieve and maintain community integration and participation. (7-1-95)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.02 - RULES GOVERNING AUDITS OF PROVIDERS

DOCKET NO. 16-0502-0301 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-125, 56-202(b), 56-1003, and 67-2501, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the September 3, 2003 Administrative Bulletin, Volume 03-9, page 187.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paul Leary at (208) 364-1833.

DATED this 15th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 56-135, 56-202(b), 56-1003, and 67-2501, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 17, 2003.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rulemaking:

These rules were written to cover the Department's audits of institutional providers. The

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0502-0301***
Rules Governing Audits of Providers ***PENDING RULE (Chapter Repeal)***

Department no longer conducts these audits, so the rules no longer have meaning and are being repealed.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule is no longer utilized and needs to be repealed.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Lloyd Forbes at (208) 364-1833.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before September 24, 2003.

DATED this 23rd day of July, 2003.

Sherri Kovach
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IDAPA 16.05.02 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.01 - RULES GOVERNING FAMILY AND CHILDREN'S SERVICES

DOCKET NO. 16-0601-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is July 1, 2004. This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 16-1624, 16-2001, 16-2402, 56-202(b), 56-203(b), 56-204(a), 56-204A, 56-1003 and 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The 2004 Legislature provided for foster care payment rate increase beginning July 1, 2004. The temporary rule is being amended to show the increase in the rate table.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the January 7, 2004, Idaho Administrative Bulletin, Volume 04-1, pages160 and 161.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Chuck Halligan at (208) 334-6559.

DATED this 3rd day of June, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0601-0401***
Family and Children's Services ***PENDING RULE***

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 16-1624, 16-2001, 16-2402, 56-202(b), 56-203(b), 56-204(a), 56-204A, 56-1003, and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than January 21, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rulemaking:

The 2003 Legislature provided for foster care payment rates to increase beginning July 1, 2003. The rate table in Section 483 is being amended to reflect this increase.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with deadlines in amendments to governing law or federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because amendments were made to confer a benefit.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Chuck Halligan, (208) 334-6559.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before January 28, 2004.

DATED this 11th day of August, 2003.

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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

483. PAYMENT TO FAMILY FOSTER CARE PROVIDERS.
Monthly payments for care provided by foster care families are:

Family Foster Care Payments - Table 483			
Ages	0-5	6-12	13-18
Monthly Room and Board	$~~*251*~~ ~~*261*~~ *274*	$~~*275*~~ ~~*286*~~ *300*	$~~*394*~~ ~~*410*~~ *431*

~~*(3-30-01)*~~(7-1-04)T

01. Gifts. An additional thirty dollars ($30) for Christmas gifts and twenty dollars ($20) for birthday gifts shall be paid in the appropriate months. (3-18-99)

02. Clothing. Costs for clothing shall be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child. (3-18-99)

03. School Fees. School fees due upon enrollment shall be paid, based upon the Department's determination of the child's needs. (3-18-99)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.01 - RULES GOVERNING FAMILY AND CHILDREN'S SERVICES

DOCKET NO. 16-0601-0402

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is July 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 16-1624, 16-2001, 16-2402, 56-202(b), 56-203(b), 56-204(a), 56-204A, 56-1003 and 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes different from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the July Administrative Bulletin, Volume 04-7, pages 85 through 87. The changes to this document include adding a definition for the term 'deprivation' which required amending Section 010, Definitions, the section was formatted into smaller sections for ease of publishing in the future. Section 424 was amended to clarify what the abbreviation AFDC-FC meant. Section 430 was added to delete the same requirement in this section that was deleted from Section 425 in the original proposed rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Chuck Halligan, (208) 334-6559.

DATED this 15th day of November, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0601-0402***
Family and Children's Services ***PENDING RULE***

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 16-1624, 16-2001, 16-2402, 56-202(b), 56-203(b), 56-204(a), 56-204A, 56-1003, and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 21, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rulemaking:

A court decision based on a lawsuit against federal regulations regarding Title IV-E eligibility requires changes be made to the eligibility requirements in IDAPA 16.06.01, "Rules Governing Family and Children's Services".

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with court decision on certain federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because amendments were made to conform to a court decision.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Chuck Halligan, (208) 334-6559.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before July 28, 2004.

DATED this 21st day of May, 2004.

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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS AND ABBREVIATIONS *A THROUGH E*.
For the purposes of the rules contained in Idaho Department of Health and Welfare Rules, IDAPA 16.06.01, "Rules Governing Family and Children's Services," the following terms and abbreviations are used as defined ~~*herein*~~ *in Sections 010 through 013 of these rules*:
~~*(3-18-99)*~~*(7-1-03)T*

01. IV-E Foster Care. Child care provided in lieu of parental care in a foster home, children's agency or institution eligible to receive Aid to Dependent Children under Title IV-E of the Social Security Act. (3-18-99)

02. Adoption Assistance. Funds provided to adoptive parent(s) of children who have special needs and/or could not be adopted without financial or medical assistance. (5-3-03)

03. Adoption Services. Protective service through which children are provided with permanent homes, under new legal parentage, including transfer of the mutual rights and responsibilities that prevail in the parent-child relationship. (5-3-03)

04. Alternate Care. Temporary living arrangements, when necessary for a child to leave his own home, through a variety of foster care, respite care, residential treatment and institutional resources, in accordance with the protections established in Public Law 96-272, the federal "Adoption Assistance and Child Welfare Act of 1980" as amended by Public Law 105-89, the Adoption and Safe Families Act of 1997, the Child Protective Act, Section 16-1601 et seq., Idaho Code, and the Indian Child Welfare Act. (3-30-01)

05. Alternate Care Plan. A federally required component of the Family Plan for children in alternate care. The alternate care plan contains elements related to reasonable efforts, the family's plan, child's alternate care provider, compelling reasons for not terminating parental rights, Indian status, education, immunization, medical and other information important to the day-to-day care of the child. (5-3-03)

06. Assessment. First step in the planning process which results in systematic documentation of the family's issues of concern, their strengths, and desired outcomes. (3-30-01)

07. Board. The Idaho State Board of Health and Welfare. (3-18-99)

08. Case Management. A change oriented service to families that assures and coordinates the provision of family risk assessment, case planning, treatment and other services, protection, advocacy, review and reassessment, documentation and timely closure of a case. (3-18-99)

09. **Case Plan**. See "Family Plan". (3-18-99)

10. **Central Office**. The state level administrative office of the Department of Health and Welfare located in Boise, Idaho. (3-18-99)

11. **Certified Adoption Professional (formerly "qualified individual")**. An individual certified by the Department who meets the qualifications specified in Section 889 of these rules for completion of pre-placement adoption home studies, reports to the court under the Termination of Parent and Child Relationship and Adoption of Children Acts, and placement supervision reports. (3-20-04)

12. **Child Mental Health**. All of the following children under eighteen (18) years of age shall be served without regard to income or type of health insurance: (3-30-01)

a. Those who have a serious emotional disturbance or a grave disability due to a serious mental illness; and (3-30-01)

b. Present a significant risk of harm to themselves or to others, due to their mental illness; and (3-30-01)

c. Because of their mental illness are at risk for out-of-home placements or are currently in out-of-home placement and lack adequate resources to participate in their community's non-public system of care; or (3-30-01)

d. Are involuntarily committed to the Department for out-of-home placement. (3-30-01)

13. **Child Mental Health Services**. Services provided in response to the needs of children with a serious emotional disturbance and their families. These services are provided in accordance with the provisions of Section 16-2402 et seq., Idaho Code, the "Children's Mental Health Services Act". (3-30-01)

14. **Child Protection**. All children under eighteen (18) who have been harmed or threatened with harm by a person responsible for their health or welfare through non-accidental physical or mental injury, sexual abuse (as defined by state law) or negligent treatment or maltreatment, including the failure to provide adequate food, clothing or shelter shall be served without regard to income. (3-30-01)

15. **Child Protective Services**. Services provided in response to potential, alleged or actual abuse, abandonment or neglect of individuals under the age of eighteen (18) in accordance with the provisions of Section 16-1601 et seq., Idaho Code, the "Child Protective Act". (3-18-99)

16. **Compact Administrator**. The individual designated to coordinate interstate transfers of persons requiring special services in accordance with the provisions of Section 16-2101 et seq., Idaho Code; "Interstate Compact on the Placement of Children," Section 16-1901 et seq., Idaho Code; or the "Interstate Compact on Mental Health," Section 66-1201 et seq., Idaho Code; or the "Interstate Compact on Adoption and Medical Assistance," Section 39-7501 et seq.,

Idaho Code. (3-20-04)

17. Concurrent Planning. Planning which addresses a child's need for a permanent family by working toward family reunification while, at the same time, developing an alternative plan that will provide permanency for the child through adoption, guardianship, placement with a relative or other permanent placement. (3-30-01)

18. DHW Regions. Seven (7) geographically defined regions which serve as administrative units for the delivery of social services through local Department local offices. (3-18-99)

19. Day Care for Children. Care and supervision provided for compensation during part of a twenty-four (24) hour day, for a child or children not related by blood or marriage to the person or persons providing the care, in a place other than the child's or children's own home or homes. (3-18-99)

20. Day Treatment Services. Intensive nonresidential services that include an integrated set of educational, clinical, social, vocational and family interventions provided on a regularly scheduled, typically daily, basis. (3-18-99)

21. Department. The Idaho Department of Health and Welfare. (3-18-99)

22. ***Deprivation****. One of the factors used in determining AFDC-FC eligibility for children in foster care. Deprivation is a lack of, or interruption in, the maintenance, physical care, and parental guidance a child ordinarily receives from one (1) or both parents. A child is deprived by the continued absence of a parent, incapacity of a parent, death of a parent, unemployment or underemployment of the principal wage earner parent.* *(7-1-03)T*

2~~2~~3. Director. The Director of the Department of Health and Welfare or designee. (3-18-99)

2~~3~~4. Extended Family Member of an Indian Child. As defined by the law, or custom of an Indian child's tribe or, in the absence of such law or custom, a person who has reached the age of eighteen (18) and who is an Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin, or stepparent. (3-30-01)

011, DEFINITIONS AND ABBREVIATIONS F THROUGH K.

~~24~~01**. Family**. Parent(s), legal guardian(s), related individuals including birth or adoptive immediate family members, extended family members and significant other individuals, who are included in the family plan. (5-3-03)

~~25~~02**. Family and Children's Services (FACS)**. Those programs and services directed to families and children, administered by the Department and provided in accordance with these rules. (3-18-99)

~~26~~03**. Family Assessment**. An ongoing process based on information gained through a series of meetings with a family to gain mutual perception of strengths and resources that can

support them in creating long-term solutions related to identified service needs and/or safety issues that threaten family integrity, unity or the ability to care for their members. (3-18-99)

~~27~~04. **Family Case Record**. Electronic and hard copy compilation of all documentation relating to a family, including, but not limited to, legal documents, identifying information, and evaluations. (3-30-01)

~~28~~05. **Family Centered Services**. An approach to the delivery of social services that focuses on families rather than individuals. Services are based on assessment of the entire family and a negotiated family plan designed to strengthen and maintain the family, while ensuring the safety, well being and permanency of children. (3-30-01)

~~29~~06. **Family Plan**. Also referred to as Service Plan. A written document that serves as the guide for provision of services. The plan, developed with the family, clearly identifies who does what, when, how and why. The family plan incorporates any special plans made for individual family members. If the family includes an Indian child, or child's tribe, tribal elders and/or leaders should be consulted early in the plan development. (3-30-01)

~~3~~07. **Family Services Worker**. Any of the direct service personnel, including social workers, psychologists, counselors and family therapists, working in regional Family and Children's Services Programs. (3-20-04)

~~31~~08. **Field Office**. A Department of Health and Welfare service delivery site. (3-18-99)

~~32~~09. **Goal**. A statement of the long term outcome or plan for the child and family. (3-18-99)

~~33~~10. **Guardianship Assistance**. State benefits provided to legal guardian(s) for the support of a child who would otherwise remain in the guardianship of the Department of Health and Welfare. For a child to come into the Department's guardianship, parental rights must have been terminated. (5-3-03)

~~34~~11. **Independent Living**. Services provided to eligible foster or former foster youth ages fifteen (15) to twenty-one (21) designed to support a successful transition to adulthood. (3-30-01)

~~35~~12. **Indian**. Any person who is a member of an Indian tribe or who is an Alaska Native and a member of a Regional Corporation as defined in 43 U.S.C. 1606. (3-18-99)

~~36~~13. **Indian Child**. Any unmarried person who is under the age of eighteen (18) who is: (3-18-99)

a. A member of an Indian tribe, or (3-18-99)

b. Eligible for membership in an Indian tribe and the biological child of a member of an Indian tribe. (3-18-99)

~~37~~14. **Indian Child Welfare Act (ICWA)**. The Indian Child Welfare Act, 25 U.S.C.

1901, et seq. (3-18-99)

~~38~~15. **Indian Child's Tribe**. (3-18-99)

a. The Indian tribe in which an Indian child is a member or eligible for membership, or (3-18-99)

b. In the case of an Indian child who is a member of or eligible for membership in more than one (1) tribe, the Indian tribe with which the Indian child has the more significant contacts. (3-18-99)

~~39~~16. **Indian Tribe**. Any Indian Tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the Secretary because of their status as Indians, including any Alaska Native village as defined in 43 U.S.C. 1602(c). (3-18-99)

~~40~~17. **Information and Referral Services**. A service which enables individuals to gain access to human services through providing accurate, current information on community and Department resources. (3-30-01)

~~41~~8. **Intercountry Adoption Act of 2000 (P.L. 106-279).** Federal law designed to protect the rights of, and prevent abuses against children, birth families, and adoptive parents involved in adoptions (or prospective adoptions) subject to the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, and to insure that such adoptions are in the children's best interests; and to improve the ability of the federal government to assist U.S. citizens seeking to adopt children from abroad and residents of other countries party to the Convention seeking to adopt children from the United States. (5-3-03)

~~42~~19. **Interethnic Adoption Provisions of 1996 (IEPA)**. IEPA prohibits delaying or denying the placement of a child for adoption or foster care on the basis of race, color or national origin of the adoptive or foster parent(s), or the child involved. (5-3-03)

~~43~~20. **Interstate Compact on the Placement of Children (ICPC)**. Interstate Compact on the Placement of Children (ICPC) in Chapter 21, Title 16, Idaho Code, ensures that the jurisdictional, administrative and human rights obligations of interstate placement or transfers of children are protected. (3-20-04)

~~44~~21. **Issue**. Circumstances which brought a child and family to the attention of the Department. These circumstances typically involve safety issues which put the child at risk of harm. (3-30-01)

~~45~~22. **Kin**. Non-relatives who have a significant, family-like relationship with a child. Kin may include godparents, close family friends, clergy, teachers and members of a child's Indian tribe. Also known as fictive kin. (3-30-01)

~~46~~23. **Kinship Care**. Alternative care that is provided by kin. (3-30-01)

012. DEFINITIONS AND ABBREVIATIONS L THROUGH R.

***~~47~~01*.** **Legal Guardianship**. A judicially created relationship, including one made by a tribal court, between a child and a relative or non-relative caretaker which is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker of the following parental rights with respect to the child: protection, education, care and control of the person, custody of the person, and decision making. The term "legal guardian" means the caretaker in such a relationship. For purposes of these rules a child must be in Department guardianship at the time the Petition for Legal Guardianship is filed with the court. Department guardianship may only take place when there has been a termination of parental rights. (5-3-03)

***~~48~~02*.** **Licensed**. Facilities or programs being licensed in accordance with the provisions of Idaho Department of Health and Welfare Rules IDAPA 16.06.02, "Rules and Standards for Child Care Licensing".

(3-18-99)

***~~49~~03*.** **Licensing**. See Idaho Department of Health and Welfare Rules, IDAPA 16.06.02, "Rules and Standards for Child Care Licensing," Section 100. (3-18-99)

***~~5~~04*.** **Medicaid**. See "Title XIX". (3-30-01)

***~~51~~05*.** **Multiethnic Placement Act of 1994 (MEPA)**. MEPA prohibits states or public and private foster care and adoption agencies that receive federal funds from delaying or denying the placement of any child solely on the basis of race, color or national origin. (3-18-99)

***~~52~~06*.** **Objective**. Behaviorally specific description of how the family circumstances will look when the risk factors which brought a child and family to the Department's attention, either no longer exist or are significantly reduced. (3-30-01)

***~~53~~07*.** **Parent(s)**. The person(s) who, by birth or through adoption, is considered legally responsible for a child. For purposes of these rules, when it is necessary to be more specific, identifiers will be added to parent(s): birth parent(s), foster parent(s), adoptive parent(s), step-parent(s), and pre-adoptive parent(s). The term "legal guardian(s)" is not included in the definition of parent(s). (3-20-04)

***~~54~~08*.** **Permanency Planning**. A primary function of family services initiated in all cases to identify programs, services and activities designed to establish permanent home and family relationships for children within a reasonable amount of time. (3-18-99)

***~~55~~09*.** **Personal Care Services (PCS)**. Services to eligible Medicaid recipients that involve personal and medically oriented tasks dealing with the physical or functional impairments of the individual. (3-18-99)

***~~56~~10*.** **P.L. 96-272**. Public Law 96-272, the federal "Adoption Assistance and Child Welfare Act of 1980". (3-30-01)

***~~57~~11*.** **P.L. 105-89**. Public Law 105-89, the federal "Adoptions and Safe Families Act of 1997", amends P.L. 96-272 and prohibits states from delaying or denying cross-jurisdictional adoptive placements with an approved family. (3-30-01)

***~~58~~12*.** **Planning**. An orderly rational process which results in identification of goals and formulation of timely strategies to fulfill such goals, within resource constraints. (3-30-01)

***~~59~~13*.** **Prevention**. Programs, services and activities aimed at preventing child abuse and neglect and severe emotional disturbance. (3-30-01)

***~~60~~14*.** **Protective Services**. To provide assistance in response to potential, actual or alleged neglect, abuse or exploitation of children. (3-18-99)

***~~6~~15*.** **Purchase of Services**. Provision of services to children and families by local agencies or individuals who contract with DHW. (3-30-01)

***~~62~~16*.** **Qualified Expert Witness--ICWA**. A person who is most likely to be a qualified expert witness in the placement of an Indian child is: (3-18-99)

a. A member of the Indian child's tribe who is recognized by the tribal community as knowledgeable in tribal customs pertaining to family organization and child rearing practices; (3-18-99)

b. An individual who is not a tribal member who has substantial experience in the delivery of child and family services to Indians and extensive knowledge of prevailing social and cultural standards and child rearing practices within the Indian child's tribe; (3-18-99)

c. A professional person who has substantial education and experience in a pertinent specialty area and substantial knowledge of prevailing social and cultural standards and child rearing practices within the Indian community; or (3-18-99)

d. An individual regarded as being a qualified expert who is referred by the Indian child's tribe, the Department's ICWA Specialist, or the Bureau of Indian Affairs. (3-18-99)

***~~63~~17*.** **Relative**. Person related to a child by blood, marriage, or adoption. (3-30-01)

***~~64~~18*.** **Reservation**. Indian country as defined in 18 U.S.C. Section 1151, and any lands, not covered under such section, title to which is either held by the United States in trust for the benefit of any Indian tribe or individual or held by any Indian tribe or individual subject to a restriction by the United States against alienation. Such term includes but is not limited to the Kootenai Reservation, the Coeur d'Alene Reservation, the Nez Perce Reservation, the Duck Valley Reservation, and the Shoshone-Bannock Reservation. (3-18-99)

***~~65~~19*.** **Respite Care**. Time limited care provided to children. Respite care is utilized in circumstances which require short term, temporary placement of a child from the home of their usual care giver to that of another licensed or agency approved family. In general, the duration of a respite placement is from one (1) to fourteen (14) days. (3-30-01)

***~~66~~20*.** **Risk Assessment**. Standardized protocol for contact between a family services worker and a family to objectively determine if safety issues, risk issues or immediate service needs exist, which require further Family and Children's Services response. (3-30-01)

013. DEFINITIONS AND ABBREVIATIONS S THROUGH Z.

***~~67~~01*.** **SSI (Supplemental Security Income)**. Income maintenance grants for eligible persons who are aged, blind or disabled. These grants are provided under Title VI of the Social Security Act and are administered by the Social Security Administration and local Social Security Offices. (3-18-99)

***~~68~~02*.** **Safety Plan**. Plan developed by the Department and a family which assures the immediate safety of a child who has been determined to be conditionally safe or unsafe. (3-30-01)

***~~69~~03*.** **Serious Emotional Disturbance (SED)**. An emotional or behavioral disorder or a neuropsychiatric condition which results in a serious disability, which requires sustained treatment interventions and causes the child's functioning to be impaired in at least one (1) of the following areas: thought, perception, affect and behavior. A disorder shall be considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment shall be assessed using the Child and Adolescent Functional Assessment Scale (CAFAS). Substantial impairment shall require a full eight (8) scale score of eighty (80) or higher with "moderate" impairment in at least one (1) of the following three (3) scales: Self-harmful behavior; Moods/ emotions; or thinking. A substance abuse disorder or conduct disorder, and/or developmental disorder, alone does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (3-20-04)

***~~7~~0*4.** **Social Service Block Grant**. The social service block grant funds are federal funds provided to states to assist in the development of comprehensive social service programs to help those with special needs to achieve and maintain a greater degree of economic self support and self reliance, to prevent neglect, abuse, or exploitation of children and adults who are unable to protect their own interests, to prevent or reduce inappropriate institutional care, and to secure referral or admission for institutional care when other forms of care are not appropriate. (3-18-99)

***~~71~~05*.** **TAFI**. Temporary Assistance to Families in Idaho. (3-18-99)

***~~72~~06*.** **Target Population**. Group of persons, residing within a defined geographical area, who are identified as being at risk for an adverse social or health condition or combination of conditions and whom the program is designed to serve. (3-18-99)

***~~73~~07*.** **Title IV-E**. Title under the Social Security Act which provides funding for foster care maintenance and adoption assistance payments for certain eligible children. (3-20-04)

***~~74~~08*.** **Title XIX (Medicaid)**. Title under the Social Security Act which provides "Grants to States for Medical Assistance Programs". (3-18-99)

***~~75~~09*.** **Title XXI**. (Children's Health Insurance Program). Title under the Social Security Act which provides access to health care for uninsured children under the age of nineteen (19). (3-18-99)

***~~76~~10*.** **Tribal Court**. A court with jurisdiction over child custody proceedings and which is either a Court of Indian Offenses, a court established and operated under the code or custom of

an Indian tribe, or any other administrative body of a tribe which is vested with authority over child custody proceedings. (3-18-99)

~~77~~11. **Unmarried Parents' Services**. Unmarried parent(s) services are aimed at achieving or maintaining self-reliance or self-support for unmarried parent(s). These services include counseling for all unmarried parent(s) who need such service in relation to their plans for their children and arranging for and/or paying for prenatal and confinement care for the well-being of the parent and infant. (5-3-03)

~~78~~12. **Voluntary Services Agreement**. A written and executed agreement between the Department and parent(s) or legal guardian(s) regarding the goal, issues, objectives and task responsibility including payment. A children's mental health family services plan is the Voluntary Service Agreement. (5-3-03)

01~~1~~4. -- 019. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

425. *AID TO FAMILIES WITH DEPENDENT CHILDREN - FOSTER CARE (*AFDC-FC*)* ELIGIBILITY.
A child is eligible for *Aid To Families With Dependent Children-Foster Care (*AFDC-FC*)* if the child would have been eligible to receive AFDC aid payments except that he was removed, by court order, from the home of a parent(s) or other caretaker relative(s) and placed in foster care. AFDC-FC is also available to eligible children voluntarily placed in foster care by a parent(s). The caretaker relative(s) is the relative(s) who exercises day-to-day physical custody of the child prior to the court action or voluntary placement. *~~A child is not eligible for AFDC-FC if he is living in the home of a caretaker relative(s) for more than six (6) months and expects to continue that care.~~* The child may qualify for AFDC payments as a child living with a relative. Eligibility for AFDC-FC is determined by Family and Community Services. *~~(7-1-03)T~~(7-1-03)T*

426. AFDC-FC ELIGIBILITY REQUIREMENTS.
A child is eligible for AFDC-FC if he meets each of the eligibility requirements listed in Table 426.

AFDC-FC ELIGIBILITY REQUIREMENTS - TABLE 426	
CONDITION	**DESCRIPTION**
01. Financial Need.	A child is in financial need if, in the month court action to remove him from his home was initiated, or the month the voluntary out-of-home placement agreement is signed: He was receiving AFDC; He would have been eligible to receive AFDC if an application had been filed on his behalf; or He lived with his parent(s) or other caretaker relative(s) at some time within six (6) prior months and would have qualified for AFDC in the month of court action or voluntary placement if an application had been filed and he lived with a parent(s) or other specified relative(s) in that month.
02. Voluntary Placement in Foster Home or Voluntary Relinquishment.	A foster care placement is voluntary if the parent(s) has a written agreement with the Department to place the child in foster care. The parent retains parental rights and may terminate the agreement at any time. A voluntary relinquishment is not a voluntary placement. A voluntary relinquishment occurs when parent(s) permanently gives up rights to a child. A court order is required for a voluntarily relinquished child to qualify for AFDC-FC.
03. Age, Residence, Citizenship, and Deprivation.	The other AFDC requirements the child must meet are: Age; Residence; Citizenship; Deprivation~~ *of parental support determined in relation to the home from which the child was removed*~~; and The AFDC resource limit.
04. Court Ordered Removal.	A child not voluntarily placed must have been removed from the parent(s) or other caretaker relative(s) by court order. The initial court order must state remaining in the home would be "contrary to the welfare" of the child. For children removed on or after October 1, 1983, the court order must include a determination that reasonable efforts were made to prevent or eliminate the need for removal of the child. This judicial determination must be made within sixty (60) days of removal of the child from his home. The court order must state what reasonable efforts were made considering the family's circumstances and the safety of the child when the child is removed from the home in an emergency. When there is a judicial determination of Aggravated Circumstances, the court order must state that no reasonable efforts to reunify the family are required.
05. Custody and Placement.	The child's placement and care are the Department's responsibility. The child must live in a licensed foster home, licensed institution, licensed group home, or in a licensed relative's home.

~~*(5-3-03)*~~(7-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

430. ONGOING ELIGIBILITY.
To continue eligibility for AFDC-FC, a child must meet each of the eligibility conditions listed in Table 430.

CONTINUING ELIGIBILITY CONDITIONS, TABLE 430		
	CONDITION	**DESCRIPTION**
01.	**Financial Need.**	The child's own income, after any applicable AFDC income exclusions and disregards, must not exceed the foster care need standard established for him by the Department.
02.	**AFDC Factors.**	The child must continue to meet the following AFDC eligibility factors. Age; Residence; Citizenship; Resource limits; and Deprivation ~~*of parental support in relation to the current situation in the home from which the child was removed*~~. *(*A child *who has been* removed from the home of a caretaker relative who is not his parent, meets the deprivation requirement without review.*)*
03.	**Ongoing Custody and Placement.**	The child must remain in the Department's custody through either a current court order or a voluntary placement agreement that has not been in effect more than one hundred and eighty (180) days. They must continue to live in a licensed foster home, licensed institution, licensed group home, or a licensed relative's home.
04.	**Redetermination.**	The child's eligibility for AFDC-FC must be redetermined at least once every six (6) months. A redetermination, rather than an initial eligibility determination, is used for a child who left foster care, was placed in a non-AFDC-FC living situation such as a hospital or detention center, did not return home, remained in the Department's custody throughout his absence, and returned to foster care. Any return home other than a visit requires a new judicial determination or a new agreement and a new determination of eligibility based on current circumstances. Annual Review: An annual redetermination is required to assure that the court has determined that the Department has made reasonable efforts to finalize a permanent plan for the child. This is done at the Permanency Hearing held every twelve (12) months from the date of removal until the child is either adopted or placed in legal guardianship. The foster care payment standard is also the child's eligibility income limit for determining continued eligibility for AFDC-FC.

CONTINUING ELIGIBILITY CONDITIONS, TABLE 430		
	CONDITION	**DESCRIPTION**
05.	**Other Eligibility Considerations.**	The following must be considered for AFDC-FC eligibility: A child's eligibility does not depend on the availability of a home to which he can return; The Department must provide services designed to allow the child to return home, where not possible, the family's worker must aggressively pursue other permanent options for the child; A child receiving AFDC-FC who becomes available for adoption, remains eligible to receive AFDC-FC until he is legally adopted. The child must otherwise qualify for AFDC-FC; The child must not receive AFDC-FC and SSI, or AFDC-FC and AFDC, in the same month.

~~(3-30-01)~~*(7-1-03)T*

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.06 - RULES FOR LOANS TO GROUP HOMES FOR RECOVERING ALCOHOL AND DRUG ABUSERS

DOCKET NO. 16-0606-0401 - (CHAPTER REPEAL)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-303 and 39-311, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the July 7, 2004 Idaho Administrative Bulletin, Volume 04-07, page 88.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Pharis Stanger at (208) 334-4944.

DATED this 15th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 39-303 and 39-311, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 21, 2004.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

This entire chapter of rule is being repealed. These rules were promulgated 1989, to provide loans to group homes for recovering alcohol and drug abusers. No loans have been issued

and no funds are available for this program. The Department is repealing these rules as they are no longer necessary.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the this chapter is being repealed due to lack of funding for the program.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Pharis Stanger at (208) 334-4944.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before July 28, 2004.

DATED this 21st day of May, 2004.

Sherri Kovach - Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone
(208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

IDAPA 16.06.06 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.14 - RULES GOVERNING THE PREVENTION OF MINORS' ACCESS TO TOBACCO PRODUCTS

DOCKET NO. 16-0614-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Title 39, Chapter 57, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the August 4, 2004 Idaho Administrative Bulletin, Volume 04-8, pages 163 through 169.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Terry Pappin at (208) 334-6542.

DATED this 6th day of October, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Title 39, Chapter 57, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation

must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a non-technical explanation of the substance and purpose of the proposed rulemaking:

This rule making implements two requirements in Idaho Code that were passed during the 2003 Legislative session under Senate Bill No. 1067 and House Bill No. 357. These changes are found in Title 39, Chapter 57, Idaho Code and require that inspections of "adult only" permit locations are exempt from inspections assisted by a minor and that the Department issue permits to those entities selling tobacco products via the internet, telephone or fax machine. House Bill No. 357 also requires that those who deliver tobacco products must be issued permits. The rule changes also include additions of required sections that were not in this chapter of rule.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

These rules are necessary in order to protect the public health, safety and welfare; and to comply with amendments to governing law.

FEE SUMMARY: No fee is being imposed or increased by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, informal negotiated rulemaking was conducted. A rules workgroup was formed made up of individuals representing interested parties. This included: shipping entities - UPS, FedEx, and the United States Post Office; law enforcement agencies - Idaho State Police, Idaho Sheriff's Association, and the Idaho Peace Officer's Association; retailer associations - Idaho Petroleum Marketer's Association, Idaho Wholesalers Association, Idaho Retailer's Association and the Online Tobacco Retailer's Association. The Idaho Office of the Attorney General was also involved. Four meetings were set up in Boise between August, 2003, and October, 2003, for discussion of the proposed rules changes. Copies of the draft rules were mailed to the above interested parties. Several initial phone calls were received but no written comments.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Terry Pappin at (208) 334-6542.

Anyone can submit written comments regarding this rule. All written comments must be directed to the undersigned and must be postmarked on or before August 25, 2004.

DATED this 24th day of June, 2004.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

003. ADMINISTRATIVE APPEALS~~*-AND ADMINISTRATIVE PROCEEDINGS*~~.
All administrative ~~*A*~~appeals ~~*and proceedings shall be*~~ are governed by ~~*the Idaho Department of Health and Welfare Rules,*~~ provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". ~~*(4-5-00)*~~(7-1-03)T

004. ~~*PUBLIC RECORDS*~~ INCOPORATION BY REFERENCE.
~~*The Tobacco Project Office will comply with Sections 9-337 through 9-347, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempt, as set forth in Section 9-340, Idaho Code, and other state and federal laws and regulations, all public records in the custody of the Tobacco Project Office are subject to disclosure.*~~ No documents have been incorporated by reference. ~~*(4-5-00)*~~(7-1-03)T

~~***005. 006. (RESERVED).***~~

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

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (7-1-03)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (7-1-03)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (7-1-03)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (7-1-03)T

05. Internet Website. The Department's internet website is found at "http://www2.state.id.us/dhw/". (7-1-03)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.
Any use or disclosure of Department records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records". (7-1-03)T

007. -- 009. (RESERVED).

0~~07~~10. DEFINITIONS.
The terms used in this rule are defined as follows: (4-5-00)

01. Business. Any company, partnership, firm, sole proprietorship, association, corporation, organization, or other legal entity, or a representative of the foregoing entities that sells or distributes tobacco products. Wholesalers' or manufacturers' representatives in the course of their employment are not included in the scope of these rules. (4-5-00)

02. Delivery Sale. The distribution of tobacco products to a consumer in a state where either: (7-1-03)T

a. The individual submits the order for a purchase of tobacco products by a telephone call or other voice transmission method; data transfer via computer networks, including the internet and other online services; or by use of a facsimile machine transmission or use of the mails; or (7-1-03)T

b. When tobacco products are delivered by use of the mails or a delivery service. (7-1-03)T

03. Delivery Service. Any person who is engaged in the commercial delivery of letters, packages, or other containers. This includes permittees taking a delivery sale order and who delivers the tobacco products without using a third party delivery service. (7-1-03)T

0~~2~~4. Department. The Department of Health and Welfare (DHW) or its duly authorized representative. ~~(4-5-00)~~(7-1-03)T

~~***03. DHW**. Department of Health and Welfare.*~~ ~~(4-5-00)~~

05. Direct Sale. Any face to face, or in person sale, of a tobacco product by a permittee or their employee to an individual. (7-1-03)T

0~~4~~6. Distribute. To give, deliver, sell, offer to give, offer to deliver, offer to sell or cause any person to do the same or hire any person to do the same. (4-5-00)

0~~5~~7. Effective Training. Training must include, at a minimum, the provisions of the law regarding minors' access to tobacco products as indicated on the suggested Employee Training form which is included with the permit provided by the Department and found in Appendix A of these rules. Such training will be presumed effective for purposes of civil penalty actions in the first, second, and third violations within a two (2) year period. (3-15-02)

0~~6~~8. Evidence of Effective Training. Documentation provided by a permittee in response to a violation of this chapter clearly identifying that the permittee had a training program meeting the definition for effective training in place at the time of the violation and had on file a form signed by the employee prior to the violation stating understanding of the tobacco laws dealing with minors and the unlawful purchase of tobacco. (3-15-02)

0~~7~~9. **Minor**. A person under eighteen (18) years of age. (4-5-00)

~~08~~10. **Permit**. A permit issued by the Department for the sale or distribution of tobacco products. A permit must include endorsements to indicate the type of service offered by the permittee. Where the permittee uses more than one (1) method for sale or delivery of a tobacco product, the permit must reflect the required endorsement for each method. ~~*(4-5-00)*~~(7-1-03)T

11. **Permit Endorsement**. An endorsement identifies a sale or delivery method used by a permittee to sell tobacco products. There are three (3) types of endorsements that may be included on a permit. The three (3) endorsement types are Delivery Sales, Delivery Service and Direct Sales. (7-1-03)T

12. **Retail Sales Minor Exempt Permit**. A permit that is issued to retail locations whose revenues from the sale of alcoholic beverages for onsite consumption are at least fifty-five percent (55%) of total revenues, or whose products and services are primarily obscene, pornographic, profane or sexually oriented. A permittee issued this type of permit is exempt from minor assisted inspections where minors are not allowed on the premises and such prohibition is clearly posted at all entrances. (7-1-03)T

~~09~~13. **Permittee**. The holder of a valid permit for the sale or distribution of tobacco products. (4-5-00)

1~~0~~4. **Photographic Identification**. In all cases the identification must bear a photograph and a date of birth. Verification is not required by these rules if the buyer is known to the seller to be age eighteen (18) or older. Types of identification include: (4-5-00)

a. State, district, territorial, possession, provincial, national or other equivalent government driver's license; or (4-5-00)

b. Identification card or military identification card; or (4-5-00)

c. A valid passport. (4-5-00)

1~~1~~5. **Random Unannounced Inspection**. An inspection of business by a law enforcement agency or by the Department, with or without the assistance of a minor, to monitor compliance of this chapter. (4-5-00)

a. Random. At any time without a schedule or frequency. (4-5-00)

b. Unannounced. Without previous notification. (4-5-00)

1~~2~~6. **Seller**. The person who physically sells or distributes tobacco products. (4-5-00)

1~~3~~7. **Tobacco Product**. Any substance that contains tobacco including, but not limited to, cigarettes, cigars, pipes, snuff, smoking tobacco, tobacco paper, or smokeless tobacco. (4-5-00)

1~~4~~8. **Vending Machine**. Any mechanical, electronic or other similar device which,

upon the insertion of tokens, money or any other form of payment, dispenses tobacco products. (4-5-00)

1~~5~~9. Vendor Assisted Sales. Any sale or distribution in which the customer has no access to the product except through the assistance of the seller. The seller must physically dispense the tobacco product to the purchaser. A business is exempt from vendor assisted sales if it meets the following criteria: (4-5-00)

a. Tobacco products comprise at least seventy-five percent (75%) of total merchandise as determined by sales reported to the Idaho State Tax Commission; (4-5-00)

b. Minors are not allowed in exempt businesses and there is a sign on all entrances prohibiting minors; and (4-5-00)

c. There must be a separate entrance to the outside air or to a common area not under shared ownership by the exempt business. (4-5-00)

~~16~~20. Violation. An action contrary to Title 39, Chapter 57, Idaho Code, or IDAPA 16.06.14, "Rules Governing the Prevention of Minors' Access to Tobacco Products". (4-5-00)

~~17~~21. Without a Permit. A business that has failed to obtain a permit or a business whose permit is suspended or revoked. (4-5-00)

0~~08~~11. -- 019. (RESERVED).

020. APPLICATION FOR PERMIT.
All businesses which sell or distribute tobacco products to the public must obtain a permit issued annually for no charge by the Department of Health and Welfare. (4-5-00)

01. Where to Obtain an Application for Permit. A~~n~~ hard-copy application can be obtained, at no cost to the applicant, from the Department of Health and Welfare, Division of Family and Community Services, PO Box 83720, Boise, Idaho, 83720-0036. ~~*Application may be made through online services where available.*~~ A permit may also be obtained, at no cost to the applicant, via the internet. The internet website is found at www.tobaccopermits.com/Idaho/.
~~*(3-20-04)*~~(7-1-03)T

02. ~~*Separate*~~ Permits. A separate permit must be obtained for each place of business. The permit is non-transferable to another person, business, or location. The applicant must request endorsements for each method of sale or delivery it uses. If a place of business sells or distributes tobacco by more than one (1) method, it must have and endorsement for each type.
~~*(3-15-02)*~~(7-1-03)T

03. Renewal of Permit. All permits must be renewed annually and are valid for twelve (12) calendar months. (4-5-00)

a. The Department will mail notices of renewal for permits no later than ninety (90) days prior to the expiration date on the permit. (4-5-00)

b. An application for renewal must be submitted annually by each business through written application or online services where available. (3-15-02)

c. A business with multiple sites may submit a single written application to renew the permit at each site, so long as the application is accompanied by a list of business locations and addresses. (3-15-02)

d. A permit will not be renewed for any location until any past due fines for violations are paid in full. Fines are considered past due when not paid within ten (10) days of the citation date, or within ten (10) days after notification that the fine is upheld upon appeal. Violation fines under appeal are not considered past due. (3-20-04)

04. Application for Exemption. Businesses seeking exemption from vendor assisted sales must submit information to the Department to establish compliance with criteria set forth in Subsections 007.14.a. through 007.14.c. (3-20-04)

021. PERMITTEE RESPONSIBILITIES.
The permittee is responsible for the following: (4-5-00)

01. Possession of Permit. Each business site must have a permit. (4-5-00)

02. Visibility. The permit must be available upon request at each site. (3-15-02)

03. Display of Sign. Each business may display, at each business site, a sign which states: "State Law Prohibits the Sale of Tobacco Products to Persons Under the Age of Eighteen (18) Years. Proof of Age Required. Anyone Who Sells or Distributes Tobacco to a Minor is Subject to Strict Fines and Penalties. Minors are Subject to Fines and Penalties." (4-5-00)

04. Effective Training. Each permittee is responsible to train employees as to the requirements of Title 39, Chapter 57, Idaho Code, and these rules. (4-5-00)

a. Unless the permittee has its own training program as described in Subsection 021.04.b., the employer must, at a minimum, read to the employee or prospective employee who may be responsible for sale or distribution of tobacco products, or assure the employee or prospective employee has read the information contained on the Employee Training form found in Appendix A of these rules and have him initial each statement, and sign the form indicating an understanding of the provisions of the law governing minors' access to tobacco products.(4-5-00)

b. Permittee may have their own training program but it must contain at least each of the elements listed in the Employee Training form found in Appendix A of these rules and the employee or prospective employee who may be responsible for sale or distribution of tobacco products must affirm in writing their acknowledgment of such training. (4-5-00)

05. Permit Requirements. All permittees are required to be familiar with and comply with the requirements of Title 39, Chapter 57, Idaho Code as that act pertains to the permittee's sales of tobacco products. (7-1-03)T

022. DELIVERY SALE ADDITIONAL REQUIREMENTS.

In addition to the requirements of Title 39, Chapter 57, Idaho Code, all permittees holding a Delivery Sale Endorsement, who mail or ship tobacco products must: (7-1-03)T

01. **Shipping Package Requirements**. Imprint in clearly legible, black ink letters, that are no less than one (1) inch tall, the words "TOBACCO PRODUCT, MUST BE 18 YEARS OF AGE TO ACCEPT" on the exterior top and bottom of the shipping package. (7-1-03)T

02. **Delivery Requirements**. Require that tobacco products only be delivered in a face-to-face delivery to the address on the original shipping label. The individual receiving the delivery must be verified to be at least eighteen (18) years of age and have the same address as on the original shipping label. (7-1-03)T

02~~2~~3. -- 050. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

101. INSPECTIONS.

01. Random and Unannounced Inspections. The total number of random and unannounced inspections under Section 101 shall be determined by: (3-15-02)

a. The number of permittees on the last day of each year multiplied by the percentage of violations for the preceding year multiplied by a factor of ten (10). A calculation checklist is provided under Appendix B; (3-20-04)

b. In no instance shall the total number of inspections be less than the number of permittees, or exceed twice the number of permittees. (3-15-02)

c. The Department and the Idaho State Police must conduct at least one (1), unannounced inspection per year at every known business location identified as a retailer of tobacco products to the public. All additional inspections required to meet the total number specified under Section 101 must be conducted in a random manner. (3-20-04)

02. Who Will Inspect. Inspections will be conducted for all minor exempt permit locations by an adult enforcement officer. For all other permit locations, inspections will be conducted by an adult enforcement officer accompanied by a minor. ~~*(4-5-00)*~~(7-1-03)T

03. Law Enforcement Agency Inspections. (4-5-00)

a. In addition to the inspections set forth in Subsection 101.01, any law enforcement agency may conduct inspections consistent with agency policy and procedure with or without a minor at any business location, at any time, where tobacco products are sold or distributed to the public. (3-15-02)

b. Law enforcement agencies conducting inspections under Subsection 101.03.a. will

report the results from their inspections to the Department. All citations will become part of the permittee's permanent record. (3-15-02)

04. Complaint Investigation. (3-15-02)

a. The Department must refer all written complaints concerning the sale of tobacco products to minors to the appropriate agency for investigation. Investigation activities include, but are not limited to, inspections to determine the compliance with this chapter. (3-20-04)

b. Inspections conducted as part of the investigation of a written complaint are not included in the overall number of inspections identified under Subsections 101.01 and 101.03. Citations issued during the investigation of a written complaint must be added to the permittee's permanent record. (3-20-04)

05. Issuance of Citation or Report. (4-5-00)

a. For inspections conducted under Subsection 101.01 a representative of the business will be provided with a report, within two (2) business days, after the inspection was conducted and no violations were found, or a representative of the business will be issued a citation within two (2) business days after the random unannounced inspection. (3-15-02)

b. For inspections conducted under Subsections 101.03 and 101.04, a representative of the business will be provided with a report, within two (2) business days, after the result of the inspection is received by the Department and no violations were found, or a representative of the business will be issued a citation within two (2) business days after the result of the inspection is received by the Department. The date the Department provides notification of the citation must be used for determination of timely payment of fines and all other administrative actions including requests for waivers and request for appeals. (3-20-04)

102. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.09.01 - DAY CARE CENTER HEALTH STANDARDS

DOCKET NO. 16-0901-0401 - (CHAPTER REPEAL)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1003 and 39-1110, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rules was published in the July 7. 2004 Idaho Administrative Bulletin, Volume 04-7, page 89. This rule is repealed in its entirety.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Richard Horne at (208)522-0310.

DATED this 25th day of August, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1003 and 56-1007, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 21, 2004.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

This entire chapter of rules is being repealed. These rules were promulgated for Public Health Districts in 1988. These adopted standards are no longer current and are redundant

because other rules address these issues.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the repeal of this chapter is no longer necessary.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Richard Horne at (208) 522-0310.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before July 28, 2004.

DATED this 21st day of May, 2004.

Sherri Kovach - Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone
(208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

IDAPA 16.09.01 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 19 - BOARD OF DENTISTRY

19.01.01 - RULES OF THE IDAHO STATE BOARD OF DENTISTRY

DOCKET NO. 19-0101-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is October 1, 2004. The pending rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 54-912(4), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reason for adopting the pending rule and amending the temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The purpose for adopting the pending rule is to implement and effectuate legislation enacted in the Idaho Dental Practice Act during the 2004 legislative session. The pending rules provide the following: specific requirements for the issuance and renewal of the extended access dental hygiene endorsement; specific requirements to entitle a dental hygienist to volunteer in an extended access oral health care program; a specific list of permissible and prohibited functions for a dental hygienist practicing under specified levels of supervision in a private dental office or in an extended access oral health care program; a specific list of permissible and prohibited functions for a dental assistant practicing under the direct supervision of a dentist; and continuing education standards for volunteer dentists and dental hygienists holding an extended access dental hygiene endorsement.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, as the result of public comment. In order to keep the temporary rule in place while the pending rule awaits legislative approval, the Board of Dentistry amended the temporary rule with the same revisions which were made to the pending rule. The original text of the proposed rule was published in the June 2, 2004, Idaho Administrative Bulletin, Vol. 04-6, pages 38 through 45.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and pending rules, contact Michael J. Sheeley, Executive Director, Idaho State Board of Dentistry, at (208) 334-2369.

DATED this 19th day of July, 2004.

BOARD OF DENTISTRY ***Docket No. 19-0101-0401***
Rules of the State Board of Dentistry ***PENDING RULE***

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: The effective date of the temporary rules is July 1, 2004.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-912(4), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than 5:00 p.m. (MST) on June 16, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of the proposed rulemaking is to provide rules in order to implement and effectuate legislation enacted in the Idaho Dental Practice Act during the 2004 legislative session. The proposed rulemaking provides the following: specific requirements for the issuance and renewal of the extended access dental hygiene endorsement; specific requirements to entitle a dental hygienist to volunteer in an extended access oral health care program; a specific list of permissible and prohibited functions for a dental hygienist practicing under differing levels of supervision in a private dental office or in an extended access oral health care program; a specific list of permissible and prohibited functions for a dental assistant while practicing under the direct supervision of a dentist; and continuing education requirements for volunteer dentists and dental hygienists holding an extended access dental hygiene endorsement.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a) and (b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

The temporary adoption of the rules is appropriate in order to implement and effectuate legislation enacted in the Idaho Dental Practice Act during the 2004 legislative session. The rules also protect and benefit the public by means of creating standards for the issuance of an extended access dental hygiene endorsement which will greatly expand a dental hygienist's ability to provide dental hygiene services to children and elderly, handicapped and indigent persons in both public settings and other charitable programs.

FEE SUMMARY: There are no fees included in these rules proposed for temporary adoption.

BOARD OF DENTISTRY ***Docket No. 19-0101-0401***
Rules of the State Board of Dentistry ***PENDING RULE***

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the Board of Dentistry undertook the following actions in connection with these rules. The proposed rules were published in the Spring of 2003 Board of Dentistry's Newsletter which was disseminated to every dentist and dental hygienist licensed in Idaho. The Board of Dentistry requested and received numerous written comments regarding the proposed rules. Many of the comments received from both dentists and dental hygienists were incorporated into the proposed rules. The members of the Board of Dentistry also negotiated the proposed rules with representatives of the Idaho State Dental Association, a professional association that represents 85% to 90% of the licensed dentists in Idaho, and participated in discussions with additional members of the Idaho State Dental Association at seven (7) component meetings conducted around the state of Idaho

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Michael J. Sheeley, Executive Director, Idaho State Board of Dentistry, at (208) 334-2369.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before 5:00 p.m. (MST) on June 23, 2004.

DATED this 11th day of May, 2004.

Michael J. Sheeley, Executive Director
Idaho State Board of Dentistry
708 ½ W. Franklin Street
Boise, Idaho 83720
(208) 334-2369 (telephone)
(208) 334-3247 (facsimile)

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

004. INCORPORATION BY REFERENCE (RULE 4).
Pursuant to Section 67-5229, Idaho Code, this chapter incorporates by reference the following documents: (7-1-93)

01. Documents. (7-1-93)

a. American Association of Oral and Maxillofacial Surgeons, Office Anesthesia Evaluation Manual, 6th Edition, 2000. (3-15-02)

b. American Dental Association, Council on Dental Education, Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, October 2000. (3-15-02)

c. American Dental Association, Council on Dental Education, Guidelines for Use of

Conscious Sedation, Deep Sedation and General Anesthesia for Dentists, October 2000.(3-15-02)

~~**d.** *American Dental Association, Infection Control Recommendations for the Dental Office and the Dental Laboratory, JADA, August 1992.* *(7-1-93)*~~

~~**e**~~**d.** Centers for Disease Control and Prevention, DHHS, ~~*Recommended*~~ Guidelines for Infection Control ~~*Practice for Dentistry*~~ in Dental Health-Care Settings, ~~*1993*~~ 2003. ~~*(3-18-99)*~~(7-1-04)T

~~**f**~~**e.** American Dental Association, Principles of Ethics, Code of Professional Conduct and Advisory Opinions (ADA Code), January 2003(as amended). (3-20-04)

02. Availability. These documents are available for public review at the Idaho State Board of Dentistry, 708 1/2 West Franklin Street, Boise, Idaho 83720, or the Idaho State Law Library, Supreme Court Building, 451 W. State Street, Boise, Idaho 83720. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

026. -- 02~~9~~8. (RESERVED).

029. DENTAL HYGIENISTS - LICENSE ENDORSEMENTS (RULE 29).
Subject to the provisions of the Dental Practice Act, Chapter 9, Title 54, Idaho Code, and these rules, the Board may grant license endorsements to qualified dental hygienists as follows: (7-1-04)T

01. Extended Access Dental Hygiene Endorsement. Upon application, the Board may grant an extended access dental hygiene endorsement to a person holding an unrestricted active status dental hygienist's license issued by the Board who provides satisfactory proof that the following requirements are met: (7-1-04)T

a. The person has been licensed as a dental hygienist during the two (2) year period immediately prior to the date of application for an extended access dental hygiene endorsement; (7-1-04)T

b. For a minimum of one thousand (1000) total hours within the previous two (2) years, the person has either been employed as a dental hygienist in supervised clinical practice or has been engaged as a clinical practice educator in an approved dental hygiene school; (7-1-04)T

c. The person has not been disciplined by the Board or another licensing authority upon grounds that bear a demonstrable relationship to the ability of the dental hygienist to safely and competently practice under general supervision in an extended access oral health care program. (7-1-04)T

02. Extended Access Dental Hygiene Endorsement Exception. Any person holding an unrestricted active status dental hygienist's license issued by the Board who is employed as a

dental hygienist in an extended access oral health care program in this state shall be granted an extended access dental hygiene endorsement without being required to satisfy the experience requirements specified in this rule. (7-1-04)T

03. **Volunteer Dental Hygiene Services**. A person holding an unrestricted active status dental hygienist's license issued by the Board may provide dental hygiene services in an extended access oral health care program without being issued an extended access dental hygiene license endorsement under the following circumstances: (7-1-04)T

a. The dental hygiene services must be performed in an extended access oral health care program under the supervision of a dentist who is employed or retained by or is a volunteer for the program; (7-1-04)T

b. The dental hygiene services performed shall be limited to oral health screening, preparation of health history, fluoride treatment, non-surgical periodontal treatment, oral prophylaxis, the application of caries preventative agents, the application of pit and fissure sealants with recommendation that patient will be seen by a dentist and preventive dental health instruction; (7-1-04)T

c. The dental hygienist must perform the dental hygiene services on a volunteer basis and shall not accept any form of remuneration for providing the services; and (7-1-04)T

d. The dental hygienist may not provide dental hygiene services under this provision for more than five (5) days within any calendar month. (7-1-04)T

04. **Renewal**. Upon payment of the appropriate annual license fee and completion of required continuing education credits specified for a dental hygiene license endorsement, a person meeting all other requirements for renewal of a license to practice dental hygiene shall be entitled to renewal of a dental hygiene license endorsement upon April 1 of each year. An endorsement shall immediately expire and be cancelled at such time as a person no longer holds an unrestricted active status dental hygienist's license issued by the Board or upon a person's failure to complete the required continuing education credits. (7-1-04)T

030. DENTAL HYGIENISTS - PRACTICE (RULE 30).
Subject to the provisions of the Dental Practice Act, Chapter 9, Title 54, Idaho Code, dental hygienists are hereby ~~*prohibited from*~~ authorized to perform~~*ing*~~ the activities specified below: ~~*(3-18-99)*~~(7-1-04)T

01. ~~***Expanded Functions***~~ **General Supervision**. ~~*Administration of local anesthetic and nitrous oxide except under the indirect supervision and responsibility of a licensed dentist or attending physician in a hospital setting.*~~ A dental hygienist may perform specified duties under general supervision as follows: ~~*(3-18-99)*~~(7-1-04)T

a. Performing oral prophylaxis (including removal of supragingival and subgingival calculus, stains and accretions from teeth); (7-1-04)T

b. Performing intra-oral and extra-oral assessments (including charting of the oral cavity and surrounding structures, taking case histories and periodontal assessment); (7-1-04)T

c. Developing patient care plans for prophylaxis and non-surgical periodontal therapy in accordance with the treatment parameters set by supervising dentist; (7-1-04)T

d. Performing root planing; (7-1-04)T

e. Performing non-surgical periodontal therapy; (7-1-04)T

f. Performing closed subgingival curettage; (7-1-04)T

g. Administration of local anesthesia; (7-1-04)T

h. Removal of marginal overhangs (use of high speed handpieces or surgical instruments is prohibited); (7-1-04)T

i. Application of topical antibiotics or antimicrobials (used in non-surgical periodontal therapy); (7-1-04)T

j. Instructing patients in techniques of oral hygiene and preventive procedures; (7-1-04)T

k. Placement of antibiotic treated materials pursuant to written order and site specific; (7-1-04)T

l. Performing all duties which may be performed by a dental assistant; and (7-1-04)T

m. Performing such other duties as approved by the Board. (7-1-04)T

02. ~~***Restorative Procedures***~~ **Indirect Supervision**. ~~*The operative preparation of teeth for the placement of restorative materials or the placement or carving of restorative materials.*~~ A dental hygienist may perform specified duties under indirect supervision as follows: ~~*(7-1-93)*~~(7-1-04)T

a. Administration and monitoring of nitrous oxide; (7-1-04)T

b. All dental hygienist duties specified under general supervision; and (7-1-04)T

c. Performing such other duties as approved by the Board. (7-1-04)T

03. ~~***General Anesthesia***~~ **Direct Supervision**. ~~*Administration of any general anesthesia.*~~ A dental hygienist may perform specified duties under direct supervision as follows: ~~*(7-1-93)*~~(7-1-04)T

a. Use of a laser restricted to gingival curettage and bleaching; (7-1-04)T

b. All dental hygienist duties specified under general and indirect supervision; and (7-1-04)T

c. Performing such other duties as approved by the Board. (7-1-04)T

~~***04. Written Orders**. The dental hygienist is prohibited from working under general supervision unless written orders are received, recorded in the patient's record, and signed by the supervising dentist within the twelve (12) months preceding treatment by the dental hygienist.*~~
~~*(3-18-99)*~~

031. DENTAL HYGIENISTS - PROHIBITED PRACTICE (RULE 31).
Subject to the provisions of the Dental Practice Act, Chapter 9, Title 54, Idaho Code, and these rules, a dental hygienist may not perform certain specified duties. (7-1-04)T

01. Prohibited Duties. A dental hygienist is prohibited from performing the duties specified below: (7-1-04)T

a. Definitive diagnosis and dental treatment planning; (7-1-04)T

b. The operative preparation of teeth for the placement of restorative materials; (7-1-04)T

c. The placement or carving of restorative materials; (7-1-04)T

d. Administration of any general anesthesia or conscious sedation; (7-1-04)T

e. Final placement of any fixed or removable appliances; (7-1-04)T

f. Final removal of any fixed appliance; (7-1-04)T

g. Cutting procedures utilized in the preparation of the coronal or root portion of the tooth; (7-1-04)T

h. Cutting procedures involving the supportive structures of the tooth; (7-1-04)T

i. Placement of the final root canal filling; (7-1-04)T

j. Final impressions of any tissue-bearing area, whether hard or soft tissue; (7-1-04)T

k. Occlusal equilibration procedures for any prosthetic restoration, whether fixed or removable; (7-1-04)T

l. Final placement of prefabricated or cast restorations or crowns; and (7-1-04)T

m. Such other duties as specifically prohibited by the Board. (7-1-04)T

03~~1~~2. -- 034. (RESERVED).

035. DENTAL ASSISTANTS - PRACTICE (RULE 35).

01. Direct Supervision. A dental assistant may perform specified activities under

direct supervision as follows: (7-1-04)T

a. Recording the oral cavity (existing restorations, missing and decayed teeth); (7-1-04)T

b. Placement of topical anesthetic agents (prior to administration of a local anesthetic by a dentist or dental hygienist); (7-1-04)T

c. Removal of excess bonding material from temporary and permanent restorations and orthodontic appliances (using hand instruments or contra-angle handpieces with disks or polishing wheels only); (7-1-04)T

d. Expose and process radiographs; (7-1-04)T

e. Take impressions for preparation of diagnostic models, bleach trays, fabrication of night guards, temporary appliances, temporary crowns or bridges; (7-1-04)T

f. Record diagnostic bite registration; (7-1-04)T

g. Record bite registration for fabrication of restorations; (7-1-04)T

h. Provide patient education and instruction in oral hygiene and preventive services; (7-1-04)T

i. Placement of cotton pellets and temporary restorative materials into endodontic access openings; (7-1-04)T

j. Placement and removal of arch wire; (7-1-04)T

k. Placement and removal of orthodontic separators; (7-1-04)T

l. Placement and removal of ligature ties; (7-1-04)T

m. Cutting arch wires; (7-1-04)T

n. Removal of loose orthodontic brackets and bands to provide palliative treatment; (7-1-04)T

o. Adjust arch wires; (7-1-04)T

p. Etching of teeth prior to placement of restorative materials; (7-1-04)T

q. Etching of enamel prior to placement of orthodontic brackets or appliances by a Dentist; (7-1-04)T

r. Placement and removal of rubber dam; (7-1-04)T

s. Placement and removal of matrices; (7-1-04)T

t. Placement and removal of periodontal pack; (7-1-04)T

u. Removal of sutures; (7-1-04)T

v. Application of cavity liners and bases; (7-1-04)T

w. Placement and removal of gingival retraction cord; (7-1-04)T

x. Application of topical fluoride agents; and (7-1-04)T

y. Performing such other duties as approved by the Board. (7-1-04)T

0~~1~~2. **Prohibited Duties**. Subject to other applicable provisions of these rules and of the Act, dental assistants are hereby prohibited from performing any of the activities specified below: (7-1-93)

a. Definitive ~~D~~diagnosis and treatment planning. ~~(7-1-93)~~(7-1-04)T

b. The placement or carving of permanent restorative materials in any manner. (7-1-93)

c. ~~*Initiate or regulate the flow of nitrous oxide on a patient*~~ Any procedure using lasers. ~~(7-1-93)~~(7-1-04)T

d. The administration of any general anesthetic, infiltration anesthetic or any injectable nerve block procedure~~;~~. ~~(3-18-99)~~(7-1-04)T

e. Any oral prophylaxis. Oral prophylaxis is defined as the removal of plaque, calculus, and stains from the exposed and unexposed surfaces of the teeth by scaling and polishing. (7-1-93)

f. Any intra-oral procedure using a highspeed handpiece, *except to the extent authorized by a Certificate of Registration or certificate or diploma of course completion issued by an approved teaching entity*. ~~(7-1-04)T~~(10-1-04)T

~~f~~g. The following expanded functions, unless authorized by a Certificate of Registration or certificate or diploma of course completion issued by an approved teaching entity and performed under direct supervision: ~~(7-1-93)~~(7-1-04)T

i. Fabrication and ~~P~~placement ~~*and remove*~~ of temporary ~~*restorations*~~ crowns; ~~(7-1-93)~~(7-1-04)T

ii. Perform the mechanical polishing of restorations; (7-1-93)

iii. Monitor the patient while nitrous oxide analgesia is being administered; ~~(3-18-99)~~(7-1-04)T

iv. Application of pit and fissure sealants; (7-1-93)

v. Coronal polishing, unless authorized by a Certificate of Registration; this refers to the technique of removing soft substances from the teeth with pumice or other such abrasive substances with a rubber cup or brush. This in no way authorizes the mechanical removal of calculus nor is it to be considered a complete oral prophylaxis. This technique (coronal polishing) would be applicable only after examination by a dentist and removal of calculus by a dentist or dental hygienist~~.~~*; and* ~~*(7-1-93)*~~(10-1-04)T

vi. Use of a highspeed handpiece restricted to the removal of orthodontic cement or resin. (10-1-04)T

0~~2~~3. Expanded Functions Qualifications. A dental assistant may be considered Board qualified in expanded functions, authorizing the assistant to perform any or all of the expanded functions described in Subsection 035.0~~1~~2.~~f~~g. upon satisfactory completion of the following requirements: ~~*(7-1-93)*~~(7-1-04)T

a. Completion of Board-approved training in each of the expanded functions with verification of completion of the training to be provided to the Board upon request by means of a Certificate of Registration or other certificate evidencing completion of approved training. The required training shall include adequate training in the fundamentals of dental assisting, which may be evidenced by: ~~*(3-18-99)*~~(7-1-04)T

i. Current certification by the Dental Assisting National Board; or (7-1-93)

ii. Successful completion of a Board-approved course in the fundamentals of dental assisting; or (3-18-99)

iii. Successfully challenging the fundamentals course. (7-1-93)

b. Successful completion of a Board-approved competency examination in each of the expanded functions. There are no challenges for expanded functions. (3-18-99)

0~~3~~4. Course Approval. Any school, college, institution, university or other teaching entity may apply to the Board to obtain approval of its courses of instruction in expanded functions. Before approving such course, the Board may require satisfactory evidence of the content of the instruction, hours of instruction, content of examinations or faculty credentials. (3-18-99)

0~~4~~5. Other Credentials. Assistants, who have completed courses or study programs in expanded functions that have not been previously approved by the Board, may submit evidence of the extent and nature of the training completed, and, if in the opinion of the Board the same is at least equivalent to other Board-approved courses, and demonstrates the applicant's fitness and ability to perform the expanded functions, the Board may consider the assistant qualified to perform any expanded function(s). (3-18-99)

(BREAK IN CONTINUITY OF SECTIONS)

050. CONTINUING EDUCATION FOR DENTISTS (RULE 50).
Effective October 1994, renewal of any active dental license will require evidence of completion of continuing education or volunteer dental practice that meets the following requirements. ~~(3-18-99)~~(7-1-04)T

01. Requirements: (3-18-99)

a. All active dentists must hold a current CPR card. (7-1-93)

b. All active dentists shall acquire fifteen (15) credits of continuing education in each renewal year. One (1) credit is defined as one (1) hour of instruction. (7-1-93)

c. Continuing education must be oral health/health-related for the professional development of a dentist. The fifteen (15) credits shall be obtained through continuing education courses, correspondence courses, college credit courses, and viewing of videotape or listening to other media devoted to dental education. (3-18-99)

d. A dentist holding an active status license issued by the Board shall be allowed one (1) credit of continuing education for every two (2) hours of verified volunteer dental practice performed during the renewal year up to a maximum of five (5) credits. (7-1-04)T

02. Documentation. In conjunction with the annual license renewal, the dentist shall provide a list of continuing education credits obtained and verification of hours of volunteer dental practice performed and certify that the minimum requirements were completed in the one (1) year period. ~~(7-1-93)~~(7-1-04)T

051. CONTINUING EDUCATION FOR DENTAL HYGIENISTS (RULE 51).
Effective April 1994, renewal of any active dental hygiene license or dental hygiene license endorsement will require evidence of completion of continuing education or volunteer dental hygiene practice that meets the following requirements. ~~(3-18-99)~~(7-1-04)T

01. Requirements For Renewal Of An Active Status Dental Hygiene License: ~~(3-18-99)~~(7-1-04)T

a. All active dental hygienists must hold a current CPR card. (6-2-92)

b. All active dental hygienists shall acquire twelve (12) credits of continuing education in each renewal year. One (1) credit is defined as one (1) hour of instruction. (6-2-92)

c. Continuing education must be oral health/health-related education for the professional development of a dental hygienist. The twelve (12) credits shall be obtained through continuing education courses, correspondence courses, college credit courses, viewing of videotape or listening to other media devoted to dental hygiene education. (3-18-99)

d. A dental hygienist holding an active status license issued by the Board shall be

allowed one (1) credit of continuing education for every two (2) hours of verified volunteer dental hygiene practice performed during the renewal year up to a maximum of five (5) credits. (7-1-04)T

02. Requirements For Renewal Of An Extended Access Dental Hygiene License Endorsement. In addition to any other continuing education requirements for renewal of a dental hygiene license, a person granted an extended access dental hygiene license endorsement shall complete six (6) credits of continuing education in each renewal year in the specific practice areas of medical emergencies, local anesthesia, oral pathology, care and treatment of geriatric, medically compromised or disabled patients and treatment of children. (7-1-04)T

0~~2~~3. Documentation. In conjunction with the annual license and endorsement renewal, the dental hygienist shall provide a list of continuing education credits obtained and verification of hours of volunteer dental hygiene practice performed and certify that the minimum requirements were completed in the one (1) year period. ~~*(6-2-92)*~~(7-1-04)T

IDAPA 19 - BOARD OF DENTISTRY

19.01.01 - RULES OF THE IDAHO STATE BOARD OF DENTISTRY

DOCKET NO. 19-0101-0402

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-912(4) and 54-924(8), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change. The proposed rule incorporated the American Dental Hygienists' Association's Code of Ethics for Dental Hygienists into the Board of Dentistry's administrative rules by reference; specified that a violation of the American Dental Hygienists' Association's Code of Ethics for Dental Hygienists constitutes unprofessional conduct by a dental hygienist that may constitute grounds for disciplinary action; specifically identified three (3) additional areas of specialty dental practice (oral and maxillofacial radiology, oral and maxillofacial pathology and dental public health) to be recognized and licensed by the Board of Dentistry; and included the three (3) additional areas of specialty dental practice to be recognized and licensed by the Board of Dentistry in the specialty advertising standards. There was no textual change between the text of the proposed rule and the text of this pending rule. The pending rule is being adopted as proposed with no changes. The original text of the proposed rule was published in the September 1, 2004 Idaho Administrative Bulletin, Volume 04-9, pages 169 through 174.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Michael J. Sheeley, Executive Director, Idaho State Board of Dentistry, at (208) 334-2369.

DATED this 4th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-912(4), Idaho Code.

BOARD OF DENTISTRY ***Docket No. 19-0101-0402***
Rules of the Idaho State Board of Dentistry ***PENDING RULE***

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 15, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The proposed rulemaking is for the following purposes: to incorporate the American Dental Hygienists' Association's Code of Ethics for Dental Hygienists into the Board of Dentistry's administrative rules by reference; to specify that a violation of the American Dental Hygienists' Association's Code of Ethics for Dental Hygienists constitutes unprofessional conduct by a dental hygienist that may constitute grounds for disciplinary action; to specifically identify three (3) additional areas of specialty dental practice (oral and maxillofacial radiology, oral and maxillofacial pathology and dental public health) to be recognized and licensed by the Board of Dentistry; and to include the three (3) additional areas of specialty dental practice to be recognized and licensed by the Board of Dentistry in the specialty advertising standards.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased. N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted. Notice of the proposed rulemaking was previously provided to interested parties.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Michael J. Sheeley, Executive Director, at (208) 334-2369.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2004.

DATED this 19th day of July, 2004.

Michael J. Sheeley, Executive Director
Idaho State Board of Dentistry
708½ W. Franklin Street
Boise, Idaho 83702
(208) 334-2369 (telephone)
(208) 334-3247 (facsimile)

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

004. INCORPORATION BY REFERENCE (RULE 4).
Pursuant to Section 67-5229, Idaho Code, this chapter incorporates by reference the following documents: (7-1-93)

01. Documents. (7-1-93)

a. American Association of Oral and Maxillofacial Surgeons, Office Anesthesia Evaluation Manual, 6th Edition, 2000. (3-15-02)

b. American Dental Association, Council on Dental Education, Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, October 2000. (3-15-02)

c. American Dental Association, Council on Dental Education, Guidelines for Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists, October 2000.(3-15-02)

d. Centers for Disease Control and Prevention, DHHS, Guidelines for Infection Control in Dental Health-Care Settings, 2003. (7-1-04)T

e. American Dental Association, Principles of Ethics, Code of Professional Conduct and Advisory Opinions (ADA Code), January 2003(as amended). (3-20-04)

f. American Dental Hygienists' Association, Code of Ethics for Dental Hygienists (ADHA Code), 1995. ( )

02. Availability. These documents are available for public review at the Idaho State Board of Dentistry, 708 1/2 West Franklin Street, Boise, Idaho 83720, or the Idaho State Law Library, Supreme Court Building, 451 W. State Street, Boise, Idaho 83720. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

040. UNPROFESSIONAL CONDUCT (RULE 40).
A dentist or hygienist shall not engage in unprofessional conduct in the course of his practice. Unprofessional conduct by a person licensed under the provisions of Title 54, Chapter 9, Idaho Code, is defined as, but not limited to, one (1) of the following: (7-1-93)

01. Fraud. Obtaining fees by fraud or misrepresentation, or over-treatment either directly or through an insurance carrier. (7-1-93)

02. Unlicensed Practice. Employing directly or indirectly any suspended or unlicensed dentist or dental hygienist to practice dentistry or dental hygiene as defined in Title 54, Chapter 9, Idaho Code. (7-1-93)

03. Unlawful Practice. Aiding or abetting licensed persons to practice dental hygiene or dentistry unlawfully. (7-1-93)

04. Dividing Fees. A dentist shall not divide a fee for dental services with another party, who is not a partner or associate with him in the practice of dentistry, unless: (7-1-93)

a. The patient consents to employment of the other party after a full disclosure that a division of fees will be made; (7-1-93)

b. The division is made in proportion to the services performed and responsibility assumed by each dentist or party. (7-1-93)

05. Controlled Substances. Prescribing or administering controlled substances not reasonably necessary for, or within the scope of, providing dental services for a patient. In prescribing or administering controlled substances, a dentist shall exercise reasonable and ordinary care and diligence and exert his best judgment in the treatment of his patient as dentists in good standing in the state of Idaho, in the same general line of practice, ordinarily exercised in like cases. A dentist may not prescribe controlled substances for or administer controlled substances to himself. A dentist shall not use controlled substances as an inducement to secure or maintain dental patronage or aid in the maintenance of any person's drug addiction by selling, giving or prescribing controlled substances. (3-18-99)

06. Harassment. The use of threats or harassment to delay or obstruct any person in providing evidence in any possible or actual disciplinary action, or other legal action; or the discharge of an employee primarily based on the employee's attempt to comply with the provisions of Title 54, Chapter 9, Idaho Code, or the Board's Rules, or to aid in such compliance. (7-1-93)

07. Discipline in Other States. Conduct himself in such manner as results in a suspension, revocation or other disciplinary proceedings with respect to his license in another state. (3-18-99)

08. Altering Records. Alter a patient's record with intent to deceive. (7-1-93)

09. Office Conditions. Unsanitary or unsafe office conditions, as determined by the customary practice and standards of the dental profession in the state of Idaho and current recommendations of the American Dental Association and the Centers for Disease Control as referred to in Subsections 006.01.c. and 006.01.d. (7-1-93)

10. Abandonment of Patients. Abandonment of patients by licensees before the completion of a phase of treatment, as such phase of treatment is contemplated by the customary practice and standards of the dental profession in the state of Idaho, without first advising the patient of such abandonment and of further treatment that is necessary. (7-1-93)

11. Use of Intoxicants. Practicing dentistry or dental hygiene while under the influence of an intoxicant or controlled substance where the same impairs the dentist's or hygienist's ability to practice dentistry or hygiene with reasonable and ordinary care. (7-1-93)

12. Mental or Physical Illness. Continued practice of dentistry or dental hygiene in the case of inability of the licensee to practice with reasonable and ordinary care by reason of one

(1) or more of the following: (7-1-93)

a. Mental illness; (7-1-93)

b. Physical illness, including but not limited to, deterioration through the aging process, or loss of motor skill. (7-1-93)

13. Consent. Revealing personally identifiable facts, data or information obtained in a professional capacity without prior consent of the patient, except as authorized or required by law. (3-18-99)

14. Scope of Practice. Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities that the licensee knows or has reason to know that he or she is not competent to perform. (3-18-99)

15. Delegating Duties. Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows, or with the exercise of reasonable care and control should know, that such a person is not qualified by training or by licensure to perform them. (3-18-99)

16. Unauthorized Treatment. Performing professional services that have not been authorized by the patient or his legal representative. (3-18-99)

17. Supervision. Failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of a licensed professional. (7-1-93)

18. Legal Compliance. Failure to comply with any provisions of federal, state or local laws, statutes, rules, and regulations governing the practice of dentistry. (3-18-99)

19. Exploiting Patients. Exercising undue influence on a patient in such manner as to exploit a patient for the financial or personal gain of a practitioner or of a third party. (7-1-93)

20. Misrepresentation. Willful misrepresentation of the benefits or effectiveness of dental services. (7-1-93)

21. Disclosure. Failure to advise patients or their representatives in understandable terms of the treatment to be rendered, alternatives, and disclosure of reasonably anticipated fees relative to the treatment proposed. (3-18-99)

22. Sexual Misconduct. Making suggestive, sexual or improper advances toward a patient or committing any lewd or lascivious act upon or with a patient. (7-1-93)

23. Patient Management. Use of unreasonable and/or damaging force to manage patients, including but not limited to hitting, slapping or physical restraints. (7-1-93)

24. American Dental Association Compliance. Failure by a dentist to comply with the American Dental Association, Principles of Ethics, Code of Professional Conduct and Advisory Opinions (ADA Code), as incorporated by reference in this chapter. (3-20-04)

25. American Dental Hygienists' Association Compliance. Failure by a dental hygienist to comply with the American Dental Hygienists' Association, Code of Ethics for Dental Hygienists (ADHA Code), as incorporated by reference in this chapter. ( )

041. -- 044. (RESERVED).

045. LICENSURE OF DENTAL SPECIALISTS (RULE 45).

01. Qualifications. Each applicant shall have a general license for the practice of dentistry in the state of Idaho or another state. Any applicant who desires to be licensed in one (1) of the Board recognized specialties, which include and are limited to Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral and Maxillofacial Surgery, Orthodontics, Pediatric Dentistry, Periodontics, and Prosthodontics, must be a graduate of and hold a certificate from both a dental school and a Graduate Training Program that are accredited by the Commission on Dental Accreditation of the American Dental Association. Any dentist licensed in Idaho who has met the educational requirements and standards approved by the Board, and who has practiced in a Board recognized specialty prior to February 1, 1992, may be granted a specialty license by the Board without undergoing examination. ~~(3-20-04)~~( )

02. Application. Application for license to practice a recognized dental specialty must be filed in the office of the Board of Dentistry, Statehouse Mail, Boise, Idaho. The application must be attested before a notary public. (7-1-93)

03. Examination. Specialty licensure in those specialties recognized may be granted solely at the discretion of the Idaho State Board of Dentistry. An examination covering the applicant's chosen field may be required and, if so, will be given by the Idaho State Board of Dentistry or its agent. Candidates who are certified by the American Board of that particular specialty as of the date of application for speciality licensure, and who meet the qualifications set forth in the Board's Rules, may be granted specialty licensure by Board approval. (3-20-04)

04. Limitation of Practice. No dentist shall announce or otherwise hold himself out to the public as a specialist unless he has first complied with the requirements established by the Idaho State Board of Dentistry for such specialty and has been issued a specialty license authorizing him to do so. Any individual granted a specialty license must limit his practice to the specialty(s) in which he is licensed. (3-20-04)

046. ADVERTISING (RULE 46).

Dentists and dental hygienists licensed to practice in Idaho may advertise in any medium or by other form of public communication so long as any such advertising is not false, deceptive, misleading or not readily subject to verification. In addition to any other applicable grounds, a violation of this advertising rule shall constitute and be considered as unethical and unprofessional conduct pursuant to the Idaho Dental Practice Act and this chapter. (3-20-04)

01. General Advertising Provisions. (3-20-04)

a. "Advertisement" shall mean any public communication, made in any form or

manner whatsoever, about a licensee's professional services or qualifications for the purpose of soliciting business. "Advertising" or "advertise" shall mean holding out, broadcasting, mailing, publishing, transmitting, announcing, distributing or otherwise disseminating any advertisement, whether directly or indirectly through the efforts of another person or entity. Any sign soliciting business, whether at the location of the dental practice or otherwise, shall be considered as an advertisement. A licensee who engages or authorizes another person or entity to advertise for or on the licensee's behalf is responsible for the content of the advertisement unless the licensee can prove that the content of the advertisement was contrary to the licensee's specific directions. (3-20-04)

b. If the form or manner of advertising consists of or contains verbal communication to the public by television, radio, or other means, the advertisement shall be prerecorded and approved for broadcast by the licensee and a recording of the actual advertisement shall be retained by the licensee for a period of two (2) years. Upon receipt of a written request from the Board, a licensee shall provide any such recorded advertisement to the Board within five (5) working days. (3-20-04)

c. Any advertisement made under or by means of a fictitious or assumed business name or in the name of a professional service corporation shall be the responsibility of all licensees who are owners of the business or corporation. (3-20-04)

02. Prohibited Advertising. A licensee shall not advertise in any form or manner which is false, misleading or deceptive to the public or which is not readily susceptible to verification. False, misleading or deceptive advertising or advertising that is not readily susceptible to verification includes, but is not limited to, advertising that: (3-20-04)

a. Makes a material misrepresentation of fact or omits a material fact; (3-20-04)

b. Makes a representation likely to create an unjustified expectation about the results of a dental procedure; (3-20-04)

c. Compares a licensee's services with another licensee's services unless the comparison can be factually substantiated; (3-20-04)

d. Makes a representation that is misleading as to the credentials, education, or the licensing status of a licensee; (3-20-04)

e. Represents that the benefits of a dental insurance plan will be accepted as full payment when deductibles or copayments are required; (3-20-04)

f. Makes a representation that is intended to take advantage of the fears or emotions of a particularly susceptible type of patient; and (3-20-04)

g. Refers to benefits of dental procedures or products that involve significant risks without including realistic assessments of the safety and efficacy of those procedures or products. (3-20-04)

03. Specialty Advertising. The Board recognizes and licenses the following specialty

areas of dental practice: Dental Public Health; Endodontics; Oral and Maxillofacial Pathology; Oral and Maxillofacial Radiology; Oral and Maxillofacial Surgery; Orthodontics; Pediatric Dentistry; Periodontics; and Prosthodontics. The specialty advertising rules are intended to allow the public to be informed about recognized dental specialities and specialization competencies of licensees and to require appropriate disclosures to avoid misperceptions on the part of the public. ~~(3-20-04)~~(____)

a. An advertisement shall not state that a licensee is a specialist, or specializes in a recognized specialty area of dental practice, or limits his practice to any recognized specialty area of dental practice unless the licensee has been issued a license or certification in that specialty area of dental practice by the Board. Use of words or terms in advertisements such as "Endodontist," "Pedodontist," "Pediatric Dentist," "Periodontist," "Prosthodontist," "Orthodontist," "Oral and Maxillofacial Pathologist," "Oral Pathologist," "Oral and Maxillofacial Radiologist," "Oral Radiologist," "Oral and Maxillofacial Surgeon," "Oral Surgeon," "Specialist," "Board Certified," "Diplomate," "Practice Limited To," and "Limited To Specialty Of" shall be prima facie evidence that the licensee is announcing or holding himself out to the public as a specialist or that the licensee specializes in a recognized area of dental practice. ~~(3-20-04)~~(____)

b. A licensee who has not been licensed or certified by the Board in a recognized specialty area of dental practice may advertise as being qualified in a recognized specialty area of dental practice so long as each such advertisement, regardless of form, contains a prominent disclaimer that the licensee is "licensed as a general dentist" or that the specialty services "will be provided by a general dentist". Any disclaimer in a written advertisement shall be in the same font style and size as that in the listing of the specialty area. (3-20-04)

c. A licensee shall not advertise as being a specialist in or as specializing in any area of dental practice which is not a Board recognized and licensed specialty area unless the advertisement, regardless of form, contains a prominent disclaimer that the advertised area of dental practice is not recognized as a specialty area of dental practice by the Idaho Board of Dentistry. Any disclaimer in a written advertisement shall be in the same font style and size as that in the listing of the specialty area. (3-20-04)

IDAPA 22 - BOARD OF MEDICINE

22.01.04 - RULES BOARD OF MEDICINE FOR REGISTRATION OF SUPERVISING AND DIRECTING PHYSICIANS

DOCKET NO. 22-0104-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1806(2), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for any change.

The proposed rule was created to comply with the legislative intent of HB 659. The Idaho State Board of Medicine is adopting rule changes to reflect the elimination of the supervision requirement for advanced practice nurses.

There has been no change in the text of the proposed rule.The pending rule is being adopted as proposed with no changes. The original text of the proposed rule was published in the August 4, 2004 Idaho Administrative Bulletin, Volume 04-8, pages 172 through 176.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact, contact Nancy M. Kerr, Idaho State Board of Medicine (208) 327-7000.

DATED this 4th day of November, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: These temporary rules are effective July 1, 2004.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 54-1806 (2) Idaho Code.

BOARD OF MEDICINE ***Docket No. 22-0104-0401***
Registration of Supervising & Directing Physicians ***PENDING RULE***

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

To comply with the legislative intent of HB 659 the Idaho State Board of Medicine is adopting rule changes to reflect the elimination of supervision requirement for advanced practice nurses.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

To comply with deadlines in amendments to governing law.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: Not Applicable.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rule making was not conducted because changes were required due to a change in statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Nancy M. Kerr, Idaho State Board of Medicine (208) 327-7000.

Anyone may submit written comments regarding this the proposed rule making. All written comments must be directed to the undersigned and must be delivered on or before August 25, 2004.

DATED this 6th day of July, 2004.

Nancy M. Kerr
Executive Director
Idaho State Board of Medicine
1755 Westgate Drive
PO Box 83720
Boise, Idaho 83720-0058
(208) 327-7000
Fax (208) 327-7005

BOARD OF MEDICINE ***Docket No. 22-0104-0401***
Registration of Supervising & Directing Physicians ***PENDING RULE***

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
Pursuant to Sections 54-1807(1)(2), 54-1814(17), 54-3902(7), and 54-3903, Idaho Code, the Idaho State Board of Medicine is authorized to promulgate rules to govern the activities of physicians and osteopathic physicians licensed in Idaho, who supervise the practice of physician assistants, graduate physician assistants, ~~*nurse practitioners, certified nurse-midwives, clinical nurse specialists,*~~ interns, externs, residents, and athletic trainers. ~~*(3-16-04)*~~(7-1-04)T

001. TITLE AND SCOPE.

01. Title. The rules shall be cited as IDAPA 22.01.04, "Rules of the Board of Medicine for Registration of Supervising and Directing Physicians". (3-16-04)

02. Scope. These rules govern the activities of physicians and osteopathic physicians licensed in Idaho, who supervise the practice of physician assistants, graduate physician assistants, ~~*nurse practitioners, certified nurse-midwives, clinical nurse specialists,*~~ interns, externs, residents, and athletic trainers. ~~*(3-16-04)*~~(7-1-04)T

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

~~***01. Advanced Practice Professional Nurse****. Any person duly licensed as a nurse practitioner, certified nurse-midwife, or clinical nurse specialist pursuant to the applicable Idaho statutes and the applicable rules promulgated by the Idaho State Board of Nursing.*~~ ~~*(3-19-99)*~~

0~~2~~1. Alternate Directing Physician. A designated Idaho licensed physician, registered with the Board pursuant to this chapter and Title 54, Chapter 39, Idaho Code, who oversees the practice of athletic training and is responsible for the athletic training services provided by the athletic trainer in the temporary absence of the directing physician. (3-16-04)

0~~3~~2. Alternate Supervising Physician. An Idaho licensed physician who is registered with the Board pursuant to this chapter and who has full responsibility for the medical acts and practice of a physician assistant~~,~~ or graduate physician assistant~~*, nurse practitioner, certified nurse-midwife, or clinical nurse specialist*~~ in the temporary absence of the supervising physician. An alternate supervising physician shall not supervise more than three (3) such licensees contemporaneously. The Board, however, may authorize an alternate supervising physician to supervise a total of six (6) such licensees contemporaneously if necessary to provide adequate medical care and upon prior petition documenting adequate safeguards to protect the public health and safety. ~~*(3-16-04)*~~(7-1-04)T

0~~4~~3. Alternate Supervising Physician for Externs, Interns, and Residents. A physician licensed to practice medicine and surgery or licensed to practice osteopathic medicine and surgery in Idaho who has been designated by the supervising physician and approved by and registered by the Board to supervise the extern, intern, or resident in the temporary absence of the

supervising physician. (3-16-04)

0~~5~~4. Athletic Trainer. A person who has met the qualifications for licensure as set forth in Title 54, Chapter 39, Idaho Code, is licensed under that chapter, and carries out the practice of athletic training under the direction of a designated Idaho licensed physician, registered with the Board. (3-16-04)

0~~6~~5. Board. The Idaho State Board of Medicine established pursuant to Section 54-1805, Idaho Code. (3-16-04)

0~~7~~6. Directing Physician. A designated Idaho licensed physician, registered with the Board pursuant to this chapter and Title 54, Chapter 39, Idaho Code, who oversees the practice of athletic training and is responsible for the athletic training services provided by the athletic trainer. This chapter does not authorize the practice of medicine or any of its branches by a person not so licensed by the Board. (3-16-04)

0~~8~~7. Extern. Any bona fide student enrolled in an acceptable school of medicine as defined in IDAPA 22.01.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho," Subsection 010.03, who has not received his degree. (3-16-04)

0~~9~~8. Graduate Physician Assistant. A person who is a graduate of an approved program for the education and training of physician assistants and who meets all the requirements in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," for Idaho licensure but has not yet taken and passed the certification examination, and who has been authorized by the Board, as defined in IDAPA 22.01.03, Subsection 036.01, to render patient services under the direction of a supervising physician for a period of six (6) months or has passed the certification examination but who has not yet obtained a college baccalaureate degree, and who has been authorized by the Board, as defined in IDAPA 22.01.03, Subsection 036.02, to render patient services under the direction of a supervising physician for a period of not more than five (5) years. (3-16-04)

~~1~~09. Intern. Any person who has completed a course of study at an acceptable school of medicine as defined in IDAPA 22.01.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho," Subsection 010.03, and who is enrolled in a postgraduate medical training program. (3-16-04)

1~~1~~0. Physician. A physician who holds a current active license issued by the Board to practice medicine and surgery or osteopathic medicine and surgery in Idaho and is in good standing with no restrictions upon or actions taken against his license. (3-16-04)

1~~2~~1. Physician Assistant. Any person duly licensed with the Board as a physician assistant to render patient services under the direction of a supervising physician registered with the Board, pursuant to the applicable Idaho statutes and the applicable rules promulgated by the Board. (3-16-04)

1~~3~~2. Resident. Any person who has completed a course of study at an acceptable school of medicine as defined in IDAPA 22.01.01, "Rules of the Board of Medicine for the

Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho," Subsection 010.03, and who is enrolled in a postgraduate medical training program. (3-16-04)

1~~4~~3. Supervising Physician. Any physician who is registered with the Board pursuant to this chapter and who supervises and has responsibility for the medical acts of and patient services provided by a physician assistant~~,~~ or graduate physician assistant~~, *nurse practitioner, certified nurse-midwife, or clinical nurse specialist*~~. A supervising physician shall not supervise more than a total of three (3) such licensees contemporaneously. The Board, however, may authorize a supervising physician to supervise a total of six (6) such licensees contemporaneously if necessary to provide adequate medical care and upon prior petition documenting adequate safeguards to protect the public health and safety. ~~*(3-16-04)*~~(7-1-04)T

1~~5~~4. Supervising Physician of Interns, Externs, or Residents. Any person approved by and registered with the Board who is licensed to practice medicine and surgery or osteopathic medicine and surgery in Idaho, who signs the application for registration of a extern, intern or resident, and who is responsible for the direction and supervision of their activities. (3-16-04)

(BREAK IN CONTINUITY OF SECTIONS)

020. DUTIES OF SUPERVISING PHYSICIANS.

01. Responsibilities. The supervising physician accepts full responsibility for the medical acts of and patient services provided by physician assistants~~,~~ and graduate physician assistants~~, *nurse practitioners, certified nurse-midwives, and clinical nurse specialists*~~ and for the supervision of such acts which shall include, but are not limited to: ~~*(3-16-04)*~~(7-1-04)T

a. An on-site visit at least monthly to personally observe the quality of care provided; (3-16-04)

b. A periodic review of a representative sample of medical records to evaluate the medical services that are provided. When applicable, this review shall also include an evaluation of adherence to the delegation of services agreement between the physician and physician assistant or graduate physician assistant; and (3-16-04)

c. Regularly scheduled conferences between the supervising physician and such licensees. (3-16-04)

02. Patient Complaints. The supervising physician shall report to the Board of Medicine all patient complaints received against the physician assistant or graduate physician assistant which relate to the quality and nature of medical care or patient services rendered. ~~*The supervising physician shall report to the Board of Nursing all patient complaints received against the nurse practitioner, certified nurse-midwife, or clinical nurse specialist, that relate to the quality and nature of medical care rendered.*~~ ~~*(3-16-04)*~~(7-1-04)T

03. Pre-Signed Prescriptions. The supervising physician shall not utilize or authorize the physician assistant~~, *nurse practitioner, certified nurse-midwife, or clinical nurse specialist*~~ to use any pre-signed prescriptions. ~~*(3-16-04)*~~(7-1-04)T

04. Supervisory Responsibility. A supervising physician or alternate supervising physician shall not supervise more than three (3) physician assistants~~,~~ or graduate physician assistants~~, *nurse practitioners, certified nurse-midwives, or clinical nurse specialists*~~ contemporaneously. The Board, however, may authorize a supervising physician or alternate supervising physician to supervise a total of six (6) such licensees contemporaneously if necessary to provide adequate medical care and upon prior petition documenting adequate safeguards to protect the public health and safety. The responsibilities and duties of a supervising physician may not be transferred to a business entity, professional corporation or partnership, nor may they be assigned to another physician without prior notification and Board approval. ~~*(3-16-04)*~~(7-1-04)T

05. Available Supervision. The supervising physician shall oversee the activities of the ~~*nurse practitioner,*~~ physician assistant~~,~~ or graduate physician assistant, ~~*certified nurse-midwife, or clinical nurse specialist,*~~ and must always be available either in person or by telephone to supervise, direct and counsel such licensees. The scope and nature of the supervision of the physician assistant and graduate physician assistant shall be outlined in a delegation of services agreement**,** as set forth in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," Subsection 030.03. ~~*(3-16-04)*~~(7-1-04)T

06. Disclosure. It shall be the responsibility of each supervising physician to ensure that each patient who receives the services of a physician assistant~~,~~ or graduate physician assistant~~, *nurse practitioner, certified nurse-midwife, or clinical nurse specialist*~~ is aware of the fact that said person is not a licensed physician. This disclosure requirement can be fulfilled by the use of nametags, correspondence, oral statements, office signs or such other procedures that under the involved circumstances adequately advise the patient of the education and training of the person rendering medical services. ~~*(3-16-04)*~~(7-1-04)T

021. ON-SITE REVIEW.
The Board, by and through its designated agents, is authorized to conduct on-site reviews of the activities of the supervising physicians at the locations and facilities in which the physician assistant~~,~~ or graduate physician assistant~~, *nurse practitioner, certified nurse-midwife, or clinical nurse specialist*~~ practices at such times as the Board deems necessary. ~~*(3-16-04)*~~(7-1-04)T

(BREAK IN CONTINUITY OF SECTIONS)

030. REGISTRATION BY SUPERVISING AND DIRECTING PHYSICIANS.

01. Registration and Renewal. Each supervising, directing and alternate physician must register with the Board and such registration shall be renewed annually. (3-16-04)

02. Notification. The supervising and directing physician must notify the Board of any change in the status of any physician assistant, graduate physician assistant, ~~*nurse practitioner, certified nurse-midwife, clinical nurse specialist,*~~ or athletic trainer for whom he is responsible, including, but not limited to, changes in location, duties, responsibilities, or supervision, or termination of employment. ~~*(3-16-04)*~~(7-1-04)T

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 1, 2004 Idaho Administrative Bulletin, Volume 04-9, pages 175 through 187.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandy Evans, MAEd., R.N., Executive Director, at (208) 334-3110.

DATED this 23rd day of September, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2004.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-1404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 15, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation

must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In addition to a few housekeeping matters, the proposed rulemaking is necessary to implement recent legislation requiring criminal background checks, eliminating APPN supervision, clarifying examination requirements for multistate licensure, and requiring peer review as a condition of renewal or reinstatement of APPN licensure.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

This rulemaking is necessary to implement amendments made by the legislature to governing law.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rules implement statutory requirements language or are relatively simple (updating citations).

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Sandy Evans, MAEd., R.N., Executive Director, at (208) 334-3110.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2004.

DATED this 5th day of August, 2004.

Sandy Evans, MAEd., R.N.
Executive Director
Idaho State Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720
Boise, ID 83720-0061
Phone: (208) 334-3110
Fax: (208) 334-3262

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS.

01. Accreditation. The official authorization or status granted by a recognized accrediting entity or agency other than a state board of nursing. (7-1-93)

02. Administration of Medications. The process whereby a prescribed medication is given to a patient by one (1) of several routes. Administration of medication is a complex nursing responsibility which requires a knowledge of anatomy, physiology, pathophysiology and pharmacology. Licensed nurses may administer medications and treatments as prescribed by health care providers authorized to prescribe medications. (5-3-03)

03. Approval. The process by which the Board evaluates and grants official recognition to education programs that meet standards established by the Board. (5-3-03)

04. Assist. To aid or help in the accomplishment of a prescribed set of actions. (7-1-93)

05. Assistance With Medications. The process whereby a non-licensed care provider is delegated tasks by a licensed nurse to aid a patient who cannot independently self-administer medications: (5-3-03)

06. Board. The Idaho Board of Nursing. (7-1-93)

07. Board Staff. The Executive Director and other such personnel as are needed to implement the Nursing Practice Act and these Rules. (7-1-93)

08. Charge Nurse. A licensed nurse who bears primary responsibility for assessing, planning, prioritizing and evaluating care for the patients on a unit, as well as the overall supervision of the licensed and unlicensed staff delivering the nursing care. (5-3-03)

09. Clinical Preceptor. A licensed professional nurse who acts to facilitate student training in a manner prescribed by a written agreement between the preceptor's employer and an educational institution. (5-3-03)

10. Competence. Safely performing those functions within the role of the licensee in a manner that demonstrates essential knowledge, judgment and skills. (5-3-03)

11. Curriculum. The systematic arrangement of learning experiences including didactic courses, practical experiences, and other activities needed to meet the requirements of the nursing program and of the certificate or degree conferred by the parent institution. (5-3-03)

12. Delegation. The process by which a licensed nurse assigns tasks to be performed by others. (5-3-03)

13. Disability. Any physical, mental, or emotional condition that interferes with the nurse's ability to practice nursing safely and competently. (5-3-03)

14. Emeritus License. A license issued to a nurse who desires to retire from active

practice for any length of time. (5-3-03)

15. Licensing Examination. A licensing examination that is acceptable to the board. (5-3-03)

16. License in Good Standing. A license not subject to current disciplinary action, restriction, probation or investigation in any jurisdiction. (5-3-03)

17. Limited License. A nursing license subject to specific restrictions, terms, and conditions. (5-3-03)

18. Nursing Assessment. The systematic collection of data related to the patient's health care needs. (5-3-03)

19. Nursing Diagnosis. The clinical judgment or conclusion regarding patient/client/ family/ community response to actual or potential health problems made as a result of the nursing assessment. (7-1-93)

20. Nursing Intervention. An action deliberately selected and performed to support the plan of care. (5-3-03)

21. Nursing Service Administrator. A licensed professional nurse who has administrative responsibility for the nursing services provided in a health care setting. (7-1-93)

22. Organized Program of Study. A written plan of instruction to include course objectives and content, teaching strategies, provisions for supervised clinical practice, evaluation methods, length and hours of course, and faculty qualifications. (7-1-93)

23. Patient. An individual or a group of individuals who are the beneficiaries of nursing services in any setting and may include client, resident, family, community. (5-3-03)

24. Patient Education. The act of teaching patients and their families, for the purpose of improving or maintaining an individual's health status. (5-3-03)

25. Plan of Care. The goal-oriented strategy developed to assist individuals or groups to achieve optimal health potential. (5-3-03)

26. Practice Standards. General guidelines that identify roles and responsibilities for a particular category of licensure and, used in conjunction with the decision-making model, define a nurse's relationship with other care providers. (5-3-03)

27. Probation. A period of time set forth in an order in which certain restrictions, conditions or limitations are imposed on a licensee. (5-3-03)

28. Protocols. Written standards that define or specify performance expectations, objectives, and criteria. (5-3-03)

29. Revocation. Termination of the authorization to practice. (5-3-03)

30. Scope of Practice. The extent of treatment, activity, influence, or range of actions permitted or authorized for licensed nurses based on the nurse's education, preparation, and experience. (5-3-03)

31. Supervision. ~~*Except as provided in Subsection 271.17, concerning advanced practice professional nursing, d*~~Designating or prescribing a course of action, or giving procedural guidance, direction, and periodic evaluation. Direct supervision requires the supervisor to be physically present and immediately accessible to designate or prescribe a course of action or to give procedural guidance, direction, and periodic evaluation. ~~*(5-3-03)*~~(7-1-04)T

32. Suspension. An order temporarily withdrawing a nurse's right to practice nursing. (5-3-03)

33. Universal Standards. The recommendations published by the Center for Disease Control, Atlanta, Georgia, for preventing transmission of infectious disease, also referred to as "Standard Precautions". (5-3-03)

34. Wrongful Abandonment. The termination of a nurse/patient relationship without first making appropriate arrangements for continuation of required nursing care by others. The nurse/patient relationship begins when responsibility for nursing care of a patient is accepted by the nurse. Refusal to accept an employment assignment or refusal to accept or begin a nurse/patient relationship is not wrongful abandonment. Reasonable notification, or a timely request for alternative care for a patient, directed to an attending physician or to a staff supervisor, prior to leaving the assignment, is sufficient to permit termination of the nurse/patient relationship. (5-3-03)

(BREAK IN CONTINUITY OF SECTIONS)

077. MULTISTATE LICENSURE.

01. Definitions. In Section 077, the following terms have the meanings indicated. (3-15-02)

a. Board means the regulatory body responsible for issuing nurse licenses. (3-15-02)

b. Compact means the Nurse Multistate Licensing Compact. (3-15-02)

c. Coordinated Licensure Information System (CLIS) means an integrated process for collecting, storing, and sharing information on nurse licensing and enforcement activities related to nurse licensing laws, which is administered by a nonprofit organization composed of and controlled by state nurse licensing boards. (3-15-02)

d. Home state means the party state that is the nurse's primary state of residence. (3-15-02)

e. Party state means a state that is a signatory on the compact. (3-15-02)

f. Primary state of residence means the state of an individual's declared, fixed, and permanent residence. (3-15-02)

g. Public means an individual or entity other than designated staff or representatives of party state boards or the National Council of State Boards of Nursing, Inc. (3-15-02)

02. **Examination**. No applicant may be issued a compact license granting a multistate privilege to practice unless the applicant first obtains a passing score on the applicable NCLEX (National Council Licensure Examination) examination: (7-1-04)T

a. NCLEX-RN for professional nursing; or (7-1-04)T

b. NCLEX-PN for practical nursing. (7-1-04)T

0~~2~~3. Issuance of License in Compact Party State. (3-15-02)

a. A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. This evidence shall include a declaration signed by the licensee. Further evidence that may be requested includes, but is not limited to: (3-15-02)

i. Driver's license with a home address; (3-15-02)

ii. Voter registration card displaying a home address; or (3-15-02)

iii. Federal income tax return declaring the primary state of residence. (3-15-02)

b. A nurse changing primary state of residence, from one (1) party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed thirty (30) days. (3-15-02)

c. The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance, and the thirty (30) day period in Subsection 077.02.b. shall be stayed until resolution of the pending investigation. (3-15-02)

d. The former home state license is not valid upon the issuance of a new home state license. (3-15-02)

e. If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten (10) business days, and the former home state will take action in accordance with that state's laws and regulations. (3-15-02)

0~~3~~4. Multistate Licensure Privilege Limitations. (3-15-02)

a. Home state boards shall include, in all disciplinary orders or agreements that limit

practice or require monitoring, the requirement that the licensee subject to the order or agreement shall limit the licensee's practice to the home state during pendancy of the disciplinary order or agreement. (3-15-02)

b. The requirement referred to in Subsection 077.03.a. may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and other party state boards. (3-15-02)

04~~5~~. **Information System**. (3-15-02)

a. Levels of Access. (3-15-02)

i. Public access to nurse licensure information shall be limited to: (3-15-02)

(1) The licensee's name; (3-15-02)

(2) Jurisdictions of licensure; (3-15-02)

(3) Licensure expiration date; (3-15-02)

(4) Licensure classification and status; (3-15-02)

(5) Public emergency, summary, and final disciplinary actions, as defined by contributing state authority; and (3-15-02)

(6) The status of multistate licensure privileges. (3-15-02)

ii. Non-party state boards shall have access to all CLIS data except current significant investigative information and other information as limited by contributing party state authority. (3-15-02)

iii. Party state boards shall have access to all CLIS data contributed by the party states and other information as allowed by contributing non-party state authority. (3-15-02)

b. Right to Review. (3-15-02)

i. The licensee may request, in writing, to the home state board to review data relating to the licensee in the CLIS. (3-15-02)

ii. If a licensee asserts that any data relating to the licensee is inaccurate, the burden of proof is on the licensee to provide evidence substantiating that claim. (3-15-02)

iii. Within ten (10) business days, the Board shall correct information that it finds to be inaccurate in the CLIS. (3-15-02)

c. Changes in Disciplinary Data. (3-15-02)

i. Within ten (10) business days, the Board shall report to CLIS: (3-15-02)

(1) Disciplinary action, agreement or order requiring participation in alternative programs or which limit practice or require monitoring unless the agreement or order relating to participation in alternative programs is required to remain nonpublic by the contributing state authority; (3-15-02)

(2) Dismissal of the complaint; and (3-15-02)

(3) Changes in status of disciplinary action, or licensure encumbrance. (3-15-02)

ii. The Board shall delete current significant investigative information from the CLIS within ten (10) business days after: (3-15-02)

(1) A disciplinary action; (3-15-02)

(2) An agreement or order requiring participation in alternative programs; (3-15-02)

(3) An agreement or agreements, which limit practice or require monitoring; or (3-15-02)

(4) Dismissal of a complaint. (3-15-02)

iii. The CLIS administrator shall make changes to licensure information in the CLIS within ten (10) business days upon notification by a board. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

120. REINSTATEMENT.

01. Application. Applicants for reinstatement of revoked licenses must apply on forms provided by the Board and must pay any required fees. (3-15-02)

02. Appearance Before Board. Applicants for reinstatement may be required to appear before the Board. (3-15-02)

03. Evaluation of Applications. In considering applications for reinstatement, the Board will evaluate: (3-15-02)

a. The nature and severity of the act which resulted in revocation of the license; and (7-1-91)

b. The conduct of the applicant subsequent to the revocation of license; and (6-1-78)

c. The lapse of time since revocation; and (6-1-78)

d. The degree of compliance with all terms and conditions the Board may have set forth as a prerequisite for reinstatement; and (3-15-02)

e. Any intervening circumstances that may have altered the need for compliance; and (3-15-02)

f. The degree of rehabilitation attained by the applicant as evidenced by statements sent directly to the Board from qualified people who have professional knowledge of the applicant; and (11-28-84)

g. The applicant's adherence to or violation of any applicable law or rule regulating the practice of nursing~~.~~; and ~~(3-15-02)~~(7-1-04)T

h. The applicant's criminal background information as evidenced by a current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code.(7-1-04)T

04. Board Action Possible. After evaluation, the Board may deny a reinstatement, grant a reinstatement, or issue a license permitting the applicant to practice nursing under specified terms and conditions. (3-15-02)

05. Assessment of Costs. As a condition of withdrawing, reversing, modifying or amending a suspension or revocation order, the applicant may be required to pay all or any part of the costs incurred by the Board in the proceedings in which the order was entered. (3-15-02)

06. Application for Reinstatement After Revocation. Unless otherwise provided in the order of revocation, applicants for reinstatement of revoked licenses may not apply for reinstatement for a period of two (2) years after entry of the order. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

221. EXAMINATION APPLICATION.
A completed application for licensure by examination shall consist of: (3-15-02)

01. Application. Completed, notarized application form provided by the Board; and (3-15-02)

02. Affidavit. Notarized affidavit of graduation signed by the nursing education administrator, or designee; and (3-15-02)

03. Fees. Payment of all required fees. (3-15-02)

04. Criminal Background Check. A current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (7-1-04)T

(BREAK IN CONTINUITY OF SECTIONS)

242. APPLICATION FOR LICENSURE BY ENDORSEMENT.
A completed application for licensure by interstate endorsement must include all of the following: (7-1-93)

01. Application Form. Completed, notarized application form provided by the Board; and (6-1-78)

02. Verification. Verification and documentation of licensure status from state of applicant's original licensure; and (3-15-02)

03. Employment Reference. One (1) satisfactory nursing employment reference from the three (3) year period immediately preceding the application; and (3-15-02)

04. Census Questionnaire. Completed Census Questionnaire; and (6-1-78)

05. Fee. Payment of all required fees. (3-15-02)

06. Criminal Background Check. A current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (7-1-04)T

243. -- 259. (RESERVED).

260. QUALIFICATIONS FOR LICENSURE OF GRADUATES OF SCHOOLS OF NURSING LOCATED OUTSIDE THE UNITED STATES OR ITS TERRITORIES.
A graduate from a nursing education program outside of the United States or its territories must: (3-30-01)

01. Examination. Pass examination(s), approved by the Board, which demonstrate nursing knowledge and written and spoken English proficiency. ~~*(3-30-01)*~~(7-1-04)T

02. Education Credentials. Have education qualifications that are substantially equivalent to Idaho's minimum requirements at the time of application. (3-30-01)

03. License. Hold a license in good standing from a country outside the United States or its territories. (3-30-01)

04. Examination. Take licensing examination required in Subsection 263.01 and achieve the score determined as passing for that examination by the Board. (3-30-01)

05. Applicants Licensed in Another State or Territory. Graduates of schools of nursing located outside the United States or its territories who are licensed in a state or territory who meet the requirements of Section 240 may be processed as applicants for licensure by endorsement from another state. (3-30-01)

261. APPLICATION FOR LICENSURE OF GRADUATES OF SCHOOLS OF NURSING LOCATED OUTSIDE THE UNITED STATES OR ITS TERRITORIES.
A completed application for licensure by a graduate of a nursing education program outside of the United States or its territories must include the following: (3-30-01)

01. Verification. Verification of demonstrated nursing knowledge and written and spoken English proficiency; and ~~*(3-30-01)*~~(7-1-04)T

02. Application Form. Completed notarized application form provided by the Board; and (6-1-78)

03. Official Transcript. Official transcript from the applicant's nursing education program, and certified translation if original transcript is not in English or completed equivalence credentials form issued by an organization acceptable to the Board; and (3-30-01)

04. Verification of Licensure. Verification of licensure from state, province, or country of applicant's original licensure; and (6-1-78)

05. Employment Reference. One (1) satisfactory nursing employment reference from the three (3) year period immediately preceding the application; and (3-30-01)

06. Fee. Payment of the fee for licensure by examination. (3-30-01)

07. Criminal Background Check. A current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (7-1-04)T

(BREAK IN CONTINUITY OF SECTIONS)

271. DEFINITIONS RELATED TO ADVANCED PRACTICE PROFESSIONAL NURSING.

01. Accountability. Means being answerable for one's own actions. (7-1-99)

02. Advanced Practice Professional Nurse. Means a professional nurse licensed in this state who has gained additional specialized knowledge, skills and experience through a post-basic program of study as defined herein and is authorized to perform advanced nursing practice, which may include acts of diagnosis and treatment, and the prescribing, administering and dispensing of therapeutic pharmacologic and non-pharmacologic agents, as defined herein. Advanced practice professional nurses shall include certified nurse-midwives, clinical nurse specialists, nurse practitioners, and registered nurse anesthetists. Advanced practice professional nurses, when functioning within the recognized scope of practice, assume primary responsibility for the care of their patients. This practice incorporates the use of professional judgment in the assessment and management of wellness and conditions appropriate to the advanced practice professional nurse's area of specialization. (7-1-99)

03. Authorized Advanced Practice Professional Nurse. Means an advanced practice professional nurse authorized by the board to prescribe and dispense pharmacologic and non-pharmacologic agents pursuant to Section 315. (7-1-99)

04. Certification. Means recognition of the applicant's advanced knowledge, skills and abilities in a defined area of nursing practice by a national organization recognized by the board. The certification process measures the theoretical and clinical content denoted in the advanced scope of practice, and is developed in accordance with generally accepted standards of validation and reliability. (7-1-99)

05. Certified Nurse-Midwife. Means a licensed professional nurse who has graduated from a nationally accredited nurse-midwifery program, passed a qualifying examination recognized by the board and has current initial certification or current recertification as a nurse-midwife from a national organization recognized by the board. (7-1-99)

06. Clinical Nurse Specialist. Means a licensed professional nurse who has graduated from a nationally accredited graduate program in nursing with a clinical focus, passed a qualifying examination recognized by the board and has current initial certification or current recertification as a clinical nurse specialist from a national organization recognized by the board. (7-1-99)

07. Collaboration. Means the cooperative working relationship with another health care provider, each contributing his respective expertise in the provision of patient care, and such collaborative practice includes the discussion of patient treatment and cooperation in the management and delivery of health care. (7-1-99)

08. Consultation. Means conferring with another health care provider for the purpose of obtaining information or advice. (7-1-99)

09. Diagnosis. Means identification of actual or potential health problems and the need for intervention based on analysis of data collected. Diagnosis depends upon the synthesis of information obtained during the interview, physical exam, or diagnostic tests. (7-1-99)

10. Intervention. Means measures to promote health, protect against disease, treat illness in its earliest stages, manage acute and chronic illness, and treat disability. Interventions may include, but are not limited to ordering diagnostic studies, performing direct nursing care, prescribing pharmacologic or non-pharmacologic or other therapies and consultation with or referral to other health care providers. (7-1-99)

11. Nurse Practitioner. Means a licensed professional nurse who has graduated from a nationally accredited nurse practitioner program, passed a qualifying examination recognized by the board, and has current initial certification or current recertification as a nurse practitioner from a national organization recognized by the board. (7-1-99)

12. Prescriptive and Dispensing Authorization. Means the legal permission to prescribe, deliver, distribute and dispense pharmacologic and non-pharmacologic agents to a client in compliance with board rules and applicable federal and state laws. Pharmacologic agents include legend and Schedule II through V controlled substances. (7-1-99)

13. Referral. Means directing a client to a physician or other health professional or resource. (7-1-99)

14. Registered Nurse Anesthetist. Means a licensed professional nurse who has graduated from a nationally accredited nurse anesthesia program, passed a qualifying examination recognized by the board and has current initial certification or current recertification as a nurse anesthetist from a national organization recognized by the board. (7-1-99)

15. Scope of Practice of Advanced Practice Professional Nurse. Means those activities that the advanced practice professional nurse may perform. Those activities shall be defined by the board according to the advanced practice professional nurse's education, preparation, experience and the parameters set forth by the advanced practice professional nurse's recognized, national certifying organization. (7-1-99)

16. Specialization. Means focusing the advanced practice professional nurse's clinical area of practice, including but not limited to, family health, mental health, child health, gerontological health, adult health or other. (7-1-99)

~~***17. Supervision**. Means designation of a course of action or provision of guidance and direction by a physician licensed pursuant to Chapter 18, Title 54, Idaho Code. (7-1-99)*~~

272. -- 279. (RESERVED).

280. STANDARDS OF PRACTICE FOR ADVANCED PRACTICE PROFESSIONAL NURSING.

01. Purpose. (7-1-99)

a. To establish standards essential for safe practice by the advanced practice professional nurse; and (7-1-99)

b. To serve as a guide for evaluation of advanced practice professional nursing to determine if it is safe and effective. (7-1-99)

02. Core Standards for All Categories of Advanced Practice Professional Nursing. The advanced practice professional nurse shall practice in a manner consistent with the definition of advanced practice professional nursing and the standards set forth in these rules. The advanced practice professional nurse may provide client services for which the advanced practice professional nurse is educationally prepared and for which competence has been attained and maintained. (7-1-99)

a. The advanced practice professional nurse shall consult and collaborate with other members of the health care team. (7-1-99)

b. The advanced practice professional nurse shall recognize his limits of knowledge and experience and shall consult and collaborate with and refer to other health care professionals as appropriate. (7-1-99)

c. The advanced practice professional nurse shall retain professional accountability for advanced practice professional nursing care according to the advanced practice professional nurse's scope of practice and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Subsections 400.01 and 400.02. (7-1-99)

d. The advanced practice professional nurse shall evaluate and apply current research findings relevant to the advanced nursing practice category. (7-1-99)

e. The advanced practice professional nurse shall assess clients, identify problems or conditions, establish diagnoses, develop and implement treatment plans and evaluate patient outcomes. (7-1-99)

f. The advanced practice professional nurse shall use advanced knowledge and skills in teaching and guiding clients and other health care team members. (7-1-99)

g. The advanced practice professional nurse shall use critical thinking and independent decision-making, commensurate with the autonomy, authority and responsibility of the practice category. (7-1-99)

h. The advanced practice professional nurse shall have knowledge of the statutes and rules governing advanced nursing practice, and function within the established boundaries of the appropriate advanced nursing practice category. (7-1-99)

03. Certified Nurse-Midwife. In addition to the core standards, advanced practice professional nurses in the category of certified nurse-midwife shall practice in accord with standards established by the American College of Nurse Midwives Certifying Council or the American College of Nurse Midwives. Certified nurse-midwives who meet qualifying requirements and are licensed by the board, may manage women's health care focusing on pregnancy, childbirth, the post-partum period, care of the newborn and reproductive and gynecological needs of well women as defined by the certified nurse-midwife's scope of practice. ~~*The certified nurse-midwife shall practice with supervision and provide for appropriate medical consultation, collaborative management and referral.*~~ The scope of practice of an authorized certified nurse-midwife may include prescribing and dispensing pharmacologic and non-pharmacologic agents. ~~*(7-1-99)*~~(7-1-04)T

04. Clinical Nurse Specialist. In addition to the core standards, advanced practice professional nurses in the category of clinical nurse specialist shall practice in accord with standards established by the American Nurses Credentialing Center. Clinical nurse specialists who meet qualifying requirements and are licensed by the board, may practice as expert clinicians in a particular specialty or subspecialty of nursing practice. The clinical nurse specialist provides direct client care, which may include assessing, diagnosing, planning, health promotion and preventive care within this specialized area of practice, as defined by the clinical nurse specialist's scope of practice. ~~*The clinical nurse specialist shall practice with supervision and provide for appropriate medical consultation, collaborative management and referral.*~~ The scope of practice of an authorized clinical nurse specialist may include the prescribing and dispensing of pharmacologic and non-pharmacologic agents. ~~*(7-1-99)*~~(7-1-04)T

05. Nurse Practitioner. In addition to the core standards, advanced practice professional nurses in the category of nurse practitioner shall practice in accord with standards established by the American Nurses Credentialing Center, the American Academy of Nurse Practitioners, the National Association of Pediatric Nurse Associates and Practitioners or the Association of Women's Health Obstetrics and Neonatal Nurses. Nurse practitioners who meet qualifying requirements and are licensed by the board may perform comprehensive health assessments, diagnosis, health promotion and the direct management of acute and chronic illness and disease as defined by the nurse practitioner's scope of practice. ~~*The nurse practitioner shall practice with supervision and provide for appropriate medical consultation, collaborative management and referral.*~~ The scope of practice of an authorized nurse practitioner may include the prescribing and dispensing of pharmacologic and non-pharmacologic agents.
~~*(7-1-99)*~~(7-1-04)T

06. Registered Nurse Anesthetist. In addition to the core standards, advanced practice professional nurses in the category of registered nurse anesthetist shall practice in accord with standards established by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Registered nurse anesthetists who meet qualifying requirements and are licensed by the board, may, in collaboration with a physician, dentist or podiatrist authorized to practice in Idaho, provide anesthesia care services including selecting, ordering and administering medications as defined by national standards approved by the board. The scope of practice for authorized registered nurse anesthetists may include the prescribing and dispensing of pharmacologic agents. (7-1-99)

07. Documentation of Specialization. The advanced practice professional nurse must document competency within his specialty area of practice based upon education, experience and national certification in the specialty. Nurse practitioners authorized to practice prior to July 1, 1998, must document competency within the specialty area of practice based upon education, experience and national certification in that specialty or education, experience and approval by the board. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

290. APPLICATION FOR LICENSURE - ADVANCED PRACTICE PROFESSIONAL NURSE.
The advanced practice professional nurse requesting licensure to practice as a certified nurse-midwife, clinical nurse specialist, nurse practitioner or registered nurse anesthetist must submit an application to the board which includes: (7-1-99)

01. Application Form. Completed, notarized application form provided by the board. (7-1-99)

02. Official Transcript. Official transcript from the advanced practice nursing education program verifying successful completion. (7-1-99)

03. National Certification. Verification of current national certification from the

board-recognized certifying agent; and (7-1-99)

04. Enrollment in Continuing Competency Assessment Program. In addition to verification of national certification, a certified nurse-midwife must submit proof of enrollment in the continuing competency assessment program of the American College of Nurse-Midwives which bears a current expiration date. At the end of five (5) years, the certified nurse-midwife must submit evidence of completion of the continuing competency requirement of the program. (7-1-99)

05. Fee. A non-refundable fee of ninety dollars ($90). (7-1-99)

06. Criminal Background Check. A current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (7-1-04)T

(BREAK IN CONTINUITY OF SECTIONS)

300. RENEWAL AND REINSTATEMENT OF ADVANCED PRACTICE PROFESSIONAL NURSE LICENSE.
The advanced practice professional nurse license may be renewed every two (2) years as prescribed in the Section 54-1411, Idaho Code, provided that the advanced practice professional nurse: (7-1-99)

01. Current Professional License. Maintains a current professional nurse license, or privilege, to practice in Idaho. (3-15-02)

02. Evidence of Certification. Submits evidence of current certification by a national organization recognized by the Board; and (7-1-99)

03. Evidence of Continuing Education. Provides documentation of thirty (30) contact hours of continuing education during the renewal period. Continuing education completed may be that required for renewal of national certification if documentation is submitted confirming the certifying organization's requirement is for at least thirty (30) contact hours. These contact hours may include the requirements identified in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Subsection 315.02.b. in a two (2) year period. (7-1-99)

04. Hours of Practice. Attests, on forms provided by the board, to a minimum of two hundred (200) hours of advanced professional nursing practice within the preceding two (2) year period. (7-1-99)

05. Fee. Remits a non-refundable renewal fee of fifty dollars ($50). (7-1-99)

06. Criminal Background Check. Submits a current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (7-1-04)T

07. Peer Review Process. Provides evidence, satisfactory to the board, of completion

of a peer review process acceptable to the board. Applies to: (7-1-04)T

a. CNM, Certified Nurse Midwife; (7-1-04)T

b. CNS, Clinical Nurse Specialist; and (7-1-04)T

c. NP, Nurse Practitioner. (7-1-04)T

0~~6~~8. **Exemption From Requirements**. Nurse practitioners not certified by a national organization recognized by the board and approved prior to July 1, 1998 shall be exempt from the requirement set forth in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Subsection 300.02. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

680. CURRICULUM, EDUCATIONAL PROGRAM.

01. Student Competence. (4-5-00)

a. Students enrolled in a program for unlicensed assistive personnel shall be provided the opportunity to acquire and demonstrate the knowledge, skills, and abilities for safe and effective practice. (4-5-00)

b. Students enrolled in a practical nursing program shall be provided the opportunity to acquire and demonstrate the knowledge, skills, and abilities for safe and effective nursing practice. The graduate from a practical nurse program is responsible and accountable to practice according to the standards of practice for the licensed practical nurse as defined in Section 4~~01~~60. ~~(4-5-00)~~(7-1-04)T

c. Students enrolled in a professional nurse program shall be provided the opportunity to acquire and demonstrate the knowledge, skills, and abilities for safe and effective nursing practice. The graduate from a professional nurse program is responsible and accountable to practice according to the standards of practice for the professional nurse as defined in Section 4~~6~~01. ~~(4-5-00)~~(7-1-04)T

d. Students enrolled in advanced practice professional nursing education shall be provided the opportunity to acquire and demonstrate the knowledge, skills, and abilities for safe and effective advanced nursing practice. The graduate from an advanced practice professional nursing program is responsible and accountable to practice according to the standards for the advanced practice nursing role for which the nurse is prepared as defined in Section 280. (4-5-00)

02. Program Evaluation. The program shall have a plan for total program evaluation that includes, but is not limited to the following: organization and administration, faculty, students, curriculum, and performance of graduates. Implementation of the plan and use of findings for relevant decision making must be evident. (4-5-00)

BOARD OF NURSING ***Docket No. 23-0101-0401***
Rules of the Idaho Board of Nursing ***PENDING RULE***

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.09.01 - RULES OF THE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

DOCKET NO. 24-0901-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 54-1604(3) Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Vol. 04-10, pages 431 through 434.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 8th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-1604(3), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-0901-0401***
Board of Examiners of Nursing Home Administrators ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Correct Board's website address, clarify application review process, provide qualifications for endorsement applicants, and require that nursing home administrators-in-training work in a licensed nursing home and complete a course of study pertinent to administrators.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees or charges imposed or increased as a result of these rules.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because there were no controversial changes made.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 23rd day of August, 2004.

Rayola Jacobsen, Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945,fax

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF THE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS (RULE 5).
The office of the Board of Examiners of Nursing Home Administrators is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is ibol@ibol.state.id.us. The Board's official web site is at ~~*www2.state.id.us/ibol/nha*~~ https://www.ibol.idaho.gov/nha.htm. ~~*(3-13-02)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS (RULE 10).

01. **Board**. The Board of Examiners of Nursing Home Administrators as prescribed in Section 54-1601, Idaho Code. (7-1-93)

02. **Bureau**. The Bureau of Occupational Licenses as prescribed in Sections 54-1603 and 67-2602, Idaho Code. (3-13-02)

03. **NAB**. NAB shall mean the national association of boards of examiners for nursing home administrators. ( )

011. -- 0~~9~~4~~9~~. (RESERVED).

050. APPLICATIONS (RULE 050).
Applications will be on forms approved by the Board. ( )

01. **Board Consideration**. No application will be considered for any action unless accompanied by the appropriate fees and until the required supporting documentation is received by the Bureau. ( )

02. **Filing Deadline**. To be considered by the Board, properly completed applications must be received by the Bureau at least thirty (30) days prior to the first day of the month in which the Board will meet. ( )

03. **Lack of Activity**. Applications on file with the Board that lack activity for any period of twelve (12) months shall be terminated unless good cause is demonstrated to the Board. ( )

051. -- 099. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

300. ~~*RECIPROCAL*~~ ENDORSEMENT (RULE 300).
~~*An*~~ Each applicant for licensure by ~~*reciprocal*~~ endorsement ~~*will*~~ shall be required to ~~*take and pass the examination pertaining to Idaho law and rules governing nursing homes. Applicants are required to have taken and passed the National Association of Boards of Examiners for Nursing Home Administrators (NAB) examination*~~ document compliance with each of the following requirements. ~~*(7-1-98)*~~( )

01. **A Valid License**. Hold a valid and current nursing home administrator license issued in another state. ( )

02. **Experience**. Two (2) years of practice as a licensed nursing home administrator in another state. ( )

03. **Criminal History**. Has not been found guilty or convicted or received a withheld

judgment or suspended sentence for any felony or any crime involving moral turpitude or received discipline for a license offense in any state. ( )

04. **National Examination**. Has taken and successfully passed the NAB examination. ( )

05. **State Examination**. Has taken and successfully completed the state of Idaho examination. ( )

06. **Affidavit**. Has certified under oath to abide by the laws and rules governing the practice of nursing home administration in Idaho. ( )

301. -- 399. (RESERVED).

400. NURSING HOME ADMINISTRATORS-IN-TRAINING (RULE 400).

01. **Related Health Care** Field. "Related health care field" shall mean a field in health care related to administration. (7-1-93)

02. **Trainees**. Trainees must work on a full time basis in an Idaho licensed nursing ~~*health care facility, preferably a nursing*~~ home. Full time shall be a forty (40) hour per week work schedule with consideration for normal leave taken. Failure to comply with this rule or Section 54-1610, Idaho Code, shall not receive credit as a Nursing Home Administrator-In-Training. ~~*(7-1-98)*~~( )

a. Each trainee shall register with the Board as a Nursing Home Administrator-In-Training (AIT) by submitting an application provided by the Board together with the required fee. The effective date of each AIT program shall be the date the Board approves the application. (3-13-02)

b. Quarterly reports for those trainees employed in a nursing home must reflect that the preceptor of the trainee has instructed, assisted and given assignments as deemed necessary to fulfill the requirements of Subsection 400.03. (7-1-98)

03. **Nursing Home Administrator-In-Training Requirements**. A Nursing Home Administrator-in-Training shall be required to train in all phases of nursing home administration including the following: (7-1-93)

a. Resident Care Management. (7-1-98)

b. Personnel Management. (7-1-93)

c. Financial Management. (7-1-93)

d. Environmental Management. (7-1-98)

e. Meeting Regulations and Governing Entities Directives. (7-1-98)

f. Organizational Management. (7-1-98)

g. Completion of a specialized course of study in nursing home long-term health care administration approved by NAB or otherwise approved by the Board. ( )

04. Facility Administrator. The trainee must spend no less than thirty-two (32) hours a month with the preceptor in a training and/or observational situation in the six (6) areas of nursing home administration as outlined in Subsection 400.03. Quarterly reports must reflect particular emphasis on the six (6) phases of nursing home administration during the time spent in the nursing home. (5-3-03)

05. Preceptor Certification. (7-1-93)

a. A nursing home administrator who serves as a preceptor for a nursing home administrator-in-training must be certified by the Board of Examiners of Nursing Home Administrators. The Board will certify the Idaho licensed nursing home administrator to be a preceptor who: (7-1-98)

i. Is currently practicing as a nursing home administrator and who has practiced a minimum of two (2) consecutive years as a nursing home administrator; and (7-1-98)

ii. Who successfully completes a six (6) clock hour preceptor orientation course approved by the Board. (7-1-93)

b. The orientation course will cover the philosophy, requirements and practical application of the nursing home administrator-in-training program and a review of the six (6) phases of nursing home administration as outlined in Subsection 400.03. (7-1-93)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.14.01 - RULES GOVERNING THE BOARD OF SOCIAL WORK EXAMINERS

DOCKET NO. 24-1401-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 54-3204, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Vol. 04-10, pages 440 through 445.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 8th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-3204, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1401-0401***
Rules Governing the Board of Social Work Examiners ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Correct web address, define supervision requirements, set guidelines for supervisor registration for those pursuing licensure as clinical social workers, allow audio tapes and internet courses as continuing education and deleting references to pastoral counselors. Clinical and independent practice as defined is being extended until July 1, 2006; Supervision is being clarified as 3000 hours in not less than 2 years; and limitations on supervisors is being outlined.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

There are no fees or charges imposed or increased as a result of these rules.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because there were not controversial changes made.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 23rd day of August, 2004.

Rayola Jacobsen
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Phone
(208) 334-3945,fax

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF THE STATE BOARD OF SOCIAL WORK EXAMINERS (RULE 5). The office of the State Board of Social Work Examiners is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is ibol@ibol.state.id.us. The Board's official web site is at ~~*www2.state.id.us/ibol/swo*~~ https://www.ibol.idaho.gov/swo.htm. ~~*(3-13-02)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

201. PRACTICE OF SOCIAL WORK.

01. Baccalaureate Social Work. The application of social work theory, knowledge, methods, and ethics to restore or enhance social or psychosocial functioning of individuals, couples, families, groups, organizations, and communities. Baccalaureate social work is a generalist practice that includes assessment, planning, intervention, evaluation, case management, information and referral, supportive counseling, supervision, and consultation with clients. Baccalaureate social work also includes advocacy, education, community organization, and the development, implementation and administration of policies, programs, and activities. Bachelor level social workers are prohibited from performing psychotherapy. (3-20-04)

02. Master's Social Work. The application of social work theory, knowledge, methods and ethics, and the professional use of self to restore or enhance social, psychosocial or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities. Master's social work requires the application of specialized knowledge and advanced practice skills in the areas of assessment, treatment planning, implementation and evaluation, case management, information and referral, supportive counseling, supervision and consultation with clients, advocacy, teaching, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Master level social workers who do not hold clinical licensure may provide psychotherapy only under the supervision of a licensed clinical social worker, psychologist, or psychiatrist and in accordance with an approved supervision plan. (3-20-04)

03. Clinical Social Work. The practice of clinical social work is a specialty within the practice of master's social work and requires the application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions and addictions. Clinical social work is based on knowledge and theory of psychosocial development, behavior, psychopathology, motivation, interpersonal relationships, environmental stress, social systems, and cultural diversity, with particular attention to person-in-environment. It shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work includes, but is not limited to, individual, couples, family and group psychotherapy, and includes independent and private practice. (3-20-04)

04. Clinical Practice Exemption. A social worker licensed in Idaho at the masters level prior to August 5, 2002 engaged in clinical social work and employed directly by a physician, psychologist or other social worker, or by a public or private agency, institution, hospital, nursing home, rehabilitation center, or any similar facility may meet the supervised experience requirement for clinical licensure upon submission of documentation prior to July 1, 200~~5~~6 showing a minimum of one hundred (100) face-to-face hours of employer provided supervision. No more than seventy-five (75) hours of supervision may be provided by a licensed counselor, marriage and family therapist, or psychiatric nurse and no less than twenty-five (25) hours of supervision may be provided by a licensed clinical social worker, psychologist, or an individual licensed to practice medicine and surgery who practices in the area of psychiatry. A

licensed social worker who meets the requirements of Section 201 may continue to practice clinical social work until July 1, 200~~5~~6. An individual practicing under this exemption must still pass the clinical examination as set forth in Section 350 prior to clinical licensure.

~~*(3-20-04)*~~(____)

05. Independent Practice Of Social Work. As defined in Section 54-3207, Idaho Code, is that practice in which an individual who, wholly or in part, practices social work autonomously, with responsibility for that practice. No baccalaureate or masters level social worker shall engage in independent practice until such time as the social worker shall have worked in a supervised setting and received a minimum of three thousand (3000) hours in a supervised setting in no less than two (2) years. Anyone holding a current Idaho Social Work license who was licensed in Idaho prior to August 5, 2002 shall be exempt from the requirement to submit a plan of supervision and may apply for the Independent Practice certification. Such applicant shall, prior to July 1, 200~~5~~6, submit documentation establishing that a minimum of three thousand (3,000) hours of supervised practice, including one hundred (100) face-to-face hours, was obtained in a supervised setting and provided by a qualified and experienced professional working in the same area of practice; that supervision occurred on a regular and on-going basis; and that the supervisor(s) held a social work license in good standing. ~~*(3-20-04)*~~(____)

06. Private Practice Of Social Work. As defined in Section 54-3207, Idaho Code, is that independent practice in which an individual sets up and maintains responsibility for the contractual conditions of payment with clients, agencies, or institutions. (5-3-03)

07. Employment Of A Social Worker. A social worker employed directly by a physician, psychologist or other social worker, or by a public or private agency, institution, hospital, nursing home, rehabilitation center, or any similar facility, is not to be considered within the definition of an independent practitioner. Furthermore, a social worker who contracts with an agency or institution that assumes full responsibility for and supervises the services provided to clients is not considered to be a private practitioner. (5-3-03)

08. Supervision. Supervised experience shall be required for both independent practice status and clinical licensure. Consultative-teaching supervision is directed toward enhancement and improvement of the individual's social work values, knowledge, methods, and techniques. A total of three thousand (3,000) hours of supervised social work experience accumulated in not less than two (2) years is required. Actual ~~*Supervision*~~ supervisor contact shall be face-to-face and provided by a qualified and experienced professional working in the same area of practice~~*. Supervision*~~ and must occur on a regular and on-going basis and consist of a minimum of one hundred hours (100) hours. Ratio of supervisor/supervisee shall not exceed two (2) social workers to one (1) supervisor per hour of supervision. Supervisors must hold a degree in social work and a current license in good standing, except as noted in Subsection 201.08.c.

~~*(3-20-04)*~~(____)

a. Supervision of baccalaureate social workers pursuing licensure as independent practitioners must be provided by a licensed social worker approved to provide independent practice at the baccalaureate, masters, or clinical level. (3-20-04)

b. Supervision of masters social workers pursuing licensure as independent practitioners must be provided by a licensed social worker approved to provide independent

practice at the masters or clinical level. (5-3-03)

c. Supervision of social workers pursuing licensure as clinical level practitioners must be provided by either a licensed clinical social worker, a licensed clinical psychologist, ~~or~~ a person licensed to practice medicine and surgery who practices in the area of psychiatry, a licensed clinical professional counselor registered as a supervisor or a licensed marriage and family therapist registered as a supervisor and must focus on clinical social work as defined. No less than fifty percent (50%) of supervised experience must be provided by a licensed clinical social worker. A social worker pursuing licensure at the clinical level must document one thousand seven hundred fifty (1,750) hours of direct client contact of the required three thousand (3,000) hours in clinical social work as defined. ~~(3-20-04)~~( )

d. Supervision reports shall be submitted from each supervisor directly to the Board within thirty (30) days following each six (6) month period. Failure of the supervisor to submit the required reports in a timely manner may result in the supervisor being restricted by the Board from providing further supervision. (3-20-04)

09. Supervised Practice Required. To be eligible for licensure as an independent practitioner a candidate must: (5-3-03)

a. Meet the requirements set forth in Subsection 201.08; (3-20-04)

b. Develop a plan for supervision that must be approved by the Board prior to commencement of supervision. Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by the Board prior to the commencement of supervision by the new supervisor; and (5-3-03)

c. Not have more than two (2) supervisors at any given time. (5-3-03)

202. SOCIAL WORK SUPERVISOR REGISTRATION (RULE 202).
Effective January 1, 2006, Idaho licensed social workers shall be registered with the Board in order to provide postgraduate supervision for those individuals pursuing licensure in Idaho as a clinical social worker. ( )

01. Requirements for Registration. ( )

a. Document at least two (2) years experience as a licensed clinical social worker in Idaho. ( )

b. Document at least two thousand (2000) hours of direct client contact as a clinical social worker within the last three (3) years. ( )

c. Document fifteen (15) contact hours of education in supervisor training as approved by the board. ( )

d. Have not been the subject of any disciplinary action for five (5) years prior to application for registration. ( )

02. **Registration**. A supervisor applicant shall submit to the Bureau a completed application form as approved by the board. ( )

a. Upon receipt of a completed application verifying compliance with the requirements for registration as a supervisor, the applicant shall be registered as a supervisor. ( )

b. A supervisor's registration shall be valid only so long as the individual's clinical social worker license remains current and in good standing. ( )

c. A registered clinical social worker supervisor shall not provide supervision to more than three (3) individuals at one (1) time. ( )

20~~2~~3. -- 249. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

351. CONTINUING EDUCATION (RULE 351).

01. Continuing Education Requirements. (7-1-95)

a. Continuing education is required for renewal at all levels of social work licensure in Idaho. The board may, upon application, waive the requirements of this rule in cases involving illness or unusual circumstances interfering with the licensee's ability to practice or inability to conform to the rules. (3-20-04)

b. The completion of a minimum of twenty (20) continuing education (CE) hours annually is required to renew each licensure level. (5-3-03)

c. Compliance with the continuing education (CE) requirements for licensees shall be reported annually. A continuing education course taken in any renewal year, but not claimed for CE credit in that year, may be utilized for credit in the following renewal year. (5-3-03)

d. Each licensed social worker shall complete and return to the Bureau a Board approved continuing education report form as part of the annual renewal of licenses. (5-3-03)

e. Licensees will maintain documentation verifying CE attendance and curriculum for a period of four (4) years. This documentation will be subject to audit by the board. (5-3-03)

f. Licensees shall not be required to comply with this requirement during the first year in which they become licensed under the social work act. (5-3-03)

g. One (1) continuing education hour shall equal one (1) clock hour. (7-1-95)

h. Courses that are part of the curriculum of a university, college or other educational

institution shall be allotted CE credit at the rate of fifteen (15) CE hours for each semester hour or ten (10) CE hours for each quarter hour of school credit awarded. (7-1-95)

i. No more than ten (10) continuing education hours may be obtained from category II. (7-1-95)

j. As part of the required hours of continuing education, all licensees must complete at least one (1) hour of training every year in professional ethics. (3-20-04)

k. Applications for reinstatement of a cancelled license shall include documented proof of meeting the continuing education requirements for the previous twelve (12) months. The requirement for professional ethics training shall continue during any period of cancellation. (3-20-04)

02. Categories Of Continuing Education. (7-1-95)

a. Category I. Category I includes formally organized learning events, ideally involving face-to-face interaction with a teacher for the purpose of accomplishing specific learning objectives. Courses, workshops, conferences, practice oriented seminars, staff development and training activities coordinated and/or taught by approved and recognized educators also are included in this category. Because of our geographic location and sparse population, closed circuit T.V., video and audio tapes, internet based courses, and correspondence courses may be substituted for face-to-face contact if ~~*coordinated by an approved instructor. Videotaped presentations require a discussion period to follow that reviews the learning objectives of the taped program*~~ the course is interactive or requires an examination. ~~*(7-1-95)*~~(____)

b. Category II. Category II consists of a variety of self-directed professional study activities and growth experiences. Examples include making an initial presentation on professional issues or programs, teaching a course for the first time, presenting a lecture or conducting a workshop for the first time, editing or writing professional books or articles, and conducting professional research. (3-20-04)

c. The subject matter of all approved continuing education shall be germane to the practice of social work as defined in Section 54-3202, Idaho Code, and may include the specialties of Marriage and Family Therapy, Psychiatry, Psychiatric Nursing, or Psychology~~*, or Pastoral Counseling*~~. ~~*(5-3-03)*~~(____)

03. Continuing Education Sources. (7-1-95)

a. Continuing education course providers shall include: (5-3-03)

i. Professional Associations. Continuing education hours may be obtained by participating in activities sponsored by or approved by professional associations including but not limited to the Idaho Chapter of the National Association of Social Workers, Idaho Society for Clinical Social Workers. The professional association shall certify the number of clock hours of educational content in each sponsored or approved activity. (5-3-03)

ii. Educational Institutions. Continuing education hours may be obtained by completing coursework not below your level of licensing or by participating in continuing education programs sponsored by or approved by educational institutions accredited by a regional body recognized by the Council on Post Secondary Accreditation. The educational institution shall certify the number of clock hours of educational content in each sponsored or approved program. (7-1-95)

iii. Government Agencies, Schools and Hospitals. Continuing education hours may be obtained by participating in in-service training, courses or workshops sponsored by federal, state, or local government agencies, public school systems and licensed hospitals. The provider shall certify the number of clock hours of educational content in each approved activity. (7-1-95)

iv. Private social service agencies and other entities. Continuing education hours may be obtained by participating in continuing education programs sponsored by agencies or entities who regularly provide social work services. The provider shall certify the number of clock hours of educational content in each approved activity. (3-20-04)

b. All continuing education hours must be relevant to the profession of social work at the individual's particular level of social work licensure. The presenter's level of education must be at the licensee's level or above. Continuing education for clinical licensees must be clinical in nature except that five (5) hours each year may be non-clinical but shall be germane to the practice of social work. Final approval of acceptable programs rests with the Board. (3-20-04)

04. Documentation. (7-1-95)

a. Each licensee shall maintain documentation verifying CE attendance and curriculum for a period of four (4) years from the date of completion. This documentation will be subject to audit by the Board. (5-3-03)

b. Licensees shall attest, on their annual license renewal application, that they have satisfied the continuing education requirements. False attestation of satisfaction of the continuing education requirements on a renewal application shall subject the licensee to disciplinary action, including revocation. (5-3-03)

c. Category I documents must be in the form of a certificate of attendance, a statement signed by the provider verifying participation in the activity, or an official transcript. (5-3-03)

d. In the event a licensee fails to provide the Board with acceptable documentation of the hours attested to on the renewal application, the license will not be renewed. (7-1-95)

e. Documented proof of meeting the continuing education requirement shall be in the form of a certificate or letter from the sponsoring entity that includes the title of the activity, the subject material covered, the dates and number of hours credited, and the presenter's full name and professional credentials. (5-3-03)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.15.01 - RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

DOCKET NO. 24-1501-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 54-3404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Vol. 04-10, pages 446 through 449.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 8th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-3404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1501-0401***
Board of Counselors and Marriage/Family Therapists ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Correct website address, correct obsolete language, clarify examination required, delete references to pastoral counselors per Idaho Code. Adding a special exemption to the rules requiring continuing education for renewal of a license.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees or charges imposed or increased as a result of these rules.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because there were no controversial changes made.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 23rd day August, 2004.

Rayola Jacobsen, Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220
Boise, ID 83702
(208) 334-3233 Phone
(208) 334-3945,fax

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS (RULE 5).
The office of the Board of Professional Counselors and Marriage and Family Therapists is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is ibol@ibol.state.id.us. The Board's official web site is at ~~*www2.state.id.us/ibol/cou*~~ https://www.bol.idaho.gov/cou.htm. ~~*(3-13-02)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

225. CLINICAL PROFESSIONAL COUNSELOR LICENSURE (RULE 225).

The following requirements must be met for clinical professional counselor licensure. (3-13-02)

01. **Requirements**. The following requirements must be met: (3-13-02)

a. Hold a valid licensed professional counselor license; and (4-2-03)

b. Document two thousand (2,000) hours of direct client contact experience under supervision accumulated in no less than a two (2) year period after licensure in any state. (4-2-03)

i. All applicants for Clinical Professional Counselor license must provide verification of meeting at least one thousand (1,000) hours of supervised experience under the supervision of a licensed Clinical Professional Counselor. The remainder of the supervision may be provided by licensed Psychiatrists, Counseling/Clinical Psychologists, ~~*Certified*~~ Licensed Clinical Social Workers, ~~*Private and Independent Practice*~~ or Marriage and Family Therapists. ~~*(3-13-02)*~~( )

ii. The ratio for supervision will consist of one (1) hour of face-to-face, one-on-one (1/1) supervision to every thirty (30) hours of direct client contact. (7-1-97)

c. ~~*Document proficiency in Diagnostic Evaluation by providing verification of*~~ Effective July 1, 2005, successful completion of ~~*graduate course or other training/experience equivalent to a college course acceptable to the board*~~ National Board of Certified Counselors' National Clinical Mental Health Counseling Examination. ~~*(7-1-97)*~~( )

d. The Board shall consider the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience. (4-2-03)

02. **Supervisors**. A supervisor may supervise no more than three (3) licensed professional counselors at any one time. (7-1-97)

226. -- 23~~4~~7. (RESERVED).

~~***235. PASTORAL COUNSELORS (RULE 235).***~~
~~*The following requirements must be met for pastoral counselor licensure:* *(7-1-98)*~~

~~***01. Graduate Degree****. Hold a Master of Divinity (M.Div.) degree or doctoral degree meeting the requirements set forth in Section 54-3405A(1) Idaho Code, from an accredited university or religious institution.* *(7-1-98)*~~

~~***a.*** *An accredited university or religious institution shall be one accredited by: the Middle States Association of Colleges and Secondary Schools; the New England State Association of Colleges and Secondary Schools; the North Central Association of Colleges and Secondary Schools; the Northwest Association of Colleges and Secondary Schools; the Southern Association of Colleges and Secondary Schools; or the Western Colleges Association.* *(7-1-98)*~~

~~***b.*** *The Pastoral Counselor Program May also be accredited by the Association of Theological Schools (ATS).* *(7-1-98)*~~

~~***02.*** ***Practicum****. Completion of a practicum of supervised counseling experience of four hundred (400) contact hours.* *(7-1-98)*~~

~~***a.*** *The four hundred (400) contact hours shall be supervised at a ratio of one (1) hour of supervision for each ten (10) contact hours.* *(7-1-98)*~~

~~***b.*** *The practicum must be supervised by a qualified counselor-educator as part of a planned graduate program.* *(7-1-98)*~~

~~***03.*** ***Post-Graduate Supervised Counseling Experience****. The completion of two thousand (2,000) contact hours of post-graduate supervised counseling experience with an approved supervisor.* *(7-1-98)*~~

~~***a.*** *"Two thousand (2000) hours" hours is defined as two thousand (2,000) clock hours of experience working in a counseling setting.* *(7-1-98)*~~

~~***b.*** *The ratio of supervision to contact hours shall be one (1) hour of supervision for each twenty (20) contact hours.* *(7-1-98)*~~

~~***c.*** *An approved supervisor shall include an American Association of Pastoral Counselors approved supervisor, a licensed pastoral counselor, a licensed psychiatrist, a licensed psychologist, a licensed marriage and family therapist, or licensed professional counselor.* *(3-13-02)*~~

~~***d.*** *The Board shall consider the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience.* *(4-2-03)*~~

~~***04.*** ***Examination****.* *(7-1-98)*~~

~~***a.*** *The Board requires the successful passage of the National Counselor Examination prepared by the National Board for Certified Counselors (NBCC).* *(3-13-02)*~~

~~***b.*** *The examination will be conducted at a time and place specified by the Board.* *(7-1-98)*~~

~~***c.*** *Successful passage of the examination is defined by the Board as achievement of the passing score set by the NBCC. Reexamination shall consist of the entire examination.* *(3-13-02)*~~

~~***236. – 237. (RESERVED).***~~

(BREAK IN CONTINUITY OF SECTIONS)

250. FEES (RULE 250).

01. **Application Fee**. Application fee: (7-1-97)

a. Professional Counselor - Seventy-five dollars ($75). (3-13-02)

b. Clinical Professional Counselor - Seventy-five dollars ($75). (3-13-02)

~~**c.** *Pastoral Counselor - Seventy-five dollars ($75).* *(3-13-02)*~~

~~**d**~~**c.** Marriage and Family Therapist - Seventy-five dollars ($75). (3-13-02)

~~**e**~~**d.** Intern Registration - Twenty-five dollars ($25). (4-2-03)

02. **Professional Counselor~~,~~ and Marriage and Family Therapist~~, *and Pastoral Counselor*~~ Examination or Reexamination Fee**. The Professional Counselor~~,~~ and Marriage and Family Therapist ~~*and Pastoral Counselor*~~ license examination or reexamination fee shall be the fee as set by the provider of the approved examination. ~~*(3-13-02)*~~(____)

03. **Original License Fee**. Original License fee for Professional Counselor or Clinical Professional Counselor or Marriage and Family Therapist ~~*or Pastoral Counselor*~~ - Seventy-five dollars ($75). ~~*(4-2-03)*~~(____)

04. **Annual Renewal Fee**. Annual license renewal fee for Professional Counselor, Clinical Professional Counselor, or Marriage and Family Therapist~~*, or Pastoral Counselor*~~ - Sixty dollars ($60). ~~*(4-2-03)*~~(____)

05. **Fees are Non-Refundable**. All fees are non-refundable. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

425. CONTINUING EDUCATION (RULE 425).
Every person holding an Idaho license as a Pastoral Counselor or a Marriage and Family Therapist must annually complete twenty (20) contact hours of continuing education prior to license renewal. (4-2-03)

01. **Contact Hours**. The contact hours of continuing education shall be obtained in areas of study germane to the practice for which the license is issued as approved by the Board. One (1) contact hour for each renewal period shall be in ethics. (3-20-04)

02. **Documentation of Attendance**. It shall be necessary for the applicant to provide documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the applicant. This documentation must be maintained by the applicant and provided to the Board upon request by the Board or its agent. (4-2-03)

03. **Excess Hours**. Continuing education hours accumulated during the twelve (12)

months immediately preceding the license expiration date may be applied toward meeting the continuing education requirement for the next license renewal. No more than five (5) hours in excess of the required twenty (20) hours shall be carried forward. Excess hours may be used only during the next renewal period and may not be carried forward more than one (1) time. (4-2-03)

04. Compliance Audit. The Board may conduct random continuing education audits of those persons required to obtain continuing education in order to renew a license and require that proof acceptable to the Board of meeting the continuing education requirement be submitted to the Bureau. Failure to provide proof of meeting the continuing education upon request of the Board shall be grounds for disciplinary action in accordance with section 54-3407, Idaho Code. (4-2-03)

05. Special Exemption. The Board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board.( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.17.01 - RULES OF THE IDAHO BOARD OF ACUPUNCTURE

DOCKET NO. 24-1701-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 54-4705, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Vol. 04-10, pages 452 and 453.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 8th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-4705, Idaho Code 54-4705(1)(c).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1701-0401***
Rules Governing Idaho Board of Acupuncture ***PENDING RULE***

Correct website address, clarify source for distance learning continuing education, provide hardship exemption for continuing education. Add a section that outlines discipline as provided by Statute.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees or charges imposed or increased as a result of these rules.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because there were no controversial changes made.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 23rd day of August, 2004.

Rayola Jacobsen
Bureau Chief
Bureau of Occupational Licenses
1109 Main St. Ste. 220, Boise, ID 83702
(208) 334-3233 Ph. (208) 334-3945, fax

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF THE IDAHO STATE BOARD OF ACUPUNCTURE (RULE 5).
The office of the Board of Acupuncture is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main St., Suite 220, Boise, ID 83702. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is acu@ibol.state.id.us. The Board's official web site is at ~~*www2.state.id.us/ibol/acu*~~ http://www.ibol.idaho.gov/acu.htm. ~~*(3-20-04)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

305. CONTINUING EDUCATION (RULE 305).
In order to further protect the public health and to facilitate the administration of the Acupuncture Act, the Board has formulated the following rules: (5-3-03)

01. Subject Material. The subject material of the continuing education requirement shall be germane to the practice of acupuncture and; (5-3-03)

a. Accepted by NCCAOM, offered by accredited schools of acupuncture and oriental medicine, or otherwise approved by the Board. (5-3-03)

b. "Germane to the practice of acupuncture" shall be consistent with Section 54-4702(1)(4), Idaho Code. (5-3-03)

02. Verification of Attendance. It shall be necessary for each licensee to maintain verification of attendance by securing authorized signatures or other documentation from the course instructors or sponsoring institution substantiating any hours attended by the applicant. This verification shall be maintained by the licensee for no less than seven (7) years and provided to the Board upon the request of the Board or its agent. (5-3-03)

03. Distance Learning and Independent Study. The Board may approve a course of study for continuing education credit that does not include the actual physical attendance of the applicant in a face-to-face setting with the course instructor. Distance Learning or Independent Study courses shall be eligible for continuing education credits ~~*only*~~ if approved by NCCAOM or upon approval of the Board. ~~*(5-3-03)*~~( )

04. Requests for Approval. All requests for approval or pre-approval of educational programs must be made to the Board in writing, and must be accompanied by a statement that includes the name of the instructor or instructors, the date and time and location of the course, the specific agenda for the course, the number of continuing education credit hours requested, and a statement of how the course is believed to be pertinent to the practice of acupuncture. (5-3-03)

05. Special Exemption. The Board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board.( )

(BREAK IN CONTINUITY OF SECTIONS)

552. -- ~~999~~574.(RESERVED).

575. DISCIPLINE (RULE 575).

01. Civil Fine. The Board may impose a civil fine not to exceed one thousand dollars ($1,000) upon a licensee for each violation of Section 54-4711, Idaho Code. ( )

02. Costs and Fees. The Board may order a licensee to pay the costs and fees incurred by the Board in the investigation or prosecution of the licensee for violation of Section 54-4711, Idaho Code. ( )

576. -- 999. (RESERVED).

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.19.01 - RULES OF THE BOARD OF EXAMINERS OF RESIDENTIAL CARE FACILITY ADMINISTRATORS

DOCKET NO. 24-1901-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s)54-4205(3), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Vol. 04-10, pages 458 and 459.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 8th day of November, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-4205(3) Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1901-0401***
Board of Examiners of Residential Care Facility Administrators ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Provides that qualifications for license include good moral conduct and suitability.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees or charges imposed or increased as a result of these rules.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because there were no controversial changes made.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 23rd day of August, 2004.

Rayola Jacobsen
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., Ste. 220
Boise, ID 83702
(208) 334-3233 Phone
(208) 334-3945, fax

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. ADDRESS OF IDAHO BOARD OF EXAMINERS OF RESIDENTIAL CARE FACILITY ADMINISTRATORS (RULE 5).
The office of the Board of Examiners of Residential Care Facility Administrators is located within the Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642. The phone number of the Board is (208) 334-3233. The Board's FAX number is (208) 334-3945. The Board's e-mail address is ibol@ibol.state.id.us. The Board's official web site is at ~~*www2.state.id.us/ibol/rca*~~ www.idaho.gov/ibol/rca. ~~*(3-15-02)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

101. -- 1~~9~~49. (RESERVED).

150. QUALIFICATIONS FOR ADMINISTRATOR LICENSE (RULE 150).
Each applicant for an administrator's license and each licensed administrator, as requested by the Board, shall submit proof, along with their application, that said individual meets the following qualifications for the issuance of a license or permit, or the retention or renewal of a license: ( )

01. Good Moral Character. The applicant shall submit a criminal background check by an entity approved by the board establishing that the applicant has not been convicted, pled guilty or nolo contendere or received a withheld judgment for a felony or any crime involving dishonesty or the health, safety or welfare of a person. ( )

02. Suitability. The applicant shall submit a statement by a licensed physician establishing that the applicant has sufficient physical, emotional and mental capacity to carry out and comply with the laws and rules governing residential care facility administrators. ( )

151. -- 199. (RESERVED).

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO BOARD OF PHARMACY

DOCKET NO. 27-0101-0401

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 4, 2004 Idaho Administrative Bulletin, Volume 04-8, pages 177 through 180.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact R.K. “Mick” Markuson, Director, at (208) 334-2356.

DATED this 25th day of August, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: The effective date of the temporary rule is April 1, 2004.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not alter than August 18, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

BOARD OF PHARMACY ***Docket No. 27-0101-0401***
Rules of the Idaho Board of Pharmacy ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of the supporting reasons for temporary rulemaking and nontechnical explanation of the substance and purpose of the proposed rulemaking:

More stringent accountability requirements for Medicare, Medicaid, and third party payors in the private sector (i.e., insurance companies, benefits management companies, managed care groups, etc.) are placing an ever-increasing administrative burden on each and every prescription. This administrative burden on pharmacists creates a negative impact on health care in the state, which needs to be dealt with immediately to protect the public health, safety, and welfare. To allow licensed pharmacists adequate time to focus on the pharmacology aspects of the prescription and adequate time to focus on the individual patients and counseling for those patients, there is an immediate need to increase the number of pharmacy technicians per licensed pharmacist from two to three.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Adoption of the rule as a temporary rule with immediate effect is necessary for the protection of the public health, safety, or welfare.

FEE SUMMARY: No fee is being imposed or increased by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule needs to be effective immediately to protect the public health, safety, and welfare.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact R.K. “Mick” Markuson, Director, at (208) 334-2356.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 25, 2004.

DATED this 25th day of June 2004.

R.K. “Mick” Markuson
Director
Idaho State Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

251. PHARMACY TECHNICIANS.

01. Definition - Pharmacy Technician. Means an individual, registered with the Board who is employed or otherwise authorized by a pharmacy registered with the Board to perform routine functions, that do not require the use of a licensed pharmacist's professional judgment, in connection with the preparing, compounding, distribution or dispensing of medications at such pharmacy, and who has been adequately trained therefor according to the written standards of such pharmacy. Such written standards shall be available to the Board and its designated personnel for inspection and/or approval. (5-3-03)

02. Responsibility of Pharmacy and Pharmacist -- Assignment of Functions. (4-5-00)

a. The pharmacy and the pharmacist-in-charge are each responsible for all aspects of the sale at retail and the dispensing of medications, drugs, devices, and other materials at the pharmacy, including the preparing, compounding, distribution or dispensing of medications. No pharmacy or pharmacist may allow assignment to, or permit performance by, any individual, other than a registered pharmacy technician, a registered pharmacist extern/intern, or a licensed pharmacist, of any functions connected to the preparing, compounding, distribution or dispensing of medications at the pharmacy. (5-3-03)

b. The pharmacy or the pharmacist-in-charge may assign to, or allow performance by, a registered pharmacy technician, only of those functions connected with the preparing, compounding, distribution or dispensing of medications, which meet all of the following criteria: (5-3-03)

i. The function is routine; (4-5-00)

ii. The function is one for which the pharmacy technician is adequately trained and supervised; and (4-5-00)

iii. The function does not require the use of a licensed pharmacist's professional judgment. (4-5-00)

c. Only a registered pharmacist may do any of the following (which, without limiting the scope of the term "professional judgment", is a non-exclusive list of actions requiring a licensed pharmacist's professional judgment): (4-5-00)

i. Receive a new prescription order verbally from a prescriber or other person authorized by law. (4-5-00)

ii. Perform evaluations and interpretations of a prescription and any needed clarifications prior to filling. (4-5-00)

iii. Consult with the prescriber concerning any necessary clarification regarding a patient and his prescription. (4-5-00)

iv. Interpret any clinical data in a patient's medication record system (e.g., drug usage, refill frequency, drug interactions, etc.) (7-1-93)

v. Perform professional consultation with any prescriber, nurse or other health care professional. (7-1-93)

vi. Supervise the packaging of drugs and check the completed procedure and product. (7-1-93)

vii. Issue the new prescription to the patient or his agent with consultation. (7-1-93)

viii. Supervise the activities of pharmacy technicians to insure that all such activities are performed completely, safely and without risk or harm to patients. (4-5-00)

d. A violation of the rules on pharmacy technicians by a pharmacist or a pharmacy is unprofessional conduct, and is grounds for revocation or suspension of the pharmacist's license and/or the pharmacy registration issued under Sections 54-1722, 54-1723, 54-1724 or 54-1729, Idaho Code, or other appropriate disciplinary action. (4-5-00)

03. Supervision. Where a pharmacy technician performs one (1) or more functions in connection with the preparing, compounding, distribution or dispensing of, the pharmacy technician shall be under the supervision of a licensed pharmacist who, in addition to the pharmacy and the pharmacist-in-charge, shall be responsible for all aspects of the filled prescription including, but not limited to the following: (4-5-00)

a. Verifying drug selection, strength, dosage form and labeling against the prescription and the contents of stock container. (7-1-93)

b. Verifying selection of the proper prescription container. (7-1-93)

04. Pharmacy Technician Ratio. The ratio of pharmacists to pharmacy technicians shall be not less than one (1) pharmacist for every ~~*two*~~ three (~~2~~3) pharmacy technicians in any practice setting. ~~*(5-3-03)*~~(4-1-04)T

05. Responsibility of Pharmacy Technicians. (4-5-00)

a. Pharmacy technicians shall perform all functions properly assigned to them with all necessary care. No pharmacy technician shall accept assignment of, or perform, any functions connected with the preparing, compounding, distribution or dispensing of medications unless such pharmacy technician is employed or otherwise authorized by the assigning pharmacy and such function meets all of the criteria set forth in Subsection 251.02.b. (5-3-03)

b. The Board of Pharmacy may initiate proceedings against pharmacy technicians who perform such tasks or functions connected with the preparing, compounding, distribution or dispensing of medications: (4-5-00)

i. That are not routine functions; (4-5-00)

ii. That the pharmacy technician is not adequately trained and supervised for; or (4-5-00)

iii. That require the use of a licensed pharmacist's professional judgment. Such persons may be charged by the appropriate authorities with practicing pharmacy without a license in violation of Section 54-1726, Idaho Code. (4-5-00)

c. The Board of Pharmacy may initiate proceedings against pharmacy technicians who perform such tasks or functions connected with the preparing, compounding, distribution or dispensing of medications in a negligent or improper manner or otherwise violate the rules on pharmacy technicians. Such violations shall be grounds for revocation or suspension of the pharmacy technician's registration, or other appropriate disciplinary action. (4-5-00)

06. Identification of Pharmacy Technicians. (7-1-99)

a. All pharmacy technicians working as such in community pharmacies must be identified by a name badge designating that person as a pharmacy technician. The name badge must measure no less than one (1) inch by three (3) inches and must contain the individual's printed name directly above the title of pharmacy technician. The identification badge must be clearly visible at all times. Pharmacy technicians working in an institutional setting may be exempt from the above requirement only if the institution requires a specific badge of identification to be worn by the pharmacy technician. (4-5-00)

b. All pharmacy technicians must identify themselves as a pharmacy technician on any phone calls initiated or received by them while performing pharmacy functions. (7-1-99)

07. Registration of Pharmacy Technician. (4-5-00)

a. Annual Registration. All pharmacy technicians shall register annually with the Board. The Board will develop an appropriate annual registration notice and annual registration form to be mailed to all registered pharmacy technicians prior to June 1 of each year. The notice will state the annual pharmacy technician registration renewal fee. (4-5-00)

b. Initial Registration. Before commencing duties at a pharmacy as a pharmacy technician (including previously registered pharmacy technicians who are changing pharmacies), an individual must register with the Board, pay the registration fee, and have received a certificate of registration from the Board, provided however, an individual who has not previously had his registration as a pharmacy technician revoked or suspended may commence performing duties as a pharmacy technician immediately upon the completion and mailing of the registration form and applicable fee to the Board. The initial registration period shall be from the date of initial registration to the next annual registration date. (5-3-03)

c. Contents of Registration Form. The annual registration form and the initial registration form shall be prepared by the Board, and shall require such information regarding the individual and the employing or authorizing pharmacy as the Board may reasonably require. In addition, registration shall include the statement of the pharmacy owner (or an authorized agent of the pharmacy owner), and of the pharmacist-in-charge that either: (5-3-03)

i. The individual has been adequately trained by the pharmacist-in-charge, or by the pharmacy, to perform those routine functions in connection with the preparing, compounding, distribution or dispensing of medications as are, or will be, assigned to such individual; (4-5-00)

ii. The pharmacist-in-charge or the pharmacy owner has verified that such individual possesses adequate training to perform those routine functions in connection with the preparing, compounding, distribution or dispensing of medications as are, or will be, assigned to such individual; or (4-5-00)

iii. Such individual will be adequately so trained prior to the assignment of any routine functions in connection with the preparing, compounding, distribution or dispensing of medications. (4-5-00)

08. Discipline and Appeal. Any proceedings by the Board against any pharmacy technician shall comply in all respects with the Administrative Procedures Act, Chapter 52, Title 67, Idaho Code. (4-5-00)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO BOARD OF PHARMACY

DOCKET NO. 27-0101-0402

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-1717, 54-1718, and 54-1719, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed with no changes. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Volume 04-10, pages 461 through 475.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact R. K. "Mick" Markuson, Director, at (208) 334-2356.

DATED this 28th day of October, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: The effective date of the temporary rule is August 26, 2004.

AUTHORITY: In compliance with Section 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule. The action is authorized pursuant to Sections 54-1717, 54-1718, and 54-1719, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

BOARD OF PHARMACY ***Docket No. 27-0101-0402***
Rules of the Idaho State Board of Pharmacy ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the temporary and proposed rulemaking:

The pharmacy faculty at ISU along with two urban hospitals (Kootenai Medical Center in Coeur d'Alene and St. Alphonsus Regional Medical Center in Boise) have approached the Board of Pharmacy requesting authority to commence a pilot project to use teleconferencing and high-speed internet connections to bring pharmacy expertise to Idaho's rural medical facilities. The Board of Pharmacy has reviewed the proposal and has worked with the proponents to prepare temporary rules allowing the two pilot projects. The Board believes that the pilot projects themselves will create an immediate enhancement to the health and welfare of the target rural areas and requests that the Governor find that the proposed temporary rules qualify under Idaho Code § 67-5226(1)(a) - protection of the public health, safety, or welfare - and allow the rules to become effective immediately.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: Adoption of the rule as a temporary rule with immediate effect is necessary to enhance protection of the public health, safety, or welfare.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, informal negotiated rulemaking was conducted with the proponents of the telepharmacy pilot projects to be authorized under the rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact R.K. "Mick" Markuson, Director, at (208) 334-2356.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 26th day of August, 2004.

R.K. “Mick” Markuson
Director
Idaho State Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

261. TELEPHARMACY PILOT PROJECT.
The Board, through its Executive Director, may authorize specific Institutional Facilities and the Institutional Pharmacies located therein to participate in a Telepharmacy Program. The following rules shall apply to institutions so authorized by the Board for the telepharmacy practiced in the institution. The purpose of the Telepharmacy Program is to allow the provision of pharmaceutical care through the use of telecommunications and information technologies to patients at a distance from the pharmacy and pharmacist providing the pharmaceutical care. During the pilot project phase of the Telepharmacy Program, designation to participate in the Telepharmacy Program shall be at the discretion of the Board and the Executive Director. (8-26-04)T

262. DEFINITIONS.

01. Central Pharmacy. An institutional pharmacy authorized by the Board to participate in a Telepharmacy Program. (8-26-04)T

02. Consulting Pharmacists. Pharmacists employed at a Central Pharmacy who provide pharmaceutical care to patients at a Rural Institutional Facility. (8-26-04)T

03. Rural Institutional Facility. An Institutional Facility authorized by the Board to participate in a Telepharmacy Program. Rural Institutional Facilities will be those facilities such as federally designated critical access hospitals or other facilities operating in a health professional shortage area and who are unable to otherwise obtain pharmaceutical care on a timely basis twenty-four (24) hours per day. (8-26-04)T

04. Rural Institutional Pharmacy. The institutional pharmacy located within a Rural Institutional Facility. (8-26-04)T

05. Telepharmacy Program. The pilot project adopted by the Board to allow selected Central Pharmacies and selected Rural Institutional Facilities to engage in the provision of pharmaceutical care through the use of telecommunications and information technologies to patients at a distance from the pharmacy and pharmacist providing the pharmaceutical care. (8-26-04)T

263. CONTRACT FOR TELEPHARMACY PROGRAM.
A Central Pharmacy may contract with a Rural Institutional Facility for operation of a Telepharmacy Program as specified herein. (8-26-04)T

01. Contract Matters. The contract shall address the following matters: (8-26-04)T

a. Identify the director of pharmacy of the Central Pharmacy and the director of pharmacy of the Rural Institutional Pharmacy and provide for notice to the parties and to the Board in the event of a change in either director. (8-26-04)T

b. Contain a description of the telepharmacy services to be performed by the Central Pharmacy for the Rural Institutional Pharmacy, including: (8-26-04)T

i. Protocols for communication of orders for prescription drugs from the practitioners at the Rural Institutional Pharmacy to the pharmacists at the Central Pharmacy. (8-26-04)T

ii. Protocols for the Central Pharmacy to accomplish dispensing of prescription drugs at the Rural Institutional Facility and to ensure that the Central Pharmacy has sufficient Consulting Pharmacists and support staff to meet the pharmacy needs of the Institutional Facility where the Central Pharmacy is located as well as performing the pharmacy functions for the Rural Institutional Pharmacy as are contemplated under the contract. (8-26-04)T

iii. A description of the access to prescription drugs in the Rural Institutional Pharmacy under the program and protocol for maintaining the security of prescription drugs in the Rural Institutional Pharmacy. (8-26-04)T

iv. Contain a provision for the orderly transition of pharmaceutical services for the Rural Institutional Pharmacy in the event the Central Pharmacy elects to terminate its participation in the Telepharmacy Program, such transition to include an adequate time for the Rural Institutional Pharmacy to locate appropriate pharmaceutical services from another source. (8-26-04)T

v. The term of the contract shall not exceed two (2) years and shall be subject to the right of the Board and its Executive Director to conduct an annual review of the operations under the contract and of the Telepharmacy Program. (8-26-04)T

02. Additional Contract Matters. The contract may address additional matters regarding the Telepharmacy Program between the Central Pharmacy and the Rural Institutional Facility. (8-26-04)T

03. Contract Approval. The contract must be approved by the Executive Director of the Board of Pharmacy prior to the commencement of telepharmacy services between the Central Pharmacy and the Rural Institutional Facility. In reviewing the contract, the Executive Director shall evaluate the proposed terms in the light of: (8-26-04)T

a. Promoting, preserving, and protecting the health, safety, and welfare of the public; (8-26-04)T

b. Maintaining appropriate professional standards for the practice of pharmacy; and (8-26-04)T

c. Maintaining appropriate safeguards for the protection of prescription drug inventories, especially controlled substance inventories, at the Rural Institutional Pharmacy. (8-26-04)T

264. SPECIAL RULES FOR DIVISION OF RESPONSIBILITY FOR TELEPHARMACY.

Notwithstanding anything in these rules (IDAPA 27.01.01) to the contrary, for Rural Institutional Pharmacies and Central Pharmacies, and the pharmacists practicing under an approved contract for telepharmacy services, the following rules shall apply. (8-26-04)T

01. Responsibility of Director of Central Pharmacy. The director of pharmacy of the Central Pharmacy shall be responsible for all telepharmacy services performed by the Central Pharmacy under the approved contract and for meeting the requirements of the Idaho Pharmacy Act and these rules with respect to such services. The telepharmacy activities and operations performed by the Central Pharmacy under the approved contract and the ancillary personnel of the Central Pharmacy engaged in such activities and operations shall be personally and directly supervised by the director of pharmacy in the same fashion as all other activities and operations at the Central Pharmacy. (8-26-04)T

02. Responsibility of Director of Rural Institutional Pharmacy. The director of pharmacy of the Rural Institutional Pharmacy shall remain responsible for all other aspects of the Rural Institutional Pharmacy but shall not be responsible for the services performed by the Central Pharmacy under the approved contract. Where ancillary personnel are directed or supervised in telepharmacy activities by the Central Pharmacy, responsibility for such direction and supervision shall lie with the Central Pharmacy and the director thereof. (8-26-04)T

26~~1~~5. -- 290. (RESERVED).

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO BOARD OF PHARMACY

DOCKET NO. 27-0101-0403

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-1717 and 54-1719, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed with no changes. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Volume 04-10, pages 464 through 466.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact R. K. “Mick” Markuson, Director, at (208) 334-2356.

DATED this 28th day of October, 2004.

The Following Notice Was Published With The Temporary And Proposed Rule

EFFECTIVE DATE: The effective date of the temporary rule is April 1, 2004.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule. The action is authorized pursuant to Sections 54-1717 and 54-1719, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

BOARD OF PHARMACY ***Docket No. 27-0101-0403***
Rules of the Idaho State Board of Pharmacy ***PENDING RULE***

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking is needed to bring the Board's rules into compliance with federal law, which makes Ephedrine products available through prescription only. These rule changes remove rules that allow Ephedrine products to be sold over the counter.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Adoption of the rule as a temporary rule with immediate effect is necessary to comply with deadlines in amendments to governing federal law.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking is necessary to comply with changes in federal law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact R.K. "Mick" Markuson, Director, at (208) 334-2356.

Anyone may submit written comments regarding the propose rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 25th day of August, 2004.

R.K. "Mick" Markuson
Director
Idaho State Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

158. PRESCRIPTION DRUGS.

01. Designated Drugs. In addition to those drugs designated as prescription or legend drugs as defined in Section 54-1705(23), Idaho Code, the Idaho Board of Pharmacy includes

preparations containing ephedrine or salts of ephedrine, as prescription drugs. (7-1-93)

02. Exempt Drugs. A product that meets all the criteria set forth in Subsection 158.02.a. is exempt from the designation as prescription drugs under Subsection 158.01 and exempt from inclusion as a Schedule II controlled substance under Section 37-2707, Idaho Code, unless it is being used or possessed as an immediate precursory of another controlled substance. (7-1-98)

a. Products containing a formula with a ratio of twelve and one half (12.5) milligrams ephedrine to two hundred (200) milligrams guaifenesin or twenty-five (25) milligrams ephedrine to four hundred (400) milligrams guaifenesin; and not exceeding a maximum of twenty-five (25) milligrams of ephedrine per tablet, capsule, or dose; and in addition to such formula, may include only inert or inactive ingredients or substance. (7-1-98)

b. Provided, however, that hemorrhoidal ointments containing not more than two tenths percent (.2%) Ephedrine Sulfate and suppositories not exceeding four (4) milligrams Ephedrine Sulfate per suppository are also exempt pursuant to Subsection 158.02. (7-1-98)

~~**c.** *Ephedrine products that meet the following criteria are exempt from the designation as prescription drug.* *(3-16-04)*~~

~~*i. The product label must state the total amount in milligrams of ephedrine or ephedrine group alkaloids in a serving or dosage unit and the amount of the product that constitutes a serving or dosage unit.* *(3-16-04)*~~

~~*ii. The product label must state the maximum recommended twenty-four (24) hour serving or dosage for an adult human is one hundred (100) milligrams.* *(3-16-04)*~~

~~*iii. The product label must state that consumption of more than the recommended serving or dosage for the food or dietary supplement, or that consumption of a serving or dosage at a more frequent interval than recommended, may increase the risk of adverse effects.* *(3-16-04)*~~

~~*iv. The product label must contain the following warning in distinct contrast to other label printing or graphics: WARNING: Not intended for use by anyone under the age of eighteen (18). Do not use this product if you are pregnant or nursing. Consult a health care professional before using this product if you have heart disease, thyroid disease, diabetes, high blood pressure, depression or other psychiatric condition, glaucoma, difficulty in urinating, prostate enlargement, or seizure disorder, if you are using a monoamine oxidase inhibitor (MAOI) or any other prescription drug, or if you are using an over-the-counter drug containing ephedrine, pseudoephedrine or phenylpropanolamine (ingredients found in certain allergy, asthma, cough/cold, and weight control products). Discontinue use and call a health care professional immediately if you experience rapid heartbeat, dizziness, severe headache, shortness of breath or other similar symptoms.* *(3-16-04)*~~

~~*v. The product label must contain the statement: "This statement has not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease."* *(3-16-04)*~~

~~*vi. The product must contain only naturally occurring ephedrine or ephedrine alkaloids and contain no hydrochloride or sulfate salts of ephedrine alkaloids. (3-16-04)*~~

~~*vii. The single serving or dosage must not contain more than twenty-five (25) milligrams of ephedrine alkaloids and the single serving or dosage must not contain ephedrine alkaloids in excess of five (5) percent of the total capsule weight. (3-16-04)*~~

~~*viii. Sale of the product to persons under the age of eighteen (18) is prohibited. (3-16-04)*~~

~~*ix. The product must not be marketed, advertised or represented in any manner for the indication of stimulation, mental alertness, euphoria, ecstasy, a buzz or high, heightened sexual performance or increased muscle mass. (3-16-04)*~~

~~*x. Manufacturers of the product must provide an analysis of the product to the Board of Pharmacy to ensure that the product meets the requirements of applicable laws. (3-16-04)*~~

~~*xi. The manufacturer, wholesaler, or other entity which first produces the product in Idaho or first brings the product into Idaho for sale or resale must register the product with the Board using the appropriate registration form provided by the Board and provide a one hundred dollar ($100) registration fee to the Board. Registration shall expire twelve (12) months after issuance. Registration shall be renewed for a twelve (12) month period upon receipt by the Board of a one hundred dollar ($100) renewal fee. The requirements to register and to pay a fee shall terminate upon the federal Food and Drug Administration's publication in the Federal Register of a final rule establishing good manufacturing practices for dietary supplements or five (5) years after the effective date of this rule, whichever date occurs first. Upon any violation of this rule or other applicable law, the Board may revoke the registration. (3-16-04)*~~

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO BOARD OF PHARMACY

DOCKET NO. 27-0101-0404

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-1717 and 54-1718, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed with no changes. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Volume 04-10, pages 467 through 469.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact R. K. “Mick” Markuson, Director, at (208) 334-2356.

DATED this 28th day of October, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 54-1717 and 54-1718, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and

purpose of the proposed rulemaking:

The proposed rule adds specific references to standards of conduct in the practice of pharmacy for reasonable and prudent practice of pharmacy as well as the duty of licensed pharmacists to report unprofessional conduct and to cooperate with investigations by the Board of Pharmacy. The rule then also denotes as unprofessional conduct the violation of these standards.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

No fee or charge is imposed or increased pursuant to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule revisions simply clarify existing policy and should not be controversial.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact R.K. "Mick" Markuson, Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 25th day of August, 2004.

R.K. "Mick" Markuson
Director
Idaho State Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

142. STANDARDS OF CONDUCT.

01. Duty to Cooperate in Investigation. It is the duty of every licensee to cooperate with a disciplinary investigation and any failure or refusal to do so is grounds for disciplinary action. ( )

02. Duty to Report Theft, Loss, or Adulteration. It is the duty of every pharmacist-in-charge or pharmacy director to report any theft or loss of controlled substances and any

adulteration of any prescription drug to the Board, even if the theft, loss, or adulteration has been accounted for and the employee disciplined internally. ( )

14~~2~~3. -- 150. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

184. CONDUCT, UNPROFESSIONAL.
The following acts or practices by a registered pharmacist or the owner of a pharmacy are declared to be specifically, but not by way of limitation, unprofessional conduct and conduct contrary to the public interest: (7-1-93)

01. General. Manufacturing, compounding, selling, dispensing, or permitting to be manufactured, compounded, sold or dispensed substandard drugs or preparations. (7-1-93)

02. Secret Formulas. Using secret formulas. (7-1-93)

03. Allowing a Commission or Rebate. Allowing a commission or rebate to a person writing or making or otherwise ordering a prescription, or providing consultant services at no charge to receive prescription business. (7-1-93)

04. Failure to Follow Instructions. Failing to strictly follow the instructions of the person writing or making or ordering a prescription as to refilling, content or label, or giving a copy of a prescription to any person without marking said prescription across the face: "Copy for Information Only. Not to Be Filled." (7-1-93)

05. Errors or Omissions. Failing to confer with the person writing, making or ordering a prescription, if there is an error or omission therein which should be questioned. (7-1-93)

06. Advertising. Advertising in a manner that is false, misleading or deceptive including material claims of professional superiority which cannot be substantiated. (7-1-93)

07. Addiction. Being addicted or habituated to the use of alcohol or controlled substances. (7-1-93)

08. Supplying to Unqualified Persons. Supplying or diverting drugs, biological, medicines, substances or devices which are legally sold in pharmacies, so that unqualified persons can circumvent laws pertaining to the legal sale of such articles. (7-1-93)

09. Fraudulent Practice. Performing or in any way being a party to any fraudulent or deceitful practice or transaction. (7-1-93)

10. Competency. Performing any duties as a pharmacist or pharmacy owner in an incompetent, unskilled or negligent manner. (7-1-93)

11. Unprofessional Conduct. Exhibiting unprofessional conduct towards customers, employees, colleagues, inspectors or others. (7-1-93)

12. Failure to Follow Orders. Failure to follow an order of the Board. (2-23-94)

13. Inappropriate Conduct. Any activity by a pharmacist which is inappropriate to the conduct of the profession of pharmacy. (2-23-94)

14. Discipline in Other States. Conduct which results in a suspension, revocation or other disciplinary proceeding or action with respect to a pharmacy or pharmacist license that the Idaho licensee holds in another state. (7-1-98)

15. Failure to Report Theft, Loss, or Adulteration. Failure of any pharmacist-in-charge or pharmacy director to report any theft or loss of controlled substances or any adulteration of any prescription drug to the Board even if the theft, loss, or adulteration has been accounted for and the employee disciplined internally. (____)

16. Failure to Cooperate in Investigation. Failure of any licensee to cooperate with a disciplinary investigation. (____)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO BOARD OF PHARMACY

DOCKET NO. 27-0101-0405

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2005 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-1717 and 54-1719, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed with no changes. The complete text of the proposed rule was published in the October 6, 2004 Idaho Administrative Bulletin, Volume 04-10, page 470.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact R. K. “Mick” Markuson, Director, at (208) 334-2356.

DATED this 28th day of October, 2004.

The Following Notice Was Published With The Proposed Rule

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 54-1717 and 54-1719, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 20, 2004.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and

purpose of the proposed rulemaking:

The rule extends the expiration date of prescriptions from one (1) year to fifteen (15) months. Medical professionals have indicated that an additional three (3) months added to prescription order expiration dates is necessary to give patients time to complete annual examinations, which medical insurance providers will not pay for until after the one-year anniversary from their prior examination.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: No fee or charge is imposed or increased pursuant to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the change is non-controversial and the request for this rule change from medical professionals came too late in the process to allow for negotiated rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact R.K. "Mick" Markuson, Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 27, 2004.

DATED this 25th day of August, 2004.

R.K. "Mick" Markuson, Director
Idaho State Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720, Boise, ID 83720-0067
Phone: (208) 334-2356 / Fax: (208) 334-3536

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

162. PRESCRIPTION EXPIRATION.
All prescription orders that are legally refillable must have the refill instructions indicated on the face of the prescription order. All prescription orders expire ~~*one (1) year*~~ fifteen (15) months after date of issue. For long term medication orders a new prescription must be obtained and a new file number issued. ~~*(7-1-93)*~~(____)