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Appendix A. Agency Professional, Provider Handbook Modifications ................. 128
Agency – Professional

This section covers all Medicaid options and health related services provided by Agency provider types and includes therapists, school districts, charter schools, developmental disabilities agencies (DDAs), Personal Assistance Agencies (PAA), DD Waiver service providers, and Aged and Disabled (A&D) Waiver service providers as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following areas:

- Developmental Disability Agencies
- District Health Department Services
- School-Based Services
- Nursing Agency-Private Duty Nursing (PDN)
- DD Targeted Service Coordination
- Children’s Service Coordination
- Children’s Habilitation Intervention Services (CHIS)
- Children’s Support Services
- DD Waiver Services
- Aged and Disabled Waiver Services
- Personal Care Services (PCS)
- Dental Services
- Transition Management

Standards of practice require the coordination of care with other agencies operating within the same service area and are not expected to replace or substitute services already provided by other agencies.

Should the handbook ever appear to contradict relevant provisions of Idaho or federal rules and regulations, the rules and regulations prevail. Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies’ Idaho Medicaid website. Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Handbook sections that always apply include the following:

- General Billing Instructions;
- General Information and Requirements for Providers; and
- Glossary.

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3.a The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3.a.

References are included throughout the handbook for provider and staff convenience. Not all applicable references are incorporated into the handbook. Not all references provided are equal in weight.

- Case Law: Includes references to court cases that established interpretations of law that states and providers are required to follow.
- CMS Guidance: These references reflect various Centers for Medicare and Medicaid Services (CMS) publications that Idaho Medicaid reviewed in the formulation of their
policy. The publications themselves are not required to be followed for Idaho Medicaid services except where noted.

- Federal Regulations: These references are regulations from the federal level that affected policy development. Usually these include the Code of Federal Regulations, the Social Security Act and other statutes. They are required to be followed.
- Idaho Medicaid Publications: These are communications from Idaho Medicaid to providers that were required to be followed when published. These are included in the handbook for historical reference. The provider handbook supersedes other communications unless the documents are listed in the Department’s Rules, Statutes, and Policies webpage under policies in Medicaid’s department library.
- Idaho State Plan: The State Plan is the agreement between the State of Idaho and the Centers for Medicare and Medicaid Services on how the State will administer its medical assistance program.
- Professional Organizations: These references reflect various publications of professional organizations that Idaho Medicaid reviewed in the formulation of their policy. Providers may or may not be required to follow these references, depending on the individual reference and its application to a provider’s licensure and scope of practice.
- Scholarly Work: These references are publications that Idaho Medicaid reviewed in the formulation of their policy. The publications themselves are not required to be followed for Idaho Medicaid services.
- State Regulations: These references are regulations from the state level that affected policy development. They usually include statute and IDAPA. They are required to be followed.
1. **Payment**

Federal and State requirements state that Medicaid is the “payer of last resort.” Third party payments must be pursued before billing Medicaid for Individuals with Disabilities Education Act (IDEA) related services, except for Part C.

Medicaid reimburses rehabilitative and health related services on a fee-for-service basis. Community-based outpatient behavioral health services (mental health-related services) are provided under a managed care structure administered by Magellan Healthcare, Inc. Please see [https://www.MagellanOfIdaho.com](https://www.MagellanOfIdaho.com) for more information.

Provider charges to Medicaid shall be based on reimbursement rates established by DHW for their specific provider type and specialty and shall not exceed the lowest charge of the provider to others for the same service, regardless of payment source.

Rehabilitation and health related services must be billed by providers using the appropriate procedure codes or health related service codes. The appropriate ICD-10-CM code is used for the diagnosis code based on dates of service. Procedure codes are included in the Current Procedural Terminology (CPT) manual® and the Healthcare Common Procedure Coding System (HCPCS) manual.

Developmental disabilities agency providers must check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho’s Medicaid primary care case management (PCCM) model of managed care. School-based service providers are exempt from HC referral numbers to be included on claims. If the participant is enrolled, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid covered services. See the [General Information and Requirements for Providers](https://www.idaho.gov/idaho/health/medicaid/prohibitions-and-requirements), Idaho Medicaid Provider Handbook for more information.

Medicaid covers interpretation services to assist participants who are deaf or have limited English proficiency (LEP) to receive services from a provider. Medicaid payment will be made to the provider when it is necessary for the provider to hire an interpreter in order to communicate with a participant when the provider is providing a direct service. For DD service plans, interpretation services are not prior authorized and should not be reflected as a cost.

2. **Share of Cost**

The [Nursing Home and Waiver Claim Review Request Form](https://www.idaho.gov/idaho/health/medicaid/prohibitions-and-requirements) is available online under [Forms](https://www.idaho.gov/idaho/health/medicaid/prohibitions-and-requirements). The form can be filled out online, saved, and e-mailed to idnursinghomes@gainwelltechnologies.com. [Nursing Home and Waiver Claim Review Request Form Instructions](https://www.idaho.gov/idaho/health/medicaid/prohibitions-and-requirements) to fill out the form are in the same location. All fields in the forms are [required](https://www.idaho.gov/idaho/health/medicaid/prohibitions-and-requirements).

3. **Determining How to Bill Units for 15 Minute Timed Codes**

Several CPT® and HCPCS codes used for evaluations, therapy modalities, procedures, and collateral contact specify that one unit equals 15 minutes. Provider’s bill procedure codes for services delivered using these codes and the appropriate number of units of service. For any single procedure code, providers bill one 15-minute unit for treatment greater than or equal to 8 minutes. Two units should be billed when the interaction with the participant or collateral contact is greater than or equal to 23 minutes, and less than 38 minutes. Time intervals for larger numbers of units are as follows.
The pattern remains the same for treatment times in excess of two hours. Providers should not bill for services performed for less than eight minutes. This time should be documented, though it may not be billed for that day unless additional service time occurs on that same day for the same participant. The expectation (based on work values for these codes) is that a provider’s time for each unit will average 15 minutes in length.

The above schedule of times is intended to provide assistance in rounding time into 15-minute increments for billing purposes. It does not imply that any minute until the eighth should be excluded from the total count, as the timing of active treatment counted includes all time. The beginning and ending time of the treatment must be recorded in the participant’s medical record with the note describing the treatment. (For additional guidance, please consult CMS Program Memorandum Transmittal AB-00-14.)


4. Developmental Disability Agencies

Developmental disabilities agencies provide:

- Developmental therapy services to adults with developmental disabilities
- Children’s Habilitation Intervention Services (CHIS)
- Children’s Home and Community Based Services State Plan Option

Services must be consistent with the needs of persons with developmental disabilities (DD) and as outlined on the participant’s required plan of service. See IDAPA 16.03.21 for rules and regulations regarding Developmental Disabilities Agencies (DDA).

This section describes the services DDAs provide to adults. For information on Children’s services that are provided by a DDA, see the Children’s Habilitation Intervention Services section.

4.1. DDA Services

4.1.1. Developmental Therapy (DT)

Developmental therapy is a service for adult participants with developmental disabilities which is directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of:

- Self-care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living
- Economic self sufficiency

Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life or is not likely to develop without training or therapy.
Developmental therapy may be provided in group or individual formats in the center, home, or community.

(a) Covered Service Limits

The maximum amount reimbursable in any calendar year for each participant for a combination of all evaluation, assessment, and diagnostic services billed by all therapy providers is four hours.

Developmental therapy must not exceed twenty-two (22) hours per week. When provided in combination with Community Supported Employment, Developmental therapy and Community Supported Employment must not exceed forty (40) hours per week. When a participant receives adult day care (health), the combination of adult day care (health) and developmental therapy must not exceed thirty (30) hours per week.

Participants living in a Skilled Nursing Facility must not receive Developmental Therapy. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home.

Developmental therapy may be provided seven days a week, as long as the hours per week do not exceed the 22-hour limit. When billing for services, bill for the calendar week from Sunday through Saturday. Services must be consecutive dates when billing a date span. Developmental therapy must be provided in accordance with IDAPA 16.03.10, Medicaid Enhanced Plan Benefits.

Only one (1) type of therapy is reimbursed during any single time period. No therapy service is reimbursed during periods when the participant is being transported to and from the agency. For specific therapy limitations, based on type of service, see the appropriate sections of these guidelines.

(b) Non-Covered Services

When delivering Developmental Therapy, the following services are excluded for Medicaid payments by a DDA:

- Vocational services
- Educational services
- Recreational services
- Tutorial activities or assistance with educational tasks associated with educational needs that result from the participant’s disability

4.2. Prior Authorization

Developmental disabilities agency services for adults require PA from Medicaid or its designee. When requesting PA, specify which service will be rendered.

A physician’s referral must be obtained for developmental disabilities agency services.

See General Billing Instructions, Idaho Medicaid Provider Handbook for more information on billing services that require PA.

4.3. Program Requirements

For assessment, plan, and record keeping requirements associated with Developmental Disabilities Agencies, see IDAPA 16.03.10, Medicaid Enhanced Plan Benefits, Sections 649 – 659, and 16.03.21.
The planning team must meet at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant.

4.3.1. Case Record Format
The case record must be divided into program and discipline areas identified by tabs, including plan of service, medical, social, psychological, speech, and developmental (as applicable).

(a) Record Keeping
To facilitate payment from Medicaid, DDA records must contain the following information on each participant:
- Profile sheet — including identifying information as consistent with IDAPA 16.03.21.
- Physician’s referral — for adult participants, a referral signed and dated by the physician for skilled nursing services under the adult DD waiver, and for developmental disabilities agencies’ services if they are anticipated to be part of the plan of service.
- Authorized plan of service.
- Medical, Social, and Developmental History — assessment containing relevant social information on the participant.
- History/physical — a medical history and physical examination completed and signed by a physician.
- Psychological or psychiatric assessment — if applicable for the participant.
- Intervention evaluation — if applicable for the participant.
- Other assessments — as applicable to provide safe and effective care.
- Program implementation plans — as required for the participant.
- Status Reviews.

5. District Health Department Services
This section is specific to services for which the district health department can bill Medicaid. These include family planning, pregnant women (PW) clinic, Child Wellness (or EPSDT) services, and immunizations.

5.1. Family Planning Services
Family planning includes counseling and medical services provided by a district health department. Specific items covered are services for diagnosis, treatment, and related counseling.

5.1.1. Contraceptive Supplies
Medicaid will pay for contraceptive supplies including prescription diaphragms, IUDs, implants, injections, contraceptive patches, and oral contraceptives.

5.1.2. Procedure Codes
All claims for services or supplies that are provided as part of a family planning visit must be billed with the appropriate CPT® or HCPCS codes and the FP modifier.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit, new patient (Family planning, brief exam)</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit, new patient (Family planning, interim visit)</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit, new patient (Family planning, yearly visit)</td>
</tr>
</tbody>
</table>
5.1.3. Reporting National Drug Codes (NDC)

Professional claims for medications reported with HCPCS codes must include the appropriate National Drug Code (NDC) from the label of the medication supplied, units dispensed, and basis of measurement for each medication. This requirement applies to professional claims submitted electronically and on CMS-1500 claim forms. The HCPCS medications that require NDC information are listed in the current Healthcare Common Procedure Coding System (HCPCS) Manual, Appendix 1, alphabetically by both generic brand or trade name with corresponding HCPCS codes.

The collection of the NDC information is a federal requirement for all state Medicaid programs, and allows Medicaid programs to collect rebates due from drug manufacturers. This results in a significant cost saving to Idaho’s Medicaid program.

5.1.4. Diagnosis Codes

Any family planning service(s) should include a family planning diagnosis.

5.2. Child Wellness Exams

Complete information regarding child wellness exams is located in the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook. Child wellness exams are often referred to as EPSDT screens.

5.3. Immunization Program

Most vaccines provided come through the Vaccines for Children (VFC) Program from DHW, Division of Health. However, on limited occasions when the vaccine is not available from the VFC Program, the district must purchase vaccines. Vaccine administration should conform to the Advisory Committee on Immunization Practices (ACIP) guidelines for vaccine use. See Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook or http://www.cdc.gov/vaccines/acip/ for more information.
5.3.1. Administration Only of a Provider Purchased Injectable/Vaccine to a Participant with Medicare or Other Primary Payer

When billing for a participant who has both Medicare or private insurance and Medicaid, bill Medicare/private insurance first using its billing instructions. If Medicare or the other primary payer combines payment for the administration with the cost of the injectable, a separate administration fee may not be charged.

5.3.2. Administration of an Injection that is Part of a Procedure

Medicaid will not pay the administration fee when an injection is administered that is part of a procedure (e.g., allergy injections, therapeutic and diagnostic radiology, etc.).

5.4. Pregnant Women (PW)

Some district health departments are also PW clinics. They must be Medicaid-approved providers and meet the conditions for presumptive eligibility (PE) of pregnant women. A special agreement is signed between DHW and the district health department. The district health department should only utilize personnel who have attended a DHW-sponsored training program for PE qualified providers. Approved providers must be trained and certified by DHW.

5.5. Sexually Transmitted Disease (STD)

District health departments bill for STD services. Services that are free of charge to the general public cannot be billed to Medicaid. Payment is allowed if a sliding fee schedule is used.

5.6. Home Visiting

Home Visiting is an Idaho Medicaid benefit targeted to vulnerable children whose parents could use education and support on a variety of parenting topics. This service is provided through Public Health Districts (PHD) to eligible individuals.

5.6.1. Provider Qualifications

Providers that are certified in either the Parents as Teachers (PAT) or Nurse-Family Partnership (NFP), evidence-based home visiting models, are eligible to participate in the Idaho Medicaid Program. Services must be delivered according to the model in which they are certified. Providers must be enrolled with Idaho Medicaid prior to providing services and submitting claims and meet all requirements of the Division of Medicaid.

(a) References: Provider Qualifications

(i) Idaho State Plan


5.6.2. Eligible Participants

Infant/child participants under five (5) years of age and pregnant women at risk for abuse, neglect, and possible Child Welfare involvement may qualify for receive Home Visiting. To
qualify to receive this service, participants must meet three (3) or more of the priority criteria listed below:

- Families who reside in communities in need of such services, as measured by elevated concentrations of:
  - Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;
  - Poverty;
  - Crime;
  - Domestic violence;
  - High rates of high-school drop-outs;
  - Substance abuse;
  - Unemployment; or
  - Child maltreatment;
- Families with pregnant individuals under age 21;
- Families with a history of child abuse or neglect or prior interactions with child welfare services;
- Families with a history of substance abuse or who need substance abuse treatment;
- Families with users of tobacco products in the home;
- Families with children demonstrating low student achievement;
- Families with children with developmental delays or disabilities; and
- Families with individuals who are serving or formerly served in the Armed Forces, including such families with members of the Armed Forces who have had multiple deployments outside of the United States.

Services are provided to the parents of participants who meet the criteria above. A parent is defined as a person who resides with the participant, provides day-to-day care, is authorized to make healthcare decisions for the participant, and is:

- The participant’s natural or adoptive parent;
- A person, other than a foster parent, who has been awarded legal custody of the participant; or
- A person legally obligated to support the participant.

Additionally, participants must reside in one of the following counties to receive this service: Ada, Bannock, Bonner, Bonneville, Canyon, Clearwater, Jerome, Kootenai, Nez Perce, Power, Shoshone, or Twin Falls.

(a) References: Eligible Participants

(i) Idaho State Plan


5.6.3. Covered Services and Limitations

Home Visiting includes the initial assessment and annual reassessment of an individual to determine the need for any medical, educational, social, or other services. More frequent assessments may be done if medically necessary. Assessment activities include taking client history, identifying the individual's needs, completing related documentation, and gathering information from other sources such as family participants, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
This service also includes the development and periodic revision of a specific care plan that is based on the information collected through the assessment which identifies a course of action to respond to the assessment needs of the eligible individual. This plan must specify the goals and actions to address the medical, social, educational, and other services needed by the individual. It must include activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual’s authorized health care decision-maker) and others to develop those goals.

Additionally, this service includes referral and related activities to help the individual obtain needed services, including activities that help link an individual with medical, social, and educational providers or other programs capable of providing needed services. This includes making referrals to providers for needed services and scheduling appointments for the individual.

Furthermore, this service includes monitoring and follow-up activities including activities and contact necessary to ensure the care plan is implemented to adequately address the individual’s needs. These activities, and contact, may be with the participant, their family members, providers, and other entities or individuals. These activities may be conducted as frequently as necessary, but must include at least one (1) annual monitoring to assure that the following conditions are met:

- Services are being furnished in accordance with the individual’s care plan;
- Services in the care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

Home Visiting does not include when the case management activities are an integral and inseparable component of another covered Medicaid service. Additionally, it does not include when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, or services such as, but not limited to, the following:

- Research gathering and completion of documentation required by the foster care program;
- Assessing adoption placements;
- Recruiting or interviewing potential foster care parents;
- Serving legal papers;
- Home investigations;
- Providing transportation;
- Administering foster care subsidies; and
- Making placement arrangements.

(a) References: Covered Services and Limitations

(i) Federal Regulations

(ii) Idaho State Plan


5.6.4. Prior Authorization

See the General Billing Instructions, Idaho Medicaid Provider Handbook, for information regarding prior authorizations.

5.6.5. Documentation Requirements

All documentation must follow standard retention requirements including, but not limited to, those listed in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

Documentation must be made available to Department personnel acting in their official capacity immediately upon request. Services without documentation are not eligible for reimbursement. Providers should only submit records requested by the Department. Documentation sent unsolicited, or not for a service requiring prior authorization, will not be reviewed by the Department. Unreviewed documentation does not constitute approval or authorization of a service.

All Home Visiting providers must maintain records for each participant served. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services. For each participant, the following program documentation is required for each visit made or service provided to the participant:

- The dates of the case management services;
- The name of the provider agency and the person providing the case management services;
- The nature, content, and units of the case management services received, and whether goals specified in the care plan have been achieved;
- Whether the individual has declined services in the care plan;
- The need for, and occurrences of, coordination with other case managers;
- A timeline for obtaining needed services; and
- A timeline for reevaluation of the plan.

(a) References: Documentation Requirements

(i) Federal Regulations


(ii) Idaho State Plan

(iii) State Regulations


5.6.6. Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Idaho Medicaid reimburses Home Visiting on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. See the Numerical Fee Schedule for more information regarding reimbursement rates.

Home Visiting is reimbursed as one (1) encounter per visit (at least one (1) documented home visit with the eligible enrollee’s family and may include any number of documented contacts with other individuals or agencies identified through the care planning process). Reimbursement cannot exceed one (1) encounter per day. A single direct-interaction home visit typically lasts approximately one (1) hour. Home Visiting is limited to 20 encounters per year without prior authorization.

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<th>CPT® Code</th>
<th>Modifier</th>
<th>Description</th>
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<tr>
<td>T1017</td>
<td>UK</td>
<td>Targeted Case Management, per encounter</td>
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Reimbursement by Medicaid is only available if there are no other third parties liable to pay for such services, such as reimbursement under the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) or any other medical, social, educational, or other programs, except for case management that is included in an individualized education program or individualized family service plan. Public Health Districts cannot bill Medicaid on top of funding received under the MIECHV grant for the same encounter. Public Health Districts are responsible to track staff time and expenses associated with encounters and ensure Medicaid is not billed if any specific and identifiable expense is reimbursed by a third party for the same encounter.

See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

(a) References: Reimbursement

(i) Idaho State Plan

6. School-Based Services

Enrolled school districts and charter schools may receive Medicaid reimbursement for rehabilitative and health related services. School districts and charter schools may bill for the following services provided to eligible participants when ordered, recommended or referred by a physician or other practitioner of the healing arts (physician’s assistant, nurse practitioner, or clinical nurse specialist licensed by the state of Idaho). School-based services must be provided, or under the supervision of the qualified professionals as indicated for each service.

- Behavioral Consultation
- Behavioral Intervention
- Children’s Habilitative Intervention Services (CHIS)
- Crisis Intervention
- Evaluation and Diagnostic services; evaluations completed for educational services only cannot be billed
- Interdisciplinary Training
- Interpreter services (See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook)
- Medical equipment and supplies
- Speech Language Pathology (SLP), Audiology, and evaluation
- Occupational therapy (OT) and evaluation
- Personal care services (PCS)
- Physical therapy (PT) and evaluation
- Psychological evaluation
- Psychotherapy
- Skills Building/Community Based Rehabilitation Services (CBRS)
- Skilled nursing services
- Social history and evaluation
- Developmental evaluations
- Transportation services

Some services have supervision requirements. The school must have documentation that supports these requirements. The documentation must include information about the activities that took place during the supervision time.

*The Idaho Bureau of Educational Services for the Deaf and the Blind (IBESDB) is able to receive Medicaid reimbursement for Speech Therapy services for Medicaid-eligible students who meet rule requirements for the services, and who attend the IBESDB Regional/Outreach Preschool, Kindergarten, and first grade direct instruction programs throughout the state of Idaho. IBESDB will work in partnership with the home schools of the child to assure compliance with Medicaid requirements.

6.1. Interpretive Services

Medicaid covers interpretive services provided in a school to assist participants who are deaf or who do not speak or understand English when receiving a Medicaid service. Refer to the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information.

6.2. Related Services Definition

Related services are defined as the covered rehabilitative and health related services listed in IDAPA 16.03.09.853, School-Based Services – Coverage and Limitations, which are provided...
by school districts and charter schools to certain participants with disabilities who are enrolled in the Idaho Medicaid Program.

Eligibility for Medicaid reimbursement is determined using State Department of Education minimum eligibility criteria and assessment procedures (IDAPA 08.02.03, Rules Governing Thoroughness). In addition, each health-related service has its own eligibility determination requirements as identified in IDAPA.

### 6.3. School Districts and Charter Schools Eligibility

To be eligible for medical assistance reimbursement for covered services, a participant must:
- Be identified as having an educational disability and be eligible for special education.
- Have an individualized education plan (IEP), transitional individualized family service plan (IFSP) when the child turns three (3) years old, or services plan (SP) which indicates the need for one or more medically necessary health-related services.
- Be 21 years of age or younger and the semester in which their twenty-first birthday falls is not finished.
- Be eligible for Medicaid.
- Be eligible for the service for which the school district or charter school is seeking reimbursement.
- Be served by a school district or charter school.

The school must obtain a one-time consent to access public benefits or insurance from a parent or legal guardian.

### 6.4. Evaluations

All evaluations must support services billed to Medicaid. Evaluations must be completed at least every three (3) years and updated as needed while accurately reflecting the participant’s current status. Evaluations must include the following information:
- Be directed toward a diagnosis
- Recommended interventions for identified needs
- Dated signature of professional completing the evaluation

### 6.5. Evaluation and Diagnostic Services

Evaluations must be recommended or referred by a physician or other practitioner of the healing arts (nurse practitioner, physician’s assistant, clinical nurse specialist) prior to seeking reimbursement for the evaluation. Evaluations completed for educational services only cannot be billed.

In accordance with 42 C.F.R. §440.345(a), school districts or charter schools can receive reimbursement for early periodic screening, and diagnostic and treatment services for children under the age of 21. Services may include eligibility evaluations for children under the age of three (3) years who are transitioning from part C to part B of the Individuals with Disabilities Education Act (IDEA).

### 6.6. Record Keeping

The school district or charter school records must contain the following information on each participant:
- Referrals or recommendations
- Evaluations
- Individualized education program (IEP), individualized family service plan (IFSP), or services plan (SP)
• Service detail report(s)
• Other documentation as listed in the section titled Other Required Documentation. Documentation must be generated at the time of service and be available for immediate access for review and copying by the Department and its authorized agents during normal business hours.
• Each participant may have one service detail report with all therapy types included or the school district or charter school may choose to keep a separate document for each therapy type for the individual participant. The service detail report must clearly identify the type of service provided.

6.6.1. Order/Recommendations
A physician or other practitioner of the healing arts order or recommendation should be located in the participant’s file, or the physician may sign the IEP/IFSP/SP for evaluations and services billed to Medicaid. A physician’s order or recommendation is required for services and/or evaluations and must be signed and dated prior to providing services billed to Medicaid. It is preferred that the order or recommendation is from the participant’s primary care provider (PCP) if the participant is on the Healthy Connections Program; however, it is not required. For OT/PT/SLP “order” requirements, please refer to IDAPA 16.03.09.733.

6.6.2. Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP)/Services Plan (SP)
The IEP/IFSP/SP must include the type, frequency, and duration of the service(s) provided, the title of the provider(s), including the direct care staff delivering services under the supervision of the professional, and the specific place of service, if provided in a location other than the school.

The IEP/IFSP/SP must also contain measurable goals when required for the service, for each of the identified needs. Goals must be updated to reflect the current therapy, or service that is being provided and billed to Medicaid.

6.6.3. Service Detail Report (SDR)
An SDR must be completed at the time the service was provided. The SDR must include:
• Name of the participant
• Name, title, and signature of the person providing the service
• Date, start time and end time of the service, and duration of the service
• Category of service (i.e., Group Behavioral Intervention by a paraprofessional, Individual Speech Therapy by a Professional)
• Brief description of the specific areas addressed
• Place of Service, if provided in a location other than the school
• Student’s response to the service when required for the service

Documentation must be generated at the time of service and be available for immediate access for review and copying by the Department and its authorized agents during normal business hours.

6.6.4. Other Required Documentation
To support the claims to Medicaid, the school district and charter school must also maintain records that:
• Document participant reviews and/or re-evaluations and any amendments made to the treatment plan by the appropriate professionals. Documented review of progress toward service goals must occur at least every 120-days. The 120-day reviews are considered part of the oversight requirements and are not billable separately.
• Document supervisory visits (which are required to include the activities that took place during the supervision), that are conducted by professionals when paraprofessionals are utilized.
• Document Agency Provider Qualifications, including required certificates, licenses, and resumes indicating qualifications for position held.
• Document that the school district or charter school notified the participant’s parents of the health-related services and equipment that the school district intended to bill to Medicaid. Notification must describe the services, service providers, and state the type, location, frequency and duration of the services.
• Document that the school district or charter school requested the name of the student’s primary care physician and requested a written consent to release and obtain information between the primary care physician and the school.
• Document delivery of evaluations and plans to other community and state agencies if the school district or charter school has obtained a written consent to obtain and release the information.

6.6.5. Excluded Services
Under the Medicaid rules in IDAPA 16.03.09.853.01, School-Based Services – Coverage and Limitations, the following services are excluded from payment:
• Vocational services
• Educational services
• Recreational services
• Services provided to students who are inpatients in nursing homes or hospitals

6.7. Provider Staff Qualifications
Medicaid reimburses for services provided by qualified professionals. The qualifications for providers of covered services are identified in, IDAPA 16.03.09.855, School-Based Services – Agency Provider Qualifications and Duties.

6.7.1. Paraprofessionals
Paraprofessionals for behavioral intervention must be a least eighteen (18) years of age and demonstrate the knowledge and have the skills needed to support the program. They also must meet the paraprofessional requirements to be considered “highly qualified,” which means that the paraprofessional has completed 32 college credit hours or has passed a paraprofessional praxis test to show competency.

The schools may use paraprofessionals to provide occupational therapy (OT) and speech-language pathology (SLP) as long as they are under the supervision of the appropriate professional and are in compliance with the different therapy’s licensing rules for qualifications, supervision and service requirements.

The services provided by paraprofessionals must be delegated and supervised by a professional therapist as defined by the appropriate licensure and certification rules. The portions of the IEP/IFSP/SP, which can be delegated to the paraprofessional, must be identified in the IEP/IFSP.
Requirements for the supervision of paraprofessionals are described in the professionals licensing and certification rules:

- **Occupational Therapy** - *IDAPA 24.06.01, Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants.*

- **Speech-Language Pathology** - *IDAPA 24.23.01, Rules of the Speech, Hearing and Communication Services Licensure Board.* SLP must possess a certificate of clinical competence (CCC) from the American Speech-Language-Hearing Association (ASHA) and therefore must also comply with ASHA guidelines with the oversight requirements of paraprofessionals.
  - SLP paraprofessionals supervision must be provided by an SLP professional who has a state license from Idaho Bureau of Occupational Licenses and their CCC’s from ASHA or within one year of receiving their ASHA CCC’s. The professional must observe and review the direct services performed by the paraprofessional on a monthly basis, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the SLP service. The school must have documentation of the supervision and what the professional observed and reviewed during their supervisory visit.

Behavior intervention paraprofessionals must be supervised monthly by the behavioral intervention professional or behavioral consultant based on *IDAPA 16.03.09.854*. The school must have documentation of the supervision and what the professional observed and reviewed during their supervisory visit.

Paraprofessionals may not conduct participant evaluations or establish/adjust the IEP/IFSP/SP goals. A participant’s goals must be reviewed and/or re-evaluated by the appropriate professional and the IEP/IFSP/SP adjusted as the professional’s individual practice dictates.

Any change in the participant’s condition that is inconsistent with planned progress or treatment goals necessitates a documented re-evaluation by the professional before further treatment is carried out.

### 6.8. Estimated Annual Expenditure Match

The school district or charter school is responsible for certification of the state match portion of the Medicaid payment. The state match is calculated at the Federal Financial Participation (FFP) rate effective for the current federal year.

The school district or charter school must annually calculate and document, as part of their fiscal records, the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. Federal funds cannot be used as the state’s portion of match for Medicaid service reimbursement. This documentation needs to include only the amount of dollars that have been certified and where the dollars originated. It is not necessary to designate how the dollars were spent for the purpose of certifying the match.

The appropriate matching funds will be handled in the following manner:

- **Schools** will estimate the amount needed to meet match requirements based on their anticipated monthly billings.

- **School districts** will send DHW the matching funds, either by check or ACH electronic funds transfers.

- **Matching funds** will be held in an interest-bearing trust account. The average daily balance during a month must exceed $100 in order to receive interest for that month.

- **The payments to the districts** will include both the federal and non-federal share (matching funds).
• Matching funds from the district cannot be from federal funds or used to match any other federal funds.
• Checks should be sent to DHW at the following address:
  Department of Health and Welfare
  Management Services Business Office
  PO Box 83720
  Boise, ID 83720-0036
  (208) 334-5909
• Contact the Fiscal Operations Supervisor at the above address if the school district wants to make electronic fund transfer payments for the matching funds.
• Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle.
• If sufficient matching funds are not received in advance, all Medicaid payments to the school district or charter school will be suspended and the school district or charter school will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed, and reimbursement will be made during the next payment cycle.

Medicaid will provide the school districts or charter schools a monthly statement showing the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. The school districts or charter schools will estimate the amount of their next billing and the amount of matching funds needed to pay DHW. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. If the school district or charter school has any questions, please direct those questions to the Fiscal Operations Supervisor.

6.9. Payment for Services
Payment for school districts’ or charter schools’ health related services must be in accordance with Medicaid established rates. Providers must accept DHW’s payment as payment in full. Providers may not bill Medicaid participants for the balance.

A contracted provider of the school program may not submit a separate claim to Medicaid as the performing provider for services billed under the school district or charter school’s provider number.

Failure to provide services for which reimbursement has been received or to comply with these rules and regulations established by DHW is cause for recoupment of the federal share of payments for services, sanctions, or both.

Providers must give DHW immediate access to all information required to review compliance with these rules and regulations.

Federal and State requirements state that Medicaid is the “payer of last resort.” This means that if an individual has private insurance as well as Medicaid, any third-party payments must be pursued before billing Medicaid. School-based services are also subject to billing private insurance for individuals who have this coverage for Individuals with Disabilities Education Act (IDEA) related services, in accordance with 34 CFR §300.154(d).

6.10. Prior Authorization (PA)
Prior authorization is required for certain medical equipment and supplies. See the Suppliers, Idaho Medicaid Provider Handbook guidelines for additional information.
Prior authorization will be based on a determination of medical necessity made by DHW or its
designee. If PA is required, the PA number must be included on the claim line. See the General
Billing Instructions, Idaho Medicaid Provider Handbook for more information on billing services
that require PA.

6.11. Procedure Codes
All claims submitted must contain a 5-digit health related service procedure code for billing.
Please see the School Based Services Fee Schedule for covered services. Diagnosis codes
must be specific to the student’s health condition that qualifies them to receive services and
allows the school to receive Medicaid reimbursement. Treatment must be provided in
accordance with the IEP/IFSP/SP. All providers must document all evaluations, IEP/IFSP/SP,
and other required services to be paid.

6.12. Place of Service (POS) Codes
School-based services can only be provided in the following POS:
03 School
99 Other

6.13. Medicaid Reimbursable Health Related Services
6.13.1. Behavioral Intervention/Behavioral Consultation
Medicaid reimbursement for behavioral intervention and behavioral consultation is limited to
those participants who have a developmental disability (DD) according to IDAPA 16.03.10,
501-503 Medicaid Enhanced Plan Benefits; and exhibit maladaptive behaviors that include
frequent disruptive behaviors, aggression, self-injury, criminal or dangerous behavior, and
exhibit maladaptive behaviors that interfere with their ability to access an education.

Behaviors are evidenced by a score of at least one point five (1.5) standard deviations (SD)
from the mean in at least two (2) behavior domains and by a rater familiar with the
participant, or at least two (2) standard deviations from the mean in one (1) composite score
that consists of at least three (3) behavior domains by a rater familiar with the participant,
on a standardized behavioral assessment approved by the Department.

The approved eligibility assessments for Medicaid behavioral intervention and consultation
services can be found at www.sbs.dhw.idaho.gov.

Behavioral intervention (BI) includes individual or group services.
• Group BI services must be provided by one qualified staff providing direct services to
  a maximum of three students.
• As the number and severity of the student with behavioral issues increases, the staff
  participant ratio must be adjusted accordingly.
• Group services should only be delivered when the child’s goals relate to benefiting
  from group interaction.

Participants who are eligible for behavioral intervention can receive both individual and group
services in the same day. If a participant receives both of these services, they must be
provided at different times during the day. Individual and group behavioral intervention must
include measurable goals identified on the IEP/IFSP/SP that relate to the (specific) individual
or group setting.
Behavioral consultation must be identified on the IEP. Behavioral consultation can be identified as an “as needed” service based on the needs of the participant.

6.13.2. Skills Building/Community Based Rehabilitation Services (CBRS)/School-Based Service

Medicaid reimbursement for individual and group CBRS in a school is limited to those participants who meet eligibility criteria outlined in IDAPA 16.03.09.852.01, Medicaid Basic Plan Benefits; School-Based Service: Service Specific Participant Eligibility.

- A student who is under 18 years of age must meet the Serious Emotional Disturbance (SED) eligibility criteria for children in accordance with the Children’s Mental Health Services Act, Section 16-2403, Idaho code. This criteria includes documentation of a medical mental health condition from a professional that can diagnose within their scope of practice and license, in addition, the school must obtain or conduct a Department approved assessment that identifies substantial impairment of functioning in family school or community. The approved eligibility assessments for Medicaid CBRS can be found at www.sbs.dhw.idaho.gov.

The assessment utilized to identify the substantial impairments must be obtained or conducted at least annually to determine continued eligibility for the service.

- A student who is 18 years or older must meet the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student meet the criteria for SMI, as described in 42 CFR 483.102(b)(1) and meet requirements set forth in IDAPA 16.03.09.852.01.b. The school must have documentation that supports eligibility requirements.

Refer to the School-Based Services fee schedule for covered codes. CBRS are interventions that reduce the student’s disability by assisting in gaining and utilizing skills necessary to participate in school. CBRS are not Medicaid billable for time spent observing the students with no interventions being provided.

6.13.3. Nursing Services/School-Based Service

Nursing services must include a health care plan that describes the services for which the school is receiving Medicaid reimbursement. Nursing services do not include tasks that can be delegated by a registered nurse (RN) to unlicensed assistive personnel.

6.13.4. Personal Care Services (PCS)/School-Based Service

Personal care services include medically oriented tasks related to the participant’s physical or functional requirements. Personal care services must be:

- Authorized based on the results of a PCS Assessment and PCS Allocation Tool approved by the Department to determine eligibility and number of hours for the child. These are located on the Medicaid School-Based Services website at www.sbs.dhw.idaho.gov.
- Based on a health care plan that has been developed by an RN.
- Supervised and monitored by an RN, which must be documented. Personal care service providers must complete all required records to receive Medicaid reimbursement.

To demonstrate compliance for PCS activities, the school must show an actual start time for the first PCS of the day, and an actual end time of the last PCS for the day on the service detail report. The school’s data will need to support the duration for which the school is billing Medicaid. Personal care services do not require a goal on the IEP.
Family Personal Care Services (FPCS) are not eligible under School-Based Services.

6.13.5. Transportation/School-Based Service

Medicaid reimbursement for transportation services can only be billed when:

- The participant requires special transportation assistance, a wheelchair lift, an attendant, or both.
- The transportation occurs in a vehicle specially adapted to meet the needs of a participant with a disability.
- The participant receives another Medicaid reimbursable service on the day the transportation is being provided.

Special transportation assistance can include a wheelchair lift or an attendant when the attendant is needed for the health and safety of the participant. Both the Medicaid covered service and the need for transportation must be included on the IEP/IFSP/SP. Attendant services is a one-to-one service, one staff to one participant; attendant care is not a group service.

Medicaid payments for transportation from home to school or from school to home are available for school-aged children who are receiving a Medicaid reimbursable service from the school.

<table>
<thead>
<tr>
<th>HCPC</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2001</td>
<td>Non emergency transportation, patient attendant/escort. Specify exact time. 1 Unit = 15 Minutes.</td>
</tr>
<tr>
<td>A0080</td>
<td>Non-emergency Non-Medical transportation, per mile, vehicle provided by volunteer (individual or organization), with no vested interest. Specify number of miles from pick-up to delivery. Prior Authorization for waiver service required. 1 unit = 1 mile</td>
</tr>
</tbody>
</table>

6.13.6. Medical Equipment and Supplies/School-Based Service

Authorization is limited to equipment and supplies primarily used and medically necessary for an individual participant within the school setting as indicated by the IEP or IFSP. When necessary, authorization may also be given for equipment and supplies that are used in both the home and the school but are too large to transport back and forth or would be unsafe or unsanitary to transport back and forth. Other equipment and supplies (such as wheelchairs, diapers, dressing supplies, or catheters) which are used primarily at home, but also at school, are the responsibility of the primary caretakers to obtain and provide to the school.

Medical equipment and supplies which have been paid for by Medicaid funds are for the exclusive use of the participant for whom they were ordered or billed. If the participant transfers to another school or leaves the school at which the equipment or supply was obtained, the supply or equipment must be transferred with the participant.

6.13.7. Therapy Services

Requirements for and Audiology professional services: please refer to the Audiology Services, Idaho Medicaid Provider Handbook.
Requirements for Speech-Language Pathology, Occupational Therapy and Physical Therapy services: please refer to the Therapy Services, Idaho Medicaid Provider Handbook.

7. Nursing Agency-PDN

Private Duty Nursing Services are limited to certain eligible children for whom the need for such service has been identified. The medical needs of the child must be such that the Idaho Nurse Practice Act requires the services be provided by a licensed nurse.

**Note:** Nursing services are a covered benefit for Medicaid Enhanced Plan participants.

7.1.1. Family Participation

Families are expected and encouraged to participate in the provision of care.

7.1.2. Agency Provider Qualifications

All nursing providers must be currently licensed as either an RN or LPN in Idaho and have a signed provider agreement on file with Idaho Medicaid. Nursing service providers must provide documentation of current Idaho licensure as an RN or LPN.

7.1.3. Provider Agency

The provider agency is an entity that takes responsibility for the care given and provides payroll and benefits to those care providers it employs. The entity must have a signed provider agreement on file with Idaho Medicaid.

7.2. Covered Services

Private duty nursing services are limited to the following services. The services require oversight by a Registered Nurse (RN) if provided by a Licensed Practical Nurse (LPN):

- **NG Tubes:** Nasogastric (NG) tubes include insertion and maintenance of NG tubes and participant feeding activities with or without the use of a feeding pump.
- **Volume Ventilators:** The maintenance of volume ventilators includes associated tracheotomy care when necessary.
- **Tracheotomy and Oral/Pharyngeal Suctioning:** Sterile suctioning and cleansing of the participant’s airway and removal of excess secretions from the mouth, throat, and trachea.
- **IV Therapy/Parenteral Nutrition:** Maintenance and monitoring of an IV site and administration of IV fluids and nutritional materials, which require extended time to administer.

7.2.1. Plan of Care (POC)

All services provided on an implementation plan are based on a written plan of care. The Supervisory RN is responsible for the POC, based on:

- The nurse’s assessment and observation of the participant.
- The evaluation and orders of the participant’s physician.
- Information elicited from the participant.

The POC must be approved and signed by the physician. It must also include all aspects of the medical, licensed, and personal care necessary to be performed, including the amount, type, and frequency of such services.
7.2.2. Plan of Care (POC) Update
The POC must be revised and updated based on treatment results or the participant’s changing profile of needs as necessary, but at least annually. A copy of the POC must remain in the participant’s home.

Submit annual updates and changes to the POC to Medicaid in the region in which the child lives. See the Directory, Idaho Medicaid Provider Handbook for the current regional address and phone number.

7.2.3. Prior Authorization (PA) of Services
Medicaid must authorize all private duty nursing (PDN) services prior to service delivery. The authorization will indicate the hours of service per quarter for which the service is authorized.

The decision to use a Registered Nurse (RN) or Licensed Practical Nurse (LPN) is dependent on the medical needs of the participant and the type of services required, and it must be consistent with the scope of nursing practice. This decision will ultimately be made by the Medicaid nurse reviewer who will take the opinion or input of the agency nurse into consideration before making the final decision.

Functions of a LPN can be found within the legal definition of licensed practical nurse, Section 54-1402(3), Idaho Code, (Nursing Practice Act) as well as in the Rules of the Idaho Board of Nursing, IDAPA 24.34.01, Section 200 “Practice Standards” and 54-1407 “Licenses for Practical Nursing.”

7.2.4. Non-Covered Services: Transportation
Medical transportation of the participant, such as to the physician’s office, is not a covered service under the private duty nursing program but may be covered under the Non-Emergency Medical Transportation (NEMT) service.

Contact Medicaid Transportation for transportation questions at 1 (800) 296-0509.

7.3. Nursing Oversight
Nursing oversight is the intermittent supervision of the child’s medical condition for health status or medical services within the scope of the Nurse Practice Act and must be provided when an LPN is giving the care. Nurse oversight services must be provided by an RN licensed to practice in Idaho. The services are limited to one time per month. If additional oversight visits are medically necessary, prior authorization can be requested from Medicaid.

7.4. Nurse Responsibilities
The nurse’s responsibilities are as follows:
• Immediately notify the physician of any significant changes in the participant’s physical condition or response to the service delivery.
• Evaluate changes of condition.
• Provide services in accordance with the POC.
• Maintain records of care given to include the date, time of start and end of service delivery, services provided, and comments on participant’s response to services delivered.
• LPN providers must document oversight of services by an RN in accordance with the Idaho Nurse Practice Act and the Rules, Regulations, and Policies of the Idaho Board of Nursing.
7.5. Physician Responsibilities
All Private Duty Nursing services must be provided under the order of a licensed physician.

The physician must:
• Provide to Medicaid the necessary medical information to establish the participant’s medical eligibility.
• Order all services to be delivered by the nursing provider.
• Sign and date all orders and the participant’s POC.
• Update participant’s POC annually and, as changes are indicated, sign and record the date of plan approval.
• Determine if the combination of nursing services along with other community resources are no longer sufficient to ensure the health or safety of the participant and recommend institutional placement of the participant.

Note: If the child is enrolled in the HC program, the order must be from the HC PCP.

7.6. Reimbursement
The nursing provider or agency providing oversight is paid a fee-for-service as established by Medicaid. Separate claims for payment must be submitted for each provider. Refer to the Idaho Medicaid Fee Schedule library and the Personal Assistance Agencies (PAA) Services fee schedule for covered codes.

7.6.1. Registered Nurse (RN)
An RN can provide either oversight of an LPN or direct care.

7.6.2. Private Duty Nursing (PDN) Provider
Payments are limited to the services specified on the POC on file with Medicaid.

7.7. Record Keeping
Private duty nurses or nursing agencies maintain service records on each participant receiving nursing services. The record will be accessible in the participant’s home. After every visit, the provider will enter, at a minimum, the following information:
• The date and time of visit in the following format.
  
  Date — Example — 02/10/2005
  
  Time Example — 8:00 a.m. - 11:15 a.m.
• The length of visit in the following format.
  
  Example — 3 hours and 15 minutes would be 3.25 hours
• The services provided during the visit.
• A statement of the participant’s response to the services, including any changes noted in the participant’s condition.
• Any changes in the POC authorized by the referring physician as a result of changes in the participant’s condition.
• Signature and credentials of the individual providing services.

7.7.1. Transfer to Another Provider
When the care of the participant is transferred to another provider, all participant records must be delivered to and held by the participant’s family until a replacement provider assumes the case. When the participant leaves the program, the records are retained by the provider as part of the participant’s closed case record.
7.7.2. Change in Participant Status
It is the responsibility of the private duty nurse to notify the physician when there is a significant change in the participant’s condition. Physician notification must be documented in the service record.

7.8. Place of Service (POS) Codes
PDN services may only be provided in a participant’s personal residence.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>99</td>
<td>Other – unlisted facility</td>
</tr>
</tbody>
</table>

The following places are excluded as personal residences:
- Licensed Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF)
- Licensed Intermediate Care Facility for People with Intellectual Disabilities (ICF/IID)
- Licensed shelter homes
- Licensed professional foster homes
- Licensed hospital

8. DD Targeted Service Coordination

8.1. Definition
Please refer to the Idaho Administrative Rules Web site for the most recent final published rules.

DD targeted service coordination is delivered by qualified providers to assist Medicaid participants who are unable or have limited ability in gaining and coordinating access to, necessary care and services. See IDAPA 16.03.10.720 through 736 for rules regarding targeted service coordination. DD targeted service coordination services are limited to adults with Developmental Disabilities enrolled in the Medicaid Enhanced Plan.

Service coordination is a brokerage model of case management and does not include the provision of direct services.

Service coordination consists of the following functions:
- Service coordination assessment – For assessment requirements, see IDAPA 16.03.10.730.01-.02
- Plan development – For service coordination plan content requirements, see IDAPA 16.03.10.731.01-.03
- Referral and related activities – For referral and related activities requirements, see IDAPA 16.03.10.727.03
- Monitoring and follow up activities – For monitoring requirements see, IDAPA 16.03.10.727.04

Service coordinators do not have to be available on a 24-hour basis, but the plan must include an objective describing what the participant, families, and providers should do in an emergency situation.
8.1.1. Procedure Codes
All targeted service coordination claims submitted must contain a 5-digit health related service procedure code for billing. Refer to the Idaho Medicaid Fee Schedule library and the Targeted Service Coordination fee schedule for covered codes.

8.2. Targeted Service Coordination Eligibility
Participants identified below who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for persons with intellectual disabilities, are eligible for DD targeted service coordination.

Adults diagnosed with a developmental disability as defined in Section 66-402 of Idaho Code and IDAPA 16.03.10.501 through 503 are eligible for DD targeted service coordination if they meet all of the following criteria:

- Are 18 years of age or older.
- Have impairments that result in substantial functional limitations in three 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.
- Need a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and individually planned and coordinated.
- Require and choose assistance to adequately access services and supports necessary to maintain their independence in the community.

8.3. Agency Provider Qualifications

8.3.1. DD Targeted Service Coordinators
DD targeted service coordinators must:

- Be employees or contractors of a service coordinator agency that has a valid provider agreement with DHW.
- Not provide both service coordination and direct services to the same Medicaid participant.
- 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 (RN).
- Have at least 12 months supervised work experience with the population they will be serving. Work experience must be at least 20 hours per week.
- Comply with IDAPA 16.05.06, Criminal History and Background Checks.

8.3.2. Paraprofessionals
Under the supervision of a qualified service coordinator, paraprofessionals may be used to assist in the implementation of a service coordination plan. Paraprofessionals must:

- Be at least 18 years of age and have a minimum of a high school diploma or equivalency.
- Be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of service.
- Have 12 months supervised work experience with the population they will be serving.
- Comply with IDAPA 16.05.06, Criminal History and Background Checks.
- Not conduct assessments, evaluations, person centered planning meetings, 90-day face to face plan monitoring contacts, 180-day progress reviews, plan development, or plan changes.
8.3.3. **Supervision of Service Coordination**

Service coordination agencies must provide supervision to qualified service coordinators and paraprofessionals employed or under contract with the agency. Agency supervisors must have the following qualifications:

- Be an employee or contractor of a service coordination agency that has a valid provider agreement with DHW.
- Master’s degree in a human services field and one year’s supervised work experience with the population for whom they will be supervising services, or
- Bachelor’s degree in a human services field and 24 months supervised work experience with the population for whom they will be supervising services, or
- Licensed professional nurse and 24 months supervised work experience with the population for whom they will be supervising services.

8.4. **Crisis Service Coordination**

Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. A crisis is an unanticipated event, circumstance, or life situation that places a participant at risk of at least one of the following: hospitalization, loss of housing, loss of employment or major source of income, incarceration, or physical harm to self or others including family altercation or psychiatric relapse.

Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill building services.

Crisis hours are not available until four and one-half hours of service coordination have already been provided in the month. Crisis hours are limited to a maximum of 20 hours during any consecutive five-day period.

Crisis assistance must be authorized by the Department.

9. **Service Coordination for Children with Special Health Care Needs**

**Effective February 1, 2014**, the assessment and plan development for service coordination for Children with Special Health Care Needs will no longer require prior authorization (PA) from Medicaid. A PA is required prior to the delivery of service coordination services. A MEDICAID APPROVED packet complete with all the forms for the assessment, the service plan and supporting documentation are available on the DHW Medical Care page under Forms. Utilizing and correctly completing the MEDICAID APPROVED packet will expedite the prior authorization review process.

9.1. **Description**

Service coordination services are case management services delivered by qualified providers to assist Medicaid participants who are unable, or have limited ability, to gain access to, coordinate, or maintain services on their own or through other means. Service coordination services are delivered through a brokerage model and do not include the provision of direct services. The services include the following elements:

- Assessment- Evaluating the participant’s need for assistance in gaining and coordinating access to care and services. The assessment determines the prioritized needs and services of the child and must be used to develop the plan and must be documented in the plan. The parent or legal guardian of the child must be included in
the assessment process and the assessment must identify the family's needs to ensure the child's needs are met.

- **Plan Development**— A written service plan must be developed within 60 days after the participant chooses a service coordination agency. The plan must be developed using information gathered during the assessment and must be updated at least annually. The plan must address the service coordination needs of the participant as identified in the assessment. The plan must describe activities to connect the participant with appropriate resources.

- **Referral and Related Activities**—Linking the participant to needed services — finding, arranging and assisting the participant to maintain services, supports, and community resources identified on the service plan; advocating for the unmet needs of the participant; and encouraging independence.

- **Monitoring and Follow-Up Activities**—Monitoring and follow up activities are necessary to ensure the plan is implemented and adequately addresses the child's needs. These activities may be with the participant, family members, providers, legal guardians or others as needed to assist in the coordination and retention of services and to make adjustments in the plan as needed.

For additional information on assessment, plan development and monitoring activities see 9.5.1 *Required Documentation* in this handbook or refer to *IDAPA 16.03.10.730-736*.

### 9.2. Children’s Service Coordination Eligibility

Participants identified below who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for the intellectually disabled, are eligible for service coordination.

Children up to the age of 21 are eligible for service coordination if they meet all of the following criteria:

- Are between birth and the month of their 21st birthday.
- Are identified by a physician or other practitioner of the healing arts as needing service coordination services.
- Have needs that cannot be met by other available service coordination or case management resources, including paid and non-paid sources. This includes case management resources provided by the Department for children with developmental disabilities and other case management resources such as those available through the Department’s behavioral health managed care program.
- Have the following diagnosis:
  - Special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability.
- Have one or more of the following problems associated with their diagnosis:
  - The condition has resulted in a level of functioning below normal age level in one or more life areas such as school, family, or community.
  - They are at risk of placement in a more restrictive environment or they are returning from an out of home placement as a result of the condition.
  - There is danger to their health or safety, or the parents are unable to meet their needs.
  - Further complications may occur as a result of the condition without provision of service coordination services.
  - They require multiple service providers and treatments.
9.3. Agency Provider Qualifications

9.3.1. Service Coordinators
All service coordinators must be employees or contractors of an agency that has a valid provider agreement with DHW.

- Agencies that hire employees must meet all requirements, including worker’s compensation and general liability insurance, for an agency listed in the general provider agreement.
- An agency includes a minimum of at least a supervisor and a service coordinator.
- Agencies may not provide both service coordination and direct services to the same Medicaid participant.
- 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 (RN).
  - A human services field is a particular area of academic study in health, social services, education, behavioral science, or counseling.
- All service coordinators must have at least 12 months’ experience working with the population they will be serving or be supervised by a qualified service coordinator.

All service coordinators must pass DHW’s criminal history check in IDAPA 16.05.06, Criminal History and Background Checks.

9.3.2. Paraprofessionals
Under the supervision of a qualified service coordinator, paraprofessionals may be used to assist in the implementation of a service coordination plan.

- Paraprofessionals may not conduct the assessments or develop service coordination plans.
- Paraprofessionals must be able to read and write at a level equal with the paperwork and forms involved in the provision of service.
- Paraprofessionals must pass DHW’s criminal history check as described in IDAPA 16.05.06, Criminal History and Background Checks.

9.3.3. Supervision of Service Coordination
Service coordination agencies must provide supervision to qualified service coordinators and paraprofessionals employed or under contract with the agency.

Agency supervisors must have all of the following qualifications:

- Be an employee or contractor of an agency that has a valid provider agreement with DHW.
- Master’s degree in a human services field (see 9.3.1 Service Coordinators) and one year’s experience with the population for whom they will be supervising services, OR
- Bachelor’s degree in a human services field and 24 months supervised work with the population being served, OR
- Be a licensed professional nurse (RN) and have 24 months supervised work experience with the population being served.

9.4. 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.

Crisis assistance, including services to prevent hospitalization or incarceration, may be provided before the completion of an assessment and development of a plan of service.

9.5. Prior Authorization

As of February 1, 2014:
- Authorization is required for ongoing provision of service coordination.
- Assessment and plan development do not require prior authorization, but those claims are subject to review for appropriateness of services prior to payment.
- To request a prior authorization for services, complete and return the SIGNED assessment, service coordination plan AND the required supporting documentation (see the section titled Required Documentation below) via fax to the Medicaid Medical Care Unit at 1 (877) -314-8779.
- Crisis service coordination continues to require authorization for payment of claims after the service is delivered.

9.5.1. Required Documentation

All of the following documentation must be included to request prior authorization for service coordination services.
- **Assessment** - must include an assessment of the following:
  - Basic needs
  - Medical needs
  - Health and safety needs
  - Therapy needs
  - Educational needs
  - Personal needs
  - Social integration needs
  - Family needs and supports
  - Long range planning needs
  - Legal and financial needs
- **Written Service Plan** - must describe how the service coordinator intends to address the needs described in the assessment, including:
  - Problems and needs identified in the assessment, and proposed activities to meet those needs
  - Time frames for completion of activities to meet needs
  - Identification of risks and an action plan for addressing a crisis situation based on those risks
  - Identification of all services provided by the participants support system and any actions taken by the service coordinator to develop that support system
  - Documentation of who has been involved in the service planning
  - How the participant’s natural supports and existing resources will fit into the plan
  - Schedules for service coordination monitoring, progress review, and reassessment
  - Relevant details around services being arranged such as costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery, etc.

Note: Service coordinators must have contact at least every 90 days 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.

9.6. Notice of Decision (NOD)
Providers can access the Gainwell Technologies portal to view the notice of an approval for services prior to proceeding with the delivery of service coordination services.

All requests for service coordination services will be evaluated in accordance with IDAPA 16.03.10.720-736.

9.7. Billing Procedures
All service coordination services must be billed using the appropriate HCPCS. Refer to the Idaho Medicaid Fee Schedule library and the Targeted Service Coordination fee schedule for covered codes.

9.7.1. Place of Service (POS) Codes
Enter the appropriate numeric code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

9.7.2. Limitations
- Reimbursement for service coordination services is limited to four and a half (4.5) hours per month.
- Reimbursement for assessment and plan development is limited to six (6) hours per year.

9.7.3. Excluded Services
- Services which are an integral component of another Medicaid service.
- Services integral to the administration of foster care programs.
- Services integral to the administration of another non-medical program.
- Contacts with non-eligible individuals.

(a) Exceptions to Excluded Services
Contacts with non-eligible individuals may be included ONLY when the contact is directly related to identifying the needs and supports to help the participant access services.
10. Children’s Habilitation Intervention Services (CHIS)

Children’s Habilitation Intervention Services (CHIS) are evidence-informed or evidence-based therapeutic techniques that are medically necessary. These techniques are based on applied behavior analysis principles. These intervention services are delivered directly to participants with identified developmental limitations that impact the participant’s functional skills and behaviors across developmental domains. Case Management is available through Family and Community Services at the Idaho Department of Health and Welfare to assist participants accessing CHIS.¹

10.1. References: Children’s Habilitation Intervention Services

10.1.1. State Regulations


10.2. Provider Qualifications

Children’s Habilitation Intervention Services (CHIS) are delivered by individuals who meet the criteria in this section of the handbook and are employed by a certified Developmental Disabilities Agency (DDA) or are enrolled as an independent CHIS provider¹.

Evidence-Informed Interventions are interventions that use components of evidence-based techniques. They are delivered by qualified individuals not certified or credentialed in an evidence-based model³. Evidence-Informed Intervention providers include the following provider types:

- Crisis Intervention Technician¹
- Intervention Technician¹
- Intervention Specialist¹
- Intervention Professional¹

Evidence-Based interventions have been scientifically researched and reviewed in peer-reviewed journals, replicated successfully by multiple independent investigators, and have been shown to produce measurable and substantiated beneficial outcomes. They are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model⁴. Department approved evidence-based models include the Early Start Denver Model (ESDM) and the Behavior Analyst Certification Board (BACB). Any other evidence-based models identified that meet the IDAPA requirements will be reviewed and may be added to this list. Evidence-Based providers include the following provider types:

- Evidence-Based Model Intervention Paraprofessional¹
- Evidence-Based Model Intervention Specialist¹
- Evidence-Based Model Intervention Professional¹

CHIS providers must complete at least 12 hours of training each calendar year. Training must include one (1) hour of ethics and six (6) hours of behavior methodology or evidence-based interventions. Providers who have not worked a full calendar year must have documentation of at least one (1) hour of training per month providing direct services. Prorated training requirements begin the first month the individual begins providing Medicaid reimbursable services.²
The training received must be relevant to the service being delivered. Training topics can be repeated, but the training content must be different each calendar year. Staff can obtain training through various formats including in-person, from an agency or an outside source, online, attending a conference or in a classroom.²

If the individual has not completed the required training during any calendar year, they can only provide CHIS once the required number of training hours have accumulated.² As training hours accumulate, they will be accounted first to any training-deficient prior calendar year before being applied to the current calendar years training period. Training hours may not be earned in a current calendar year to be applied to a future calendar year.²

Information regarding School-Based CHIS Providers can be found in the School-Based Services section of this handbook.

### 10.2.1. References: Provider Qualifications

#### (a) State Regulations


### 10.2.2. Crisis Intervention Technician

Crisis Intervention Technicians must meet the provider qualifications of a community-based supports staff as follows:²

- Be at least 18 years of age;
- Receive a clearance from a background check under IDAPA 16.05.06, “Criminal History and Background Checks;”
- Certified in CPR and first aid;
- Have received instructions on the needs of the participant;
- Demonstrate the ability to provide services according to a plan of service;
- Have six (6) months supervised experience working with children with developmental disabilities. Individuals providing community-based supports to children birth to age three (3) must have six (6) months of documented experience with children in that age range with developmental delays or disabilities. Experience can be achieved by one (1) of the following:
  - **Previous Work Experience:** Previous work experience gained through paid employment, university practicum experience, or internship; or
• **On-the-job Supervision:** On-the-job supervised experience gained through employment with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services and at least weekly face-to-face supervision with the supervisor for six (6) months while delivering services; and

  - Complete coursework approved by the Department to demonstrate competencies related to the requirements to provide community-based supports. The coursework is an online competency training consisting of four (4) modules at the [Idaho Center on Disabilities and Human Development](https://www.idaho.edu/disabilities) website.¹

Supervision must occur monthly to ensure staff demonstrate the necessary skills to provide the services correctly. Supervision also informs if any modification for the methods implemented to address the outcomes identified in the Assessment and Clinical Treatment Plan (ACTP) is needed. Supervision includes face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant. Intervention Specialists providing services to children birth to three (3) years old must be supervised by an Intervention Specialist or Intervention Professional who has the necessary experience for that age range.³

Providers must follow the provider handbook and all applicable state and federal rules and regulations. See [General Information and Requirements for Providers](https://medicaid.idaho.gov), Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

**(a) References: Crisis Intervention Technician**

**(i) State Regulations**


**10.2.3. Intervention Technician**

Intervention Technician is a provisional position intended to allow an individual to gain the necessary degree, competency, or experience to qualify as an intervention specialist or professional. Provisional status is limited to a single, 18 successive month period, which begins when the individual begins providing Medicaid reimbursable services as an intervention technician.² An individual can no longer provide services as an intervention technician if they do not meet the requirements to become an intervention specialist within the provisional period. Intervention Technicians must meet one of the following provider qualifications below:

- Currently enrolled and is within 24 semester credits, or equivalent, to completing their bachelor’s degree or higher from an accredited institution in a human services field and is working toward meeting the experience and competency requirements to meet the qualifications as a specialist or professional;
• An individual who holds a bachelor’s degree from an accredited institution in a human services field and is working toward meeting the experience and competency requirements to meet the qualifications as a specialist or professional; or
• An individual who has a bachelor’s degree and a minimum of 24 semester credits, or equivalent, in a human services field and is working toward meeting the experience and competency requirements to meet the qualifications as a specialist or professional.²

Quarter and trimester credits can be converted to semester credits for determining provider qualification. The number of semester credits needed should be multiplied by 1.5 to determine the number of quarter credits or by 1.2 to determine the number of trimester credits needed to meet the requirement. For example, 24 semester credits are equivalent to 36 quarter credits or 28 trimester credits.

A human services field bachelor’s degree is a diverse field focused on improving the quality of life for participants. Areas of academic study include, but are not limited to, sociology, special education, counseling, psychology, or other areas of academic study.¹ An Optional Guidelines for Determining Human Services Field for CHIS tool is available to assist with determining if a degree meets the requirements in this paragraph.

Supervision must occur monthly to ensure staff demonstrate the necessary skills to provide the services correctly. Supervision also informs if any modification for the methods implemented to address the outcomes identified in the Assessment and Clinical Treatment Plan (ACTP) is needed. Supervision includes face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant.³

Providers must follow the provider handbook and all applicable state and federal rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: Intervention Technician

(i) State Regulations


10.2.4. Intervention Specialist

Intervention Specialists must hold a bachelor’s degree from an accredited institution in a human services field of a bachelor’s degree and a minimum or 24 semester credits, or equivalent, in a human services field.¹ Quarter and trimester credits can be converted to semester credits for determining provider qualification. The number of semester credits
needed should be multiplied by 1.5 to determine the number of quarter credits or by 1.2 to determine the number of trimester credits needed to meet the requirement. For example, 24 semester credits are equivalent to 36 quarter credits or 28 trimester credits.

An intervention specialist must have 1040 hours of supervised experience working with participants birth to 21 years of age who demonstrate functional or behavioral needs. They must meet competency requirements by completing the Department-approved Provider Competency Checklist for an Intervention Specialist, or a minimum of 40 hours of applied behavior analysis (ABA) delivered by an individual who is certified or credentialed to provide the training.\(^1\) Board Certified Behavior Analysts (BCBA’s) or Board-Certified Assistant Behavior Analysts (BCaBA’s) meet this requirement. These individuals must provide this training under their Board/Model requirements. The 40-hour Registered Behavior Technician (RBT) training is an approved 40-hour ABA training. Intervention specialists are not required to obtain the RBT credential.

Individuals who hold a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019, or later will be allowed to continue providing services as an intervention specialist as long as there is not a gap of more than three successive years of employment as an intervention specialist.\(^1\)

All individuals completing assessments must have at least ten (10) hours of documented training and five (5) hours of supervised experience in completing comprehensive assessments and implementation plans for individuals with functional or behavioral needs. Individuals providing services to children birth to three (3) years of age must also meet the qualifications in the CHIS for Children Birth to Three Years of Age section of this handbook.\(^1\)

An optional Intervention Specialist Qualification Worksheet is available to assist with determining provider qualifications.

Supervision must occur monthly to ensure staff demonstrate the necessary skills to provide the services correctly. Supervision also informs if any modification for the methods implemented to address the outcomes identified in the Assessment and Clinical Treatment Plan (ACTP) is needed. Supervision includes face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant. Intervention Specialists providing services to children birth to three (3) years old must be supervised by an Intervention Specialist or Intervention Professional with the necessary experience for that age range.\(^2\)

Providers must follow the provider handbook and all applicable state and federal rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

\section{(a) References: Intervention Specialist}

\subsection{(i) State Regulations}

10.2.5. Intervention Professional

Intervention Professionals must hold a master’s degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with 1,500 hours of relevant coursework, training, or both in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, psychology, education, or behavior analysis. They must also have 1,200 hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs. These requirements may be documented within the individual’s degree program, other coursework, or training.1

One (1) semester credit is equal to 16 hours of coursework or training. Quarter and trimester credits can be converted to semester credits for determining provider qualification. The number of semester credits needed should be multiplied by 1.5 to determine the number of quarter credits or by 1.2 to determine the number of trimester credits needed to meet the requirement. For example, 24 semester credits are equivalent to 36 quarter credits or 28 trimester credits.

Individuals providing services to children birth to three (3) years of age must also meet the qualifications in the CHIS for Children Birth to Three Years of Age section of this handbook.1

An Optional Intervention Professional Qualification Worksheet is available to assist with determining provider qualifications.

Providers must follow the provider handbook and all applicable state and federal rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: Intervention Professional

(i) State Regulations


10.2.6. Evidence-Based Model Intervention Paraprofessional

Evidence-Based Model (EBM) Paraprofessionals must have a high school diploma or general equivalency diploma and a para-level certification or credential in an evidence-based model approved by the Department.1 An individual who is a Registered Behavior Technician (RBT) meets the requirements of an evidence-based model paraprofessional.

Supervision must be provided under the requirements of the evidence-based model to ensure staff demonstrate the necessary skills to provide the services correctly. Supervision also informs if any modification for the methods implemented to address the outcomes identified in the Assessment and Clinical Treatment Plan (ACTP) is needed. Supervision includes face-to-face observation and direction to the staff regarding developmental and behavioral
techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant.²

Providers must follow the provider handbook and all applicable state and federal rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: Evidence-Based Model Intervention Paraprofessional

(i) State Regulations


10.2.7. Evidence-Based Model Intervention Specialist

Evidence-Based Model (EBM) Intervention Specialists must have a bachelor’s degree from an accredited institution under their certification or credentialing requirements and have a bachelors-level certification or credential in an evidence-based model approved by the Department.¹ An individual who is a board-certified assistant behavior analyst (BCaBA) meets the requirements of an EBM intervention specialist.

Individuals providing services to children birth to three (3) years of age must also meet the qualifications in the CHIS for Children Birth to Three Years of Age section of this handbook.¹

Supervision must be provided under the requirements of the evidence-based model to ensure staff demonstrate the necessary skills to provide the services correctly. Supervision also informs if any modification for the methods implemented to address the outcomes identified in the Assessment and Clinical Treatment Plan (ACTP) is needed. Supervision includes face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant. Intervention Specialists providing services to children birth to three years old must be supervised by an Intervention Specialist or Intervention Professional with the necessary experience for that age range.²

Providers must follow the provider handbook and all applicable state and federal rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: Evidence-Based Model Intervention Specialist

(i) State Regulations


10.2.8. Evidence-Based Model Intervention Professional

Evidence-Based Model (EBM) Intervention Professionals must have a master’s degree or higher from an accredited institution under their certification or credentialing requirements and a masters-level certification or credential in an evidence-based model approved by the Department. An individual who is a board-certified behavior analyst (BCBA) or holds a master’s level certification in the Early Start Denver Model meets the requirements of an EBM intervention professional.

Individuals providing services to children birth to three (3) years of age must also meet the qualifications found in the CHIS for Children Birth to Three Years of Age section of this handbook.

Providers must follow the provider handbook and all applicable state and federal rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: Evidence-Based Model Intervention Professional

(i) State Regulations


10.2.9. CHIS Delivered by an Independent Provider

Independent CHIS Providers can deliver all types of CHIS and complete assessments and implementation plans in accordance with their provider qualification. Independent CHIS Providers must meet the following requirements:

- Obtain an independent Medicaid provider agreement through the Department and maintain in good standing;
- Be CPR and first aid certified;
- Receive a clearance from a background check under IDAPA 16.05.06, “Criminal History and Background Checks;”
- Meet the requirements in the Provider Qualifications section of this handbook under their provider type;
- Receive supervision from an individual that they are not directly supervising; and
- Individuals providing services to children birth to three (3) years of age must also meet the qualifications in the CHIS for Children Birth to Three Years of Age section of this handbook.

The following provider qualifications can become an independent provider:

- Intervention Specialist
- Intervention Professional
- Evidence-Based Model Intervention Specialists
- Evidence-Based Model Intervention Professional
(a) References: CHIS Delivered by an Independent Provider

(i) Federal Guidance

(ii) Professional Organizations

(iii) State Regulations
3. “Independent CHIS Provider.” IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Sec. 575.08. Department of Administration, State of Idaho,

4. “Supervision.” IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Sec. 574.04. Department of Administration, State of Idaho,

10.2.10. CHIS for Children Birth to Three Years of Age
Individuals who provide services to children birth to three (3) years of age must have 240 hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with children birth to five (5) years of age with developmental delays or disabilities. Experience must be through paid employment, university internship, or practicum experience. Experience may be documented within the supervised experience as an Intervention Technician.1,2,3,4 The individual must also have one (1) of the following:4

- An elementary education certificate or special education certificate with an endorsement in early childhood special education.4
- A blended Early Childhood or Early Childhood Special Education (EC or ECSE) certificate.4
- A bachelor’s or master’s degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, counseling, or nursing. This individual must have a minimum of 24 semester credits from an accredited college or university, which can be within their bachelor’s or master’s degree coursework or can be in addition to the degree coursework covering the following:4
  - Promotion of development and learning for children from birth to five (5) years of age.4 Course descriptions must provide an overview of typical and atypical infant and young child development and learning and must include physical, social emotional, communication, adaptive (self-help), and cognitive development of infants and toddlers;
  - Assessment and observation methods that are developmentally appropriate for assessment of young children with developmental delays or disabilities.4 Course descriptions must include the assessment and evaluation process using both formal and informal assessment strategies. Strategies and tools for screening, assessing, and evaluating the development of infants and
children birth through five (5) years of age, including typical and atypical
development, to support young children and families;
  o Building family and community relationships to support early interventions.4 Course
descriptions must include working with families who have children
with developmental disabilities, strengthening and developing family,
professional and interagency partnerships, researching and linking families
with community resources, parent or teacher or professional, communication,
and collaborating with other professionals;
  o Development of appropriate curriculum for young children.4 Course
descriptions must include instructional strategies for working with infants,
toddlers, and young children through third grade with developmental delays
and disabilities, linking assessment to curriculum and designing instructional
programming in natural settings and formal settings for young children with
special needs, involving families in the process;
  o Implementation of instructional and developmentally effective approaches for
early learning, including strategies for children and their families.4 Course
descriptions must include a focus on implementing strategies to meet
outcomes for children with developmental delays and disabilities, and
monitoring children’s responses and overall progress; and
  o Demonstration of knowledge of policies and procedures in special education
and early intervention and demonstration of knowledge of exceptionalities in
children’s development.4 Course descriptions include foundations of special
education and knowledge and understanding of young children with
developmental disabilities.

An Optional B-3 Qualification Worksheet is available to assist with determining provider
qualifications.

(a) References: CHIS for Children Birth to Three
Years of Age

(i) State Regulations

1. “Evidence-Based Model (EBM) Intervention Professional.” IDAPA 16.03.09, “Medicaid Basic
Plan Benefits,” Sec. 575.07.c. Department of Administration, State of Idaho,

2. “Evidence-Based Model (EBM) Intervention Specialist.” IDAPA 16.03.09, “Medicaid Basic
Plan Benefits,” Sec. 575.06.c. Department of Administration, State of Idaho,

575.04.c. Department of Administration, State of Idaho,

4. “Intervention Specialist.” IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Sec. 575.03.c.
Department of Administration, State of Idaho,

10.3. Eligible Participants

Children’s habilitation intervention services (CHIS) are available for participants from birth
through the month of their 21st birthday and meet one of the following criteria:
• Demonstrate a functional need or a combination of functional and behavioral needs that require intervention services; or
• Require intervention to correct or ameliorate their condition under Early Periodic Screening, Diagnosis, and Treatment (EPSDT). See the section in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for EPSDT Services.

Participants must complete a required screening, which is used to determine whether they demonstrate functional or behavioral needs. The Required Screening section of this handbook provides further detail about the screening process.

CHIS must be recommended by a physician or other licensed practitioner of the healing arts. The term licensed practitioner of the healing arts includes: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), and physician assistants (PA). This recommendation is only required once and must be received before submitting the initial prior authorization request. CHIS providers cannot seek reimbursement for services more than 30 days before the signed and dated recommendation.

The physician’s recommendation for CHIS must be completed on the Department approved Recommendation for Children’s Habilitation Intervention Services.

Participants who are 18-21 years of age may be able to receive both CHIS and Adult DD Services. Refer to the following CHIS and Adult DD Crosswalk to assist in determining if CHIS can be provided.

<table>
<thead>
<tr>
<th>CHIS and Adult DD Crosswalk for Individuals 18-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Service</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Adult Day Health</td>
</tr>
<tr>
<td>Behavioral Consultation/Crisis Management</td>
</tr>
<tr>
<td>Residential Habilitation - Certified Family Home</td>
</tr>
<tr>
<td>Chore Services</td>
</tr>
<tr>
<td>Residential Habilitation – Daily Supported Living (High/Intense)</td>
</tr>
<tr>
<td>Developmental Therapy</td>
</tr>
<tr>
<td>Environmental Accessibility Adaptations</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
</tr>
</tbody>
</table>
### CHIS and Adult DD Crosswalk for Individuals 18-21

<table>
<thead>
<tr>
<th>Adult Service</th>
<th>Can Access CHIS?</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Habilitation - Hourly Supported Living</td>
<td>YES</td>
<td>Only when goals are separate, unique, and distinctly different to each service provided. Services cannot be provided at the same time.</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Respite Care</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Service Coordination</td>
<td>YES</td>
<td>Children’s Case Management can be accessed until Service Coordination is authorized on the Adult Service Plan.</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Transition Services</td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

#### 10.3.1. References: Eligible Participants

**(a) State Regulations**


#### 10.3.2. Required Screening

The current Department approved screening tool is the current version of the Vineland Adaptive Behavior Scales. This tool must be administered under its protocol. This screening may be conducted by the family’s chosen CHIS provider, the Department, or one of the following designees:
- Independent assessment provider;
- School;
- Psychologist;
- IDHW Crisis Prevention and Court Services team;
- Infant Toddler staff;
- DDA; or
- Independent habilitation intervention provider.
The screening only needs to be completed once before submitting the initial prior authorization request for CHIS. If a screening tool has been completed by the Department or its designee, or the participant has been determined eligible by the Department, a new screening tool is not required unless the participant has not accessed CHIS for more than 365 days. A deficit is one-point-five (1.5) or more standard deviations below the mean for functional areas or above the mean for maladaptive behavior. A functional or behavioral need is determined by the Department approved screening tool when a deficit is identified in three (3) or more of the following areas:

- Self-care;
- Receptive and expressive language;
- Learning;
- Mobility;
- Self-direction;
- Capacity for independent living;
- Economic self-sufficiency; or
- Maladaptive behavior.

Providers can bill for completing the screening. The screening can be billed only once for a maximum of one (1) hour (four (4) units) on the initial Assessment and Clinical Treatment Plan (ACTP). If a screening is completed, but an ACTP is not completed, the provider can submit the completed screening document with the signed physician recommendation for services to request reimbursement. If an additional screening must be completed, the provider must request prior authorization before completion.

(a) References: Required Screening

(i) State Regulations


10.4. Covered Services and Limitations: CHIS

Idaho Medicaid covers Habilitative Skill Building, Behavioral Intervention, Interdisciplinary Training, Crisis Intervention, and the development of the Assessment and Clinical Treatment Plan (ACTP). CHIS can be provided in the community, the participant’s home, or a Developmental Disability Agency (DDA). For CHIS, a Certified Residential Facility (CRF) is considered a home where CHIS services can be provided.

Vocational services, educational services, and recreational services are excluded from Medicaid payment.

- Vocational Services are services or programs directly related to the preparation of individuals for paid or unpaid employment.
The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or the general workforce within one year.

- Educational services are services that are:
  - Provided in buildings, rooms, or areas designated or used as a school or as educational facilities;
  - Provided during specific hours and time periods in which the educational instruction takes place in the normal school day;
  - Included in the individual educational plan (IEP) for the participant or are required by federal and state educational statutes or regulations;
  - Such services are provided to school age individuals between three and 21 years of age.\(^1\)\(^3\)

- Recreational Services are activities or services that are generally perceived as recreation, such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special occasion parties.\(^1\)
  - While Medicaid will not pay for the recreational service itself, Medicaid will pay for intervention services to be provided in the community while the participant is participating in these activities.

Duplication of services is not reimbursable.\(^4\) Services are considered duplicate when:
- Goals are not separate and unique to each service provided; or
- When more than one (1) service is provided at the same time, unless otherwise authorized.\(^1\)

### 10.4.1. References: Covered Services and Limitations

(a) **State Regulations**

1. “CHIS: Definitions.” IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Sec. 571. Department of Administration, State of Idaho,

2. “Excluded for Medicaid Payment.” IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Sec. 573.01. Department of Administration, State of Idaho,

3. School Age, Idaho Code 33-201 (2023). Idaho State Legislature,

4. “Service Delivery.” IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Sec. 573.02. Department of Administration, State of Idaho,

5. “Services.” IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Sec. 573.05. Department of Administration, State of Idaho,

### 10.4.2. Habilitative Skill Building

Habilitative Skill Building is a direct intervention service that includes techniques used to develop, improve, and maintain the developmentally appropriate functional abilities and daily living skills needed by a participant.\(^3\) It can be delivered by the following provider types:
- Intervention Technician;
• Intervention Specialist;
• Intervention Professional;
• Evidence-Based Model Intervention Paraprofessional;
• Evidence-Based Model Intervention Specialist; and
• Evidence-Based Model Intervention Professional.  

This service may include teaching and coordinating training methods with family members or others who regularly care for the eligible participant. Since this is a direct service, the participant must be present during training with family/caregivers.

Habilitative Skill Building can be provided individually or in a group. Group services are only reimbursed when the participant’s objectives relate to benefiting from group interactions. Group services must be provided by one qualified staff providing direct services to two (2) or three (3) participants receiving the service. As the number and needs of the participants increase, the participant ratio must be adjusted from three (3) to two (2).

If a provider has an authorization for habilitative skill building, an EBM intervention paraprofessional, an intervention specialist, an EBM intervention specialist, an intervention professional, or an EBM intervention professional can provide the habilitative skill building service and bill off of that authorization. Providers have this flexibility because the reimbursement rate for habilitative skill building is set at one (1) code, with no specific modifier delineating different provider qualifications.

For example, a provider has an authorization for habilitative skill building to be provided by an intervention technician. That intervention technician is out sick for a week. The provider also has a staff who meets the requirements of an intervention specialist; so, the intervention specialist can provide the habilitative skill building to that participant during that week and bill the set procedure code and modifier for habilitative skill building (H2014).

<table>
<thead>
<tr>
<th>Covered Habilitative Skill Building Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT® Code</td>
</tr>
<tr>
<td>H2014</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

(a) References: Habilitative Skill Building

(i) Idaho State Plan


(ii) State Regulations


10.4.3. Behavioral Intervention

Behavioral intervention is a direct intervention service that utilizes techniques to produce positive, meaningful behavior changes that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified skill needs. This service is available to participants who exhibit interfering behaviors that impact their independence or abilities, such as social skills, communication, or destructive behaviors. Behavioral intervention can be provided utilizing evidence-based or evidence-informed practices to promote positive behaviors and learning while reducing interfering behaviors. It can be delivered by the following provider types:

- Intervention Technician;
- Intervention Specialist;
- Intervention Professional;
- Evidence-Based Model Intervention Paraprofessional;
- Evidence-Based Model Intervention Specialist; and
- Evidence-Based Model Intervention Professional.

This service may include teaching and coordinating training methods with family members or others who care for the eligible participant. Since this is a direct service, the participant must be present during training with family/caregivers.

Behavioral Intervention can be provided individually or in a group. Group services are only reimbursed when the participant’s objectives relate to benefiting from group interactions. Group services must be provided by one (1) qualified staff providing direct services to two (2) or three (3) participants receiving the service. As the number and needs of the participants increase, the participant ratio must be adjusted from three (3) to two (2).

If 2:1 staffing is needed, the provider may request behavioral intervention to meet this need. The participant’s Assessment and Clinical Treatment Plan (ACTP) must include justification for 2:1 staffing for multiple providers to deliver the service at the same time. One (1) request should be for the procedure code, modifier needed for the service, and staff qualification. The additional staff should be identified with the procedure code, modifier needed for the staff, and the EPSDT modifier (EP). If multiple providers are delivering 2:1 services, the above will also apply, and one (1) provider must request the service with the EPSDT modifier.

If a provider has an authorization for behavioral intervention for an intervention specialist (IS), and the IS cannot provide services, the agency can have a higher qualified staff (i.e., an EBM intervention specialist, an intervention professional or an EBM intervention professional) provide the behavioral intervention for that participant and bill at the intervention specialist rate as that is what the authorization is for. The opposite would not be allowed. An intervention specialist would not be able to seek reimbursement for an authorization of behavioral intervention for an intervention professional.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Modifier</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>H0004</td>
<td>HA</td>
<td>Behavioral Intervention – Individual – Intervention Technician</td>
</tr>
<tr>
<td></td>
<td>HN</td>
<td>Behavioral Intervention – Individual – Intervention Specialist</td>
</tr>
</tbody>
</table>
Covered Behavioral Intervention Codes

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HO</td>
<td></td>
<td>Behavioral Intervention – Individual – Intervention Professional</td>
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<tr>
<td></td>
<td></td>
<td>Behavioral Intervention – Individual – EBM Intervention Paraprofessional</td>
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<tr>
<td>TF</td>
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<td>Behavioral Intervention – Group – Intervention Technician</td>
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<td>TG</td>
<td></td>
<td>Behavioral Intervention – Group – EBM Intervention Professional</td>
</tr>
</tbody>
</table>

(a) References: Behavioral Intervention

(i) Idaho State Plan

(ii) State Regulations


10.4.4. Interdisciplinary Training
Interdisciplinary Training is a companion service to Habilitative Skill Building and Behavioral Intervention. It is used to assist with implementing a participant’s health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques to meet the participant’s needs. It can be delivered by the following provider types:

- Intervention Specialist;
- Intervention Professional;
- Evidence-Based Model Intervention Specialist; and
• Evidence-Based Model Intervention Professional.¹

This service is to be used for collaboration, with the participant present, during the provision of services between the Intervention Specialist or Professional and one of the following:
  • Speech Language and Hearing Professional (SLP);
  • Physical Therapist (PT);
  • Occupational Therapist (OT);
  • Medical Professional; or
  • Behavioral or mental health professional.²

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2019</td>
<td>HT</td>
<td>Interdisciplinary Training</td>
</tr>
</tbody>
</table>

(a) References: Interdisciplinary Training

(i) State Regulations


10.4.5. Crisis Intervention

Crisis intervention includes providing direct intervention to the participant, training staff related to the participant’s needs, or developing a crisis plan.³ It can be delivered by all CHIS provider types.¹ Intervention includes decreasing interfering behaviors or increasing skills to reduce further crisis³. When providers utilize crisis for staff training, the participant is not required to be present. During the development of a crisis plan, the intervention specialist or intervention professional can use crisis intervention to update the participant’s Assessment and Clinical Treatment Plan (ACTP) or create a crisis plan that addresses the behavior occurring and the necessary intervention strategies to minimize the behavior.

A crisis is an unanticipated event, circumstance, or life situation that places a participant at risk of at least one of the following: hospitalization, out-of-home placement, incarceration, or physical harm to self or others, including family altercation or psychiatric relapse.³

The following limitations apply to crisis intervention services:
  • Must be provided in the home or community; and
  • Provided on a short-term basis of 30 days or less.³

Authorization for crisis intervention can be requested due to a crisis when no other means of support is available to the participant.³ The provider must complete a Department approved Crisis Request Form and submit it within 72 hours of service initiation for approval. If the crisis request includes future dates, the request can include 72 hours before submitting the request.²
Providers must use positive behavior interventions before and during the implementation of any restrictive intervention. Any aversive or restrictive interventions must be documented on the participant’s implementation plan(s) and meet the requirements for review and approval. Additional information can be found in the implementation plan section below.

If the participant is not currently accessing intervention services and needs to access crisis intervention, an ACTP is not required. The participant must have a completed screening, which must be submitted for review with the crisis intervention authorization request along with with the physician’s recommendation.

Crisis intervention is an eligible virtual care service. If crisis intervention is provided via virtual care, all requirements must be followed under the Idaho Medicaid virtual care services policy. Further information about Virtual Care Services can be found in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

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(a) References: Crisis Intervention

(i) State Regulations


10.4.6. Assessment and Clinical Treatment Plan
The Assessment and Clinical Treatment Plan (ACTP) is a comprehensive assessment that guides the formation of the implementation plan(s). It includes developmentally appropriate objectives and strategies related to identified needs. A qualified provider conducts an assessment to evaluate the participant’s strengths, needs, and functional abilities across
environments. This process guides the development of intervention strategies and recommendations for services related to the participant’s identified needs.2 The ACTP can be completed by the following provider types:

- **Intervention Specialist** and qualifies to complete assessments as required in the Intervention Specialist section of this chapter;
- **Intervention Professional**;
- **Evidence-Based Model Intervention Specialist**;
- **Evidence-Based Model Intervention Professional**; or
- **Independent Providers** who meet the qualifications above.1

The ACTP must be monitored and adjusted to reflect the current needs of the participant. The CHIS provider must document that a copy of the ACTP was offered to the participant or legal guardian. It must be completed on a Department approved Assessment and Clinical Treatment Plan form and meet the following standards:

- Clinical interview(s) must be completed with the parent or legal guardian;
- Administer or obtain an objective and validated comprehensive skills or developmental assessment approved by the Department.2 The ACTP Tools list the current Department approved assessments. The most current version of the assessment must be used. The assessment must have been completed within the last 365 days;
- Review of assessments, reports, and relevant history;
- Observations in at least one environment;
- A reinforcement inventory or preference assessment;
- A transition plan; and
- Be signed by the individual completing the assessment and the parent or legal guardian.2

The ACTP must be submitted to the Department, or its contractor, by the CHIS provider before delivering services. If the ACTP spans multiple days, it can be billed on the date it was completed and signed.

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(a) **References: Assessment and Clinical Treatment Plan**

(i) **State Regulations**


10.5. **Prior Authorization**

All Children’s Habilitative Intervention Services (CHIS) identified on the participant’s [Assessment and Clinical Treatment Plan (ACTP)](https://adminrules.idaho.gov/rules/current/16/160309.pdf) must be prior authorized by the Department or its contractor. The ACTP must be maintained in each participant’s file. The initial ACTP does not need to be prior authorized before completing it.¹

The provider is responsible for documenting and submitting the ACTP for PA before delivering any CHIS. The PA process is intended to help ensure the provision of medically necessary services. It includes review and approval or denial of authorization requests. Decisions will be sent to the provider and the parent or legal guardian.¹

Providers can request flexibility to allow the total number of clinically recommended hours per week to be prior authorized for use interchangeably between multiple clinically recommended provider qualification types from week to week. Providers may not seek reimbursement for more than the total number of units/hours of authorized services per week.

Providers should submit their ongoing PA requests (reviews) at a minimum of 30 calendar days before the expiration of the authorization to avoid a gap in intervention service authorizations. The Department or its contractor will review the documents submitted within ten (10) business days. If the reviewer does not have the necessary information to process the request or if documentation is missing, the provider will be notified and have ten (10) business days to submit the requested information/documentation.

If multiple providers will be delivering services, then each provider must submit their own PA requests, including all required supporting documentation. In these situations, each provider must only request the units they will be using and not the full units on the individual’s ACTP. Each provider will receive their own unique authorization. One provider cannot request services for both providers on the same request.

Additional information with regards to competing PA requests and those submissions can be found in the Telligen CHIS FAQ's.

See the [General Billing Instructions](https://adminrules.idaho.gov/rules/current/16/160309.pdf), Idaho Medicaid Provider Handbook, for more information regarding prior authorizations.
10.5.1. References: Prior Authorization

(a) State Regulations

10.5.2. Initial PA Requirements

Once the initial request for prior authorization (PA) is submitted, CHIS may be delivered for a maximum of 24 total hours for up to 30 calendar days or until the PA is approved, whichever comes first. This must be requested retrospectively on the initial ACTP. An initial request is any time a participant has never accessed CHIS or has not accessed those services in over 365 days. Initial PA requests must include the following:
- A recommendation from a physician or other practitioner of the healing arts;¹,²
- The Assessment and Clinical Treatment Plan (ACTP)¹;
- Implementation Plan(s);¹ and
- A list of all requested CHIS hours and the qualification of the individual(s) who will provide them.¹

The initial ACTP can be requested retroactively for the dates and time it took the provider to complete. The annual ACTP updates must be prior authorized before providing the service.¹

(a) References: Initial PA Requirements

(i) State Regulations


10.5.3. Ongoing PA Requirements

Prior authorizations (PA) occur every six months and are not required to be submitted on a Department approved form. An Optional Ongoing Review Template has been made available to assist with submitting ongoing PA requests.

Six-month ongoing PA requests must include the following:¹
- A list of the participant’s objectives;¹
- Graphs showing change lines;¹
- A brief analysis of data regarding progress or lack of progress in meeting each objective;¹
- A list of all requested CHIS hours and the qualification of the individual(s) who will provide them;¹
- Request for the annual Assessment and Clinical Treatment Plan (ACTP);¹ and
  - Providers may overestimate the number of annual ACTP units needed to complete the service but can only bill for the number of units used and documented for completing the annual ACTP.
If the annual ACTP is not requested on the six-month ongoing PA request and is later determined to be needed, it must be requested by a PA Amendment.

- New implementation plans.
  - Previously submitted implementation plans that have been modified do not need to be submitted.

If the provider identifies at an ongoing PA request that the participant needs to add new services or request an increase in hours of service, the provider will also update the participant’s ACTP. The update must justify or demonstrate the need for the requested new services or for the increase in hours of service. The updated ACTP must be submitted to the Department or its contractor for review and approval.

A six-month ongoing PA request does not need to be submitted by the provider if the participant discontinues services or switches providers.

- If an ongoing PA request did not get completed at the six-month mark, the participant will experience a lapse in services since a PA is not in place. A provider will need to complete the six-month ongoing PA request. The dates must align with the previously set authorization date cycle and will not be reset or changed.
- If a participant has switched providers and the new provider does not have the data/graphs from the previous provider regarding progress or lack of progress, the provider would need to state that the participant continues to demonstrate the need for intervention services.

Annual ongoing PA requests must include the following:

- A list of the participant’s objectives;
- Graphs showing change lines;
- A brief analysis of data regarding progress or lack of progress to meeting each objective;
- A list of all CHIS hours being requested and the qualification of the individual(s) who will provide them;
- New implementation plans;
  - Previously submitted implementation plans that have been modified do not need to be submitted.
- Updated annual ACTP;
- An annual written summary with an analysis of data regarding the participant’s progress or lack of progress. It should include justification for any changes made to the implementation of programming for new objectives, discontinuation of objectives, if applicable, and a summary of parent(s) or caregiver(s) response to teaching of coordinated methods; and

(a) References: Ongoing PA Requirements

(i) State Regulations


10.5.4. CHIS PA Amendments

If an update must be made to the prior authorization (PA), parents or guardians and the provider can submit a Prior Authorizations Amendment Form to request an update to the existing PA. The dates for the amendment must align with the current authorization dates.
They will not reset or restart participant’s previously established authorization dates. The request must be submitted before the change taking place. Amendments may be requested when:

- Requesting a new service or an increase in hours of a service, including an increase in hours of interdisciplinary training or annual Assessment and Clinical Treatment Plan (ACTP) units;
  - The ACTP must be updated where needed to justify the need for the new services or increase in service hours and must be submitted for PA. This request may also require the submission of an additional implementation plan(s).
- Changing providers or splitting an authorization between two (2) providers when only one (1) provider received authorization;
- Adjusting hours between staff qualification provider types; or
- Adjusting staff qualifications (changing the modifiers associated with the service).

A justification section is included on the form to provide additional information. This section can include information such as identifying sections of the ACTP that have been updated and providing justification for the request.

10.6. Documentation Requirements

All documentation must follow standard retention requirements including, but not limited to, those listed in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

Documentation must be made available to Department personnel acting in their official capacity immediately upon request. Services without documentation are not eligible for reimbursement. Providers should only submit records requested by the Department. Documentation sent unsolicited, or not for a service requiring prior authorization, will not be reviewed by the Department. Unreviewed documentation does not constitute approval or authorization of a service.

All CHIS Providers must maintain records for each participant served. Failure to maintain documentation may result in the recoupment of funds paid for undocumented services. The following program documentation is required for each visit made or service provided to each participant:

- Date, time, and duration;
- Summary of session or service provided;
  - If interdisciplinary training is provided, documentation must include who the service was delivered to and the content covered.
- Data documentation that corresponds to the implementation plans for habilitative skill building or behavioral intervention;
- Location of service delivery; and
- Signature of the individual providing the service, date signed, and credential.

10.6.1. References: Documentation Requirements

(a) State Regulations


10.6.2. Implementation Plans

Implementation plans provide details on how the intervention will be implemented and must be completed by a qualified provider as identified in the Provider Qualifications section of this handbook. All implementation plan objectives must be related to a need identified in the Assessment and Clinical Treatment Plan (ACTP) and must include the following requirements:

- Participant’s name;
- Measurable, behaviorally-stated objectives including:
  - Criteria for successful achievement; and
  - Baseline statement;
- Locations(s) where objectives will be implemented;
- Precursor behaviors for participants receiving behavioral intervention;
- Description of the treatment modality to be utilized;
- Discriminative stimulus or direction;
- Targets, steps, task analysis, or prompt level;
- Correction procedure;
- Data collection;
- Reinforcement, including type and frequency;
- A plan for generalization and a plan for family training;
- A behavior response plan for participants receiving behavioral intervention;
- Any restrictive or aversive interventions being implemented must be reviewed and approved by a licensed individual working within the scope of their practice;\(^2\) and
  - Restrictive interventions are any intervention used to restrict the rights or freedom of movement of a person. This includes chemical restraint, mechanical restraint, physical restraint, and seclusion.\(^1\)
  - Aversive interventions use unpleasant physical or sensory stimuli in an attempt to reduce undesired behavior. The stimuli usually cannot be avoided or is pain inducing.\(^1\)
- Signature of the qualified provider who completed the implementation plan, date signed, and credential.\(^2\)

If the participant is receiving behavioral intervention and habilitative skill building, the provider must have two (2) separate sets of implementation plans, one for each service being provided. This is to ensure there is no duplication of services since each service will have separate and unique goals.

The provider must document that a copy of the participant’s implementation plan(s) was offered to the participant’s parent or legal guardian.\(^2\)

(a) References: Implementation Plans

(i) State Regulations


10.7. **Reimbursement**

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Idaho Medicaid reimburses CHIS Providers on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. See the [Medicaid Fee Schedule for CHIS DDA Providers](https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3375&dbid=0&repo=PUBLIC-DOCUMENTS) and the [Medicaid Fee Schedule for CHIS Independent Providers](https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3375&dbid=0&repo=PUBLIC-DOCUMENTS) for more information regarding reimbursement rates.¹

See the [General Billing Instructions](https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3375&dbid=0&repo=PUBLIC-DOCUMENTS), Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

10.7.1. **References: Reimbursement**

(a) **Idaho Medicaid Publications**


11. **Children’s Support Services**

This section of the Idaho Medicaid Provider Handbook covers Medicaid Support services provided by 1915i Children’s Developmental Disabilities (DD) Home and Community Based Services (HCBS) State Plan Option (hereafter referred to as Children’s DD HCBS) Traditional support services include:

- Respite
- Community-Based Supports
- Family Education

Support services can also be accessed through the Family-Directed Supports (FDS) option and include:

- Family-Directed Community Supports
  - Fiscal Employer Agents
  - Support Broker
  - Community Support Worker

Those seeking support services must choose either Traditional or FDS. Additionally, Case Management is available through the Family and Community Services (FACS) at the Idaho Department of Health and Welfare (hereafter referred to as the Department) to assist participants in accessing Children’s DD HCBS. Contact the local regional FACS DD Program office at 208-334-6500 or toll free at 877-333-9681 for information.

Visit the [Children’s Developmental Disability](https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3375&dbid=0&repo=PUBLIC-DOCUMENTS) website for forms, processes, contact information, and ongoing updates.

11.1. **Provider Qualifications**

All providers must have a valid provider agreement with the Department and meet the provider qualifications for the service(s) provided.³ Those providing respite or community-based supports must have a separate provider agreement, including those who are providers of Children’s Habilitation Intervention Services (CHIS). The following is a list of providers able to enter into a Medicaid provider agreement and deliver Children’s DD HCBS:¹
• Developmental Disabilities Agencies (DDAs);
• Independent respite providers;
• Independent community-based supports (CBS) providers; and
• Independent Children’s Habilitation Intervention Service (CHIS) Providers.

All children’s support services provided by a DDA or independent provider must be supervised. Independent respite and CBS providers are supervised by the Department through the Department agreement. The supervisor must meet the intervention specialist or professional qualifications. The observation and review of the services must be performed at least monthly to ensure staff demonstrate the necessary skills to provide services. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

11.1.1. References: Provider Qualifications

(a) Federal Regulations
1. Provider Qualifications, 42 CFR 441.730 (2021), Government Printing Office

(b) State Regulations


4. “CHIS: Provider Qualifications and Duties.” IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Sec. 575 Department of Administration, State of Idaho,

5. “General Training Requirements.” IDAPA 16.03.21, “Developmental Disability Agencies,” Sec. 302 Department of Administration, State of Idaho,

11.1.2. Respite

Providers of respite services must be at least 16 years of age when employed by a DDA, or if providing independent respite services, the provider must be at least 18 years of age and be a high school graduate or have a GED. Additionally, providers must meet the following qualifications:

- Have received instructions on the needs of the participant and demonstrate the ability to provide services according to a participant’s plan of service;
- Complete DHW’s background check process; and
- Be certified in CPR and First Aid.
(a) **References: Respite**

(i) **State Regulations**

2. “General Training Requirements.” IDAPA 16.03.21, “Developmental Disability Agencies,” 
   Sec. 302.03 Department of Administration, State of Idaho, 

11.1.3. **Community-Based Supports**
Providers of community-based supports (CBS) must meet the following minimum qualifications:

- Be at least 18 years of age;
- Have received instructions on the needs of the participant and demonstrate the ability to provide services according to a plan of service;
- Must have documentation of at least six (6) months of supervised experience working with children with developmental disabilities (DD). Experience as an independent respite provider is not sufficient to meet this requirement. This can be achieved the following ways:
  - Have previous work experience gained through paid employment, university practicum experience, or internship; or
  - On-the-job supervised experience through employment at a DDA with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing before delivering direct supports services, and a minimum of weekly face-to-face supervision with the supervisor for six (6) months while delivering services.
- Complete Department approved coursework. The coursework is an on-line competency training consisting of four (4) modules at the [Idaho Center on Disabilities and Human Development website](https://adminrules.idaho.gov/rules/current/16/160310.pdf);
  - Intervention providers also provided CBS are not required to take the online CBS course, as they already have qualifications that exceed those required to provide CBS. However, independent intervention providers must separately enroll as independent CBS providers.
- Receive a clearance from a background check; and
- Certified in CPR and First Aid.

Individuals providing CBS to participants birth to age three (3) must have six (6) months of documented experience with DD participants in that age range.

(a) **References: Community-Based Supports**

(i) **State Regulations**

3."Individuals Subject to a Background Check.” IDAPA 16.05.06.100, “Criminal History and Background Checks, https://adminrules.idaho.gov/rules/current/16/160506.pdf

11.1.4. Family Education

Family education can be provided by a certified Developmental Disability Agency (DDA) or by an individual with an independent habilitation intervention provider agreement who meets qualifications as an intervention specialist or intervention professional. Additionally, providers of family education services must meet ongoing intervention training requirements. Refer to the Children’s Habilitation Intervention Services section of this handbook for more information.

(a) References: Family Education

(i) State Regulations


11.1.5. Fiscal Employer Agent

Fiscal Employer Agents (FEA) must meet the requirements outlined in the provider agreement with the Department and Section 3504 of the Internal Revenue Code. Additionally, FEAs must not provide other direct services to the participant or employ the guardian, parent, spouse, payee, or conservator of the participant or have direct control over the participant’s choice.

(a) References: Fiscal Employer Agent

(i) Federal Regulations


(ii) State Regulations


11.1.6. Support Broker

Support Brokers must meet the following qualifications:

- Be 18 years of age or older;
- Completion of college courses or community classes or workshops that count toward a degree in the human services field;
• Have at least two (2) years experience with children who have a DD diagnosis;
• Attend a DHW-led initial FDS Support Broker training;
• Pass an application exam;
• Complete DHW’s background check process; and
• Complete 12 hours per year ongoing training, with a minimum of six (6) training hours in a classroom setting.

(a) References: Support Broker

(i) State Regulations

11.1.7. Community Supports Worker
Community Supports Workers must meet the following qualifications: 3
• Complete employment agreement specifying supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports; 2
• Complete DHW’s background check process (or documentation that this requirement has been waived by the participant);
• Current state licensure or certifications when identified supports require them; and
• At least 16 years old when supervised by a caregiver in the home or at least 18 years old to transport or work without supervision. 1

(a) References: Community Supports Worker

(i) Federal Regulations

(ii) State Regulations


11.2. Eligible Participants
The Department must determine whether a participant is eligible for services. Eligibility requires the following criteria to be met: 1
• Birth through age 17;
• Documented Developmental Disability (DD) diagnosis;
• Medicaid eligible; and
• Meets needs-based criteria of the 1915(i) Children’s DD Home and Community Based Services (HCBS) State Plan Option benefit.

Initial and annual eligibility assessments must be performed by the Independent Assessment Contractor (IAC) under contract with the Department. Participants must be determined eligible before receiving Children’s DD HCBS. When a participant is determined eligible, the IAC assigns the participant an annual budget that will be used for their Children’s DD HCBS. The participant can choose to use their budget for Traditional or Family-Directed Services.

11.2.1. References: Eligible Participants

(a) State Regulations


11.3. Covered Services and Limitations

Idaho Medicaid covers the following Children’s DD HCBS for eligible Medicaid participants: 4

• Respite;
• Community-based supports;
• Family education; or
• Family-directed community supports; 1
  o Financial management services; 5
  o Support broker services; and
  o Community support workers.

Children’s DD HCBS involve the collaboration of a family-centered planning team to develop the plan of service for the participant. 4 For traditional services, the family-centered planning team must include the participant, the parent or legal guardian, and the participant’s Case Manager. The team may include others identified by the family or agreed upon as important to the process by the family and the Department.

Children’s DD HCBS are limited by the participant's individualized budget amount. Duplication of services cannot be provided. Services are considered duplicate when: 2

• An adaptive equipment and support service address the same goal.
• Multiple adaptive equipment items address the same goal.
• Goals are not separate and unique to each service provided.
• More than one (1) service is provided at the same time, unless otherwise authorized.

Vocational, educational, and recreational services are excluded from reimbursement for Children’s DD HCBS. Refer to the Children’s Habilitation Intervention Services section of this handbook for a more detailed explanation of excluded services.

Children’s DD HCBS are not reimbursable under Idaho Medicaid when provided in an institution, including a Residential Care Facility (RCF). A Developmental Disability Agency (DDA) cannot provide Children’s DD HCBS at an RCF.

11.3.1. References: Covered Services and Limitations

(a) Federal Regulations

(b) State Regulations


11.3.2. Respite

Respite provides intermittent short-term supervision to the participant to relieve the unpaid primary caregiver.¹ Respite is also available in response to a family emergency or crisis. Respite may be provided in the participant’s home, the home of an independent respite provider, DDA, or in the community.

The following general limitations apply:
- Payment does not include room and board;
- Cannot be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work;
- Must only be offered to participants living with an unpaid caregiver who requires relief;
- Cannot exceed 14 consecutive days;
- Cannot be provided at the same time other Medicaid services are being provided except when an unpaid caregiver is receiving family education;
- Must not use restraints on the participant, other than physical restraints in the case of an emergency to prevent injury to the participant or others. The use of emergency restraints must be documented in the participant’s record; and
- When respite is provided in a group setting, there must be at least one (1) qualified staff providing direct services to every six (6) participants.
  - As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly.

Independent respite providers cannot provide respite in a DDA setting. Additionally, independent providers must meet the following criteria to provide group respite:
- The independent respite provider is a relative of every participant; and
- The service is provided in the home of the participant or the independent respite provider.
Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

(a) References: Respite

(i) State Regulations


11.3.3. Community-Based Supports

Community-Based Supports (CBS) provide assist participants with a DD by facilitating their independence and integration into the community. This service allows for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities.

The following limitations apply:

- CBS is only allowed in a DDA or the participant’s home to allow preparation for, or transition from, a community activity, or to assist with needs that cannot be addressed otherwise in the community;
- Part of every CBS session must occur in the community;
- CBS must not replace services provided in school, therapy, or replace the role of the primary caregiver;
- CBS must ensure the participant is involved in age and peer-appropriate activities according to the ability of the participant; and
- When CBS are provided in a group, there must be at least one (1) qualified staff providing direct services for up to six (6) participants. As the number and severity of participants increases, the staff-to-participant ratio must be adjusted accordingly.
- Cannot be provided in a public school or public charter school.

CBS providers must complete status reviews at least every six (6) months. Provider status reviews must be completed more frequently when required on the plan of service. Department approved forms can be found at Department Provider Forms for Developmental Disabilities.
(a) References: Community-Based Supports

(i) State Regulations


11.3.4. Family Education

Family education is professional assistance to family members or others who care for the participant to help them better meet the participant’s specific needs. Family education provides an orientation to Developmental Disabilities and educates families on basic strategies for behavioral modification and individualized intervention techniques.

When family education is provided in a group setting, the group must not exceed five (5) families of children with a DD diagnosis. Family education cannot be provided at the same time other Medicaid services are being provided, except for respite.

Family education providers must survey the parent or legal guardian’s satisfaction of the service immediately following each education session. Family education providers must maintain documentation of the training in the participant's record, including the delivery of activities outlined in the plan of service.

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(a) References: Family Education

(i) Federal Regulations


(ii) State Regulations


11.3.5. **Family-Directed Community Supports**

Families of participants eligible for Children’s DD HCBS may choose to direct their individualized budget rather than receive traditional services. This option is only available to participants who live at home with their parent or legal guardian. All services under the Family-Directed Community Supports (FDCS) option must be delivered on a one-to-one basis. The services must be identified on a plan of service developed by the family-centered planning team and prior authorized by the Department. Additionally, financial management services are provided by a fiscal employer agent (FEA) to participants who have chosen to direct their services under the consumer-directed community supports option for Children’s DD HCBS.

**(a) References: Family-Directed Community Supports**

(i) **State Regulations**


(b) **Support Broker Services**

Support brokers are individuals hired by participants and advocate on their behalf. They assist the participant with planning, negotiating, and budgeting. The support broker must complete and submit the packet of information provided by the fiscal employer agent (FEA) before beginning employment for the participant. The information packet must include the support broker application approval by the Department, a completed background check, and a completed employment agreement with the participant. The employment agreement must include the negotiated hourly rate for the support broker, and the type, frequency, and duration of services. The hourly rate cannot exceed the maximum hourly rate established by the Department.

Support broker services must include the following:

- Assist with the person-centered planning process;
- Develop and sign a written support and spending plan (SSP) to be authorized by the Department. The SSP must include:
  - Paid and unpaid supports that the participant needs and wants.
  - Related risks identified with the participant’s wants and preferences.
  - A comprehensive risk plan for each potential risk that includes at least three backup plans should a support fail.
- Assist the participant to review and monitor their budget;
- Submit documentation related to the participant’s satisfaction with supports when requested by the Department;
- Follow Department quality assurance measures when requested;


- Assist the participant to complete the annual re-determination process as needed, including updating the SSP and submitting it to the Department for authorization;
- Assist the participant to meet the participant responsibilities for consumer directed services and protect their own health and safety, as needed;
- Complete a background check waiver form when a participant chooses to waive that requirement for a Community Support Worker (CSW). These forms can be obtained by the chosen FEA; and
- Assist participants already enrolled in Family-Directed Community Supports (FDCS) transition to adult DD services.

Support broker services may also include the following duties when requested by the participant:
- Assist the participant to develop and maintain a circle of support;
- Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports;
- Assist the participant to negotiate rates for paid community support workers;
- Maintain documentation of supports provided by each community support worker and participant’s satisfaction with these supports;
- Assist the participant to monitor community supports;
- Assist the participant to resolve employment-related problems;
- Assist the participant to identify and develop community resources to meet specific needs; and
- Assist the participant in distributing the SSP to community support workers or vendors.

The support broker must not be employed by an agency providing paid community supports to the same participant. They must not be the guardian, parent, payee, or conservator of the participant, or have direct control over the participant’s choices. Additionally, the support broker must not be able to both influence a participant’s decision making and receive undue financial benefit.³

Support brokers must give at least 30 days written notice before terminating services. They must assist the participant to identify a new support broker. They must also provide the participant and new support broker with a written service transition plan. The transition plan must include an updated SSP that reflects current supports being received, details about the existing community support workers, and unmet needs.

(c) References: Support Brokers

(i) State Regulations


(d) **Community Support Workers**

Community support workers (CSW) provide identified supports to the participant. The CSW must obtain state licensing or certification when required. Supports include activities that address the participant's preference for:

- Personal support to help the participant maintain health, safety, and basic quality of life;
- Relationship support to help build a natural support network and community;
- Emotional support to help the participant learn and practice behaviors consistent with their goals;
- Transportation support for their goals; and
- Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes their increased independence.

CSWs must not be, or take the role of, the parent or legal guardian of the participant. They must not have direct control over the participant's choices. They must avoid any conflict of interest. They must not receive undue financial benefit from the participant's choices. Additionally, CSWs cannot be paid to complete any legal obligations of the participant's parent or legal guardian.

Before providing services, a CSW must complete an employment packet with the participant and chosen Fiscal Employer Agent (FEA). CSWs must also document the time required to perform the support and accurately report the time on forms provided by the FEA or submit a completed invoice to the FEA. Invoices must include the support type provided, date of service, and negotiated rate. Invoices must be signed by the participant or their legal guardian and the CSW.

(e) **References: Community Support Workers**

(i) **State Regulations**


11.4. **Prior Authorization**

Prior authorization (PA) is intended to help ensure the delivery of appropriate services and supports. Services are reimbursable when identified on the authorized plan of service and are consistent with the Department's PA process for Home and Community Based Settings. The participant's plan of service must be reauthorized annually. A signed provider signature page must be obtained for plans at the initial start of services and annually. The Department must review and authorize the new plan of service before the expiration of the current plan. Before the expiration of the existing plan of service, the Case Manager must:

- Contact the parent or legal guardian to determine the individuals they want to participate in the family centered planning meeting.
• Notify the providers who appear on the plan of service of the annual review date.
• Obtain a copy of the current annual provider status review, if applicable, from each provider for use by the family-centered planning team.
• Meet with the family-centered planning team to develop a new plan of service.

Delivery of each service identified on the plan of service cannot be initiated until the plan has been signed by the parent or participant's decision-making authority, the provider responsible for service delivery, and has been authorized by the Department. PAs are not a guarantee of payment, and all other Department requirements must be fulfilled. Refer to the PA chapter of the Agency Professional handbook for general PA requirements.

See the General Billing Instructions, Idaho Medicaid Provider Handbook, for more information regarding prior authorizations.

11.4.1. References: Prior Authorization

(a) State Regulations


11.5. Documentation Requirements

All documentation must follow standard retention requirements including, but not limited to, those listed in the Documentation section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook. Refer to Community-Based Supports and Family Education for their specific documentation requirements.

Providers of Children’s DD HCBS must maintain records for each participant served. Providers must include written documentation of the service provided during each visit made to the participant, containing the following information:

• Date, time, and location of visit;
• Summary of session and support services provided during the visit;
• Length of visit, including time in and time out;
• Signature and date of the individual providing the service.

Documentation must be made available to the Department immediately upon request. Services without documentation are not eligible for reimbursement. Documentation sent unsolicited, or not for a service requiring prior authorization, will not be reviewed by the Department. Unreviewed documentation does not represent approval or authorization of a service. Specific requirements for each support service can be found in the Covered Services and Limitations section of this chapter.

11.5.1. References: Documentation

(a) State Regulations


11.5.2. Plan Development and Monitoring

The participant’s plan of service is developed within their individualized budget. The plan must include all Children’s DD HCBS and identify other Medicaid services and supports available to the participant. The plan must also identify services outside of Medicaid, if available, that can help the participant meet their desired goals.

The Department Case Manager must monitor the plan of service. The family-centered planning team will determine their preference for frequency of contact from the Case Manager; however, the plan monitor must meet face-to-face with the participant and their parent or legal guardian at least annually. The plan of service must always be authorized by the Department before the delivery of services. The participant’s plan of service must include the following:

- Functional needs assessment;
- Health status;
- Strengths and weaknesses;
- Identified goals and desired outcomes;
- Identified services and supports; and
- Risk factors and how they will be minimized.

For community-based services, plan monitoring includes the following:

- At least every six (6) months and annually, a review of the plan of service with the parent or legal guardian to identify the current status of services, barriers to success, and any necessary changes to the plan.
- Documentation of the six-month and annual provider status review (PSR) reviews must be submitted to the participant’s Case Manager. The annual PSR must be submitted to the plan monitor 45 calendar days before the expiration of the existing plan of service.
- Monthly coordination of services and supports with the family and service providers to assure collaboration across services and identification of any barriers to service delivery.
- Satisfaction surveys regarding quality and quantity of services.

The participant’s plan of service may be adjusted during the year based on needs and the participant’s or decision-making authority’s request with an addendum to the plan. Adjustment of the plan of service requires the signature of the parent or legal guardian. Before implementing any plan adjustments, providers must obtain the signed addendum and submit an updated provider signature page to the Case Manager.

As Children’s DD HCBS fall under Idaho’s 1915(i) Children’s DD HCBS State Plan Option, plans for these services that include restrictive interventions must be approved by the Children’s DD Program before implementation to ensure compliance with federal requirements. Any provider implementing restrictive interventions during the delivery of Children’s DD HCBS must complete the Restrictive Interventions Implementation and Instructions and Form and follow the process for review and approval. The instructions and form can be found in the Department’s 1915(i) HCBS Traditional Supports library.

(a) References: Plan Development and Monitoring

(i) Federal Regulations

11.6. Reimbursement

Medicaid reimburses Children’s DD HCBS on a fee-for-service basis.¹ Refer to the Idaho Medicaid Fee Schedule webpage and the Children’s DD & CHIS DDA Fee Schedule or Children’s DD & CHIS Independent Provider Fee Schedule. See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

11.6.1. References: Reimbursement

(a) State Regulations


12. Waiver Services for Adults with Developmental Disabilities

12.1. Overview of Policy for DD Waiver Program

Waiver services are covered for Medicaid Enhanced Plan participants. Currently, Idaho has one waiver for adults diagnosed with developmental disabilities, which is for individuals at least 18 years of age who meet intermediate care facility for people with intellectual disabilities (ICF/IID) level of care requirements.

For an adult participant to be eligible for the DD waiver, the Department or its designee must find that the participant:

- Must be financially eligible for Medicaid.
- Must have a primary diagnosis of being intellectually disabled or have a related condition defined in section 66-402, Idaho Code.
- Must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition.
- Requires services due to a developmental disability that impairs his or her mental or physical function or independence.
• Is capable of being maintained safely and effectively in a non-institutional setting and would, in the absence of such services, need to reside in an ICF/IID.

A participant who is determined by the Department to be eligible for services under the DD waiver may elect not to utilize waiver services but may choose admission to an ICF/IID.

12.2. Place of Service (POS) Codes

DD waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community.

12.2.1. Place of Service (POS) Exclusions

The following living situations are specifically excluded as a place of service for DD waiver services:

- Licensed, skilled, intermediate care facility, certified nursing facility (NF), or hospital.
- Licensed intermediate care facility for people with intellectual disabilities (ICF/IID).
- Residential care or assisted living facility.

12.3. Plan of Service

All DD waiver services must be provided based on a plan of service written by a plan developer and approved by the Department.

A plan developer is defined as a paid or non-paid person identified by the participant who is responsible for developing one plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process.

Plan developers are required to also monitor the plan.

If the participant uses a paid plan developer, the plan developer must be employed by a service coordination agency.

The paid/non-paid plan developer is the plan monitor unless there is a service coordinator in which case the service coordinator assumes the roles of both service coordinator and plan monitor.

12.3.1. Individual Support Plan (ISP) Plan Development

The plan must be developed with the participant and their person-centered planning team. The person-centered planning team may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid funded services that can help the participant meet desired goals.

The annual plan of service must be submitted within 45 days prior to the expiration of the existing plan of service.

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

A participant's plan of service must be re-authorized annually.
Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required.

12.3.2. Addendum to the Plan of Service

A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department.

12.3.3. Implementation Plans

Providers of the following DD services are responsible for developing an implementation plan:
- Residential Habilitation (Supported Living and Certified Family Home)
- Supported Employment
- Skilled Nursing
- Behavioral Consultation/Crisis Management
- Adult Day Health

Implementation plans must identify specific objectives that demonstrate how the provider will assist the participant to meet the participant’s goals and needs identified in the plan of service.

The implementation plan must be completed within 14 days after the initial provision of service and revised whenever participant needs change.

Documentation of implementation plan changes will be included in the participant record. This documentation must include, at a minimum:
- The reason for the change
- Documentation of coordination with other service providers (where applicable)
- The date the change was made
- The signature of the person making the change complete with the date and title.

Providers listed above must submit provider status reviews six months after the start date of the plan of service and annually to the plan monitor.

12.4. Important Billing Instructions

Dates of service must be within the Sunday through Saturday calendar week on a single claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday. Failure to comply with the Sunday through Saturday billing will result in claims being denied. In addition, one detail line on a DD claim form cannot span more than one calendar month. If the end of the month falls in the middle of a week two separate claims must be used.

In the example (Figure 12-1), the last week in August 2001, begins Sunday, August 26, 2001, and ends Saturday, September 1, 2001. Two separate claims must be entered for this week. One claim will have service dates of 08/26/2001 through 08/31/2001. The second claim will have service dates of 09/01/2001 through 09/01/2001.

Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim as long as the same quantity of services have been provided each day.
12.5. Payment

Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department.

Provider claims for payment must be submitted on claim forms provided or approved by the Department.

All waiver services must be identified on the plan of service and prior authorized by the Department. The prior authorization process is to ensure the provision of right care, in the right place, at the right price, and with the right outcomes.

The reimbursement rates calculated for services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant’s home or other service delivery location when the participant is provided transportation.

A physician’s referral is required for skilled nursing services provided under the DD Waiver.

12.6. Share of Cost

Only participants who qualify under 42 CFR 435.217 are required to pay a co-payment.

Idaho Native American Indians who are accessing care from Indian Health facilities or show they are eligible and referred through contract health services are exempted from cost sharing requirements.

12.7. Record Keeping

Record information will be maintained on all participants receiving waiver services.

- Direct service provider information, which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information:
  - Date and time of visit.
  - Services provided during the visit.
  - A statement of the participant’s response to the services, if appropriate to the service provided, including any changes in the participant’s condition.
  - Length of visit, including time in and time out, if appropriate to the service provided.
  - Unless the participant is determined by the service coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record.
A copy of the above information will be maintained in the participant’s home unless authorized to be kept elsewhere by the Department. Failure to maintain to such documentation will result in the recoupment of funds paid for the undocumented services.

12.7.1. Change of Provider Information
If the provider has a change of name, address, or telephone number, immediately notify Idaho Medicaid by submitting a maintenance record update. Indicating updated provider information on a claim form is not acceptable and the appropriate changes cannot be made.

13. Skilled Nursing Services – DD Waiver

13.1. Service Description
Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such, care must be provided by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. Nursing services may include but are not limited to:

- The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material.
- The maintenance of volume ventilators, including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning.
- Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis.
- Injections.
- Blood glucose monitoring.
- Blood pressure monitoring.

13.2. Agency Provider Qualifications
Nursing Service Providers must be licensed in Idaho as an R.N. or L.P.N. in good standing or must be practicing on a federal reservation and be licensed in another state. Skilled Nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

For DD waiver participants, this service may be delivered by an Individual or Agency provider.

14. Behavior Consultation/Crisis Management (BC/CM) DD Waiver

14.1. Service Description
Behavior consultation and crisis management services are services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services include emergency back-up involving the direct support of the participant in crisis.
14.2.  Agency Provider Qualifications

14.2.1.  Behavior Consultation and Crisis Management (BC/CM) Providers

Behavior Consultation/Crisis Management providers must meet the following:
- Work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and
- Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education, or a closely related course of study; or
- Be a licensed pharmacist; or
- Be a Qualified Intellectual Disabilities Professional (QIDP).
- Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

This service may be delivered by an Individual or Agency provider.

14.2.2.  Emergency Back-up Providers

Emergency back-up providers must meet the minimum residential habilitation Agency Provider Qualifications described under IDAPA 16.04.17, Residential Habilitation Agencies.

15.  Chore Services – DD Waiver

15.1.  Service Description

Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment:
- Intermittent assistance may include the following:
  - Yard maintenance
  - Minor home repair
  - Heavy housework
  - Sidewalk maintenance
  - Trash removal to assist the participant to remain in their home
- Chore activities may include the following:
  - Washing windows
  - Moving heavy furniture
  - Shoveling snow to provide safe access inside and outside the home
  - Chopping wood when wood is the participant's primary source of heat
  - Tacking down loose rugs and flooring
- These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for them, and when no other relative, caretaker, landlord, community volunteer, agency, or third-party payer is willing to or is responsible for their provision.
- In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant.

15.2.  Agency Provider Qualifications

Providers of chore services must meet the following minimum qualifications:
• Be skilled in the type of service to be provided.
• Demonstrate the ability to provide services according to a plan of service.

Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

For DD waiver participants, this service may be delivered by an Individual or Agency provider.

16. Residential Habilitation – DD Waiver

16.1. Service Description
Residential habilitation services which consist of an integrated array of individually-tailored services and supports are furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or Certified Family Home. The services and supports that may be furnished consist of the following:

• Habilitation services aimed at assisting the individual to acquire, retain, or improve his or her ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one or more of the following areas:
  o Self-direction
  o Money management
  o Daily living skills
  o Socialization
  o Mobility

• Behavior shaping and management Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or participant's primary caregivers are unable to accomplish on his or her own behalf.

• Skills training to teach to waiver participants, family members, alternative family caregivers, or a participant’s roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility, and other therapeutic programs. Skills training services that may be provided to a participant under the DD Waiver cannot duplicate skill training services the same participant may be receiving under the Idaho Behavioral Health Plan.

16.2. Residential Habilitation – Supported Living

16.2.1. Service Description
When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, Residential Habilitation Agencies, and must be capable of supervising the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency.

Supported Living is defined as one (1), two (2), or three (3) participants who live in their own home or apartment and require staff assistance. A residence is considered to be the participant’s own home when it is owned or rented by the participant. The home is defined to be owned or rented by the participant when the participant has entered into a valid mortgage,
lease, or rental agreement for the residence and when the participant is able to provide the Department with a copy of the agreement.

When two (2) or three (3) participants reside in the same home, services may be provided through individual or group staffing arrangements as approved by the Department.

### 16.2.2. Agency Provider Qualifications

Providers of residential habilitation services must meet the following requirements:

- **Direct service staff** must meet the following minimum qualifications:
  - Be at least eighteen (18) years of age.
  - Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service.
  - Have current CPR and First Aid certifications.
  - Be free from communicable diseases.
  - Each staff person assisting with participant medications must successfully complete and follow the “Assistance with Medications” course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or complete other Department-approved training.
  - Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

- **Have appropriate certification or licensure if required to perform tasks which require certification or licensure.** All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects:
  - Purpose and philosophy of services
  - Service rules
  - Policies and procedures
  - Proper conduct in relating to waiver participants
  - Handling of confidential and emergency situations that involve the waiver participant
  - Participant rights
  - Methods of supervising participants
  - Working with individuals with developmental disabilities

- **Training specific to the needs of the participant** Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include, at a minimum:
  - Instructional techniques: Methodologies for training in a systematic and effective manner
  - Managing behaviors: Techniques and strategies for teaching adaptive behaviors
  - Feeding
  - Communication
  - Mobility
  - Activities of daily living
  - Body mechanics and lifting techniques
  - Housekeeping techniques

- **Maintenance of a clean, safe, and healthy environment** the provider agency will be responsible for providing ongoing training specific to the needs of the participant as needed.
16.2.3. Participant Rights

Providers are required to ensure participants are afforded certain rights under applicable federal and state regulations for Supported Living services. These rights include, but are not limited to:

- Dignity and respect.\(^1\)
- Freedom from coercion and restraint.\(^1\)
- A written agreement such as a lease, residency agreement, admission agreement or other document in place at the time of occupancy. It must include protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant laws.\(^1,2\)
- Privacy in their sleeping or living unit.\(^1,2\)
- An entrance door to their unit with a lock that only the participant and appropriate staff have keys to.\(^1,2\)
- Units must be integrated in and support community access, including opportunities to seek employment, engage in community life, control personal resources and receive services in the community.\(^1\)
- Choice of units from among options including non-disability specific units and an option for a private unit. This must be documented in the person-centered plan.\(^1\)
- Physical accessibility to the unit.\(^1,2\)
- Freedom to furnish and decorate their sleeping or living units.\(^1,2\)
- Choice of roommates.\(^1,2\)
- Services that optimize but does not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.\(^1\)
- Facilitated individual choice regarding services and supports, and who provides them.\(^1\)
- Control of their own schedules and activities.\(^1,2\)
- Access to food at any time.\(^1,2\)
- Visitors of their choosing at any time.\(^1,2\)

(a) References: Participant Rights

(i) Federal Regulations


(ii) State Regulations


16.3. Residential Habilitation – Certified Family Home

16.3.1. Service Description

An individual who provides direct residential habilitation services in their own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, Certified Family Homes, and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services he provides.
16.3.2. Agency Provider Qualifications

CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications:

- Be at least eighteen (18) years of age
- Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service
- Have current CPR and First Aid certifications
- Be free from communicable diseases
- Each CFH provider of residential habilitation services assisting with participant medications must successfully complete and follow the “Assistance with Medications” course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training.
- CFH providers of residential habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
- Have appropriate certification or licensure if required to perform tasks which require certification or licensure.

All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs.

Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department and/or its contractor and include the following areas:

- Purpose and philosophy of services
- Service rules
- Policies and procedures
- Proper conduct in relating to waiver participants
- Handling of confidential and emergency situation that involve the waiver participant
- Participant rights
- Methods of supervising participants
- Working with individuals with developmental disabilities
- Training specific to the needs of the participant

Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following:

- Instructional Techniques: Methodologies for training in a systematic and effective manner
- Managing behaviors: Techniques and strategies for teaching adaptive behaviors
- Feeding
- Communication
- Mobility
- Activities of daily living
- Body mechanics and lifting techniques
- Housekeeping techniques
- Maintenance of a clean, safe, and healthy environment

The Department or its contractor will be responsible for providing ongoing training to the CFH provider of residential habilitation specific to the needs of the participant as needed.
16.3.3. Participant Rights

Providers are required to ensure participants are afforded certain rights under applicable federal and state regulations for certified family home services. The provider must have a written acknowledgement that the resident has received a copy of their rights and that they have been reviewed annually. These rights include, but are not limited to:

- Freedom from discrimination on the basis of race, color, national origin, sex, religion, age, disability or veteran status.
- Dignity and respect including courteous treatment by staff and confidentiality of records.
- Freedom from coercion, intimidation or manipulation and physical or chemical restraint.
- Freedom from exploitation, physical, mental or sexual abuse, neglect, corporeal punishment, involuntary seclusion.
- Freedom of religion.
- The ability to choose their own medical, pharmacy and dental providers.
- Refusal of any routine care of a personal nature from any person the participant is uncomfortable with.
- To be informed in writing about the formulation of advanced directives.
- A written agreement such as a lease, residency agreement, admission agreement or other document in place at the time of occupancy. It must include protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant laws.
- An entrance door to their unit with a lock that only the participant and appropriate staff have keys to.
- Privacy in their accommodations, medical and other treatment, written and telephone communications, use of their image or video, visits and meetings of family and resident groups.
- A diet that corresponds to their religious or health-related restrictions. The ability to refuse a restricted diet.
- Choice of roommates.
- Freedom to furnish and decorate their sleeping or living units.
- A safe and sanitary living environment free from illicit drug use or possession and other criminal activities.
- Units must be integrated in and support community access, including opportunities to seek employment, engage in community life, control personal resources and receive services in the community. If employed by the provider, wages must meet state and federal requirements. The participant cannot be forced to accept employment by the provider.
- Choice of units from among options including non-disability specific units and an option for a private unit. This must be documented in the person-centered plan.
- Services that optimize but does not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitated individual choice regarding services and supports, and who provides them.
- Physical accessibility to the unit.
- Records that are maintained and current with the participant’s negotiated plan of service and physician’s history and physical that includes medications and special treatments. This includes information about specific health problems of the resident which are necessary in a medical emergency. Also, emergency contact information including the name, address and telephone number of an individual identified by the participant. Any other health-related, emergency or pertinent information the
participant requests be on record. Records must be available to the participant.
Healthcare professionals must have access to records with the participant’s consent.

- Record of all personal property and funds belonging to the resident that are entrusted to the provider including copies of receipts for property. Records must be available to the participant.
- A response to any inquiry to the provider by the participant within a reasonable timeframe.
- Participant personal possessions such as wearing their own clothes, retaining and use of personal property in living area, and an individual storage area in their living area with at least one lockable drawer or cabinet. Personal possessions may not create a fire or life safety hazard.
- Control of personal funds. This includes receipt of funds received from the Department and the difference in room and board and care allowance. The participant cannot be required to deposit the funds with the provider. Providers must hold, safeguard and account for all personal funds in their possession with written authorization from the participant. In the event of death, personal fund balances are refunded to the Department.
- Visitors. This includes immediate access by the participant’s physician, any representative of the Department, the state ombudsman for the elderly or their designee, and any protection or advocacy system designated by the governor pursuant to 42 U.S.C. 15043 and 42 U.S.C. 10801. Immediate family or other relatives have immediate access with the consent of the participant. Other visitors of their choosing at any time with reasonable restrictions if supported by a specific assessed need and justified in the person-centered service plan.
- Control of their own schedules and activities.
- Access to food at any time.
- Ability to submit a grievance regarding the behavior of other residents, treatment or care received or not received without fear of reprisal or discrimination and prompt efforts of the provider to resolve the grievance.
- Ability to file a complaint with the Department.
- Examination of the most recent home inspection reports and any corrective action plan for the certified family home.
- 30-day notice of non-emergency transfer or discharge unless a three day written notice is provided due to non-payment of bill, violation of written conditions of admission agreement, or the unlawful delivery, production or use of a controlled substance at the certified family home.
- Access to a list of other available certified family homes in the event of a transfer.

(a) References: Participant Rights

(i) Federal Regulations


(ii) State Regulations


17. Respite Care DD Waiver

17.1. Service Description
Respite services are short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments.

Respite care services may be provided in the participant’s residence, the private home of the respite provider, the community, a Developmental Disabilities Agency, or an Adult Day Health Facility.

17.2. Agency Provider Qualifications
Providers of respite care services must meet the following minimum qualifications:
- Have received care giving instructions in the needs of the person who will be provided the service
- Demonstrate the ability to provide services according to a plan of service
- Have no communicable diseases

Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

For DD waiver participants, this service may be delivered by an Individual or Agency provider.

17.3. Procedure Codes

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>Diagnosis</th>
<th>Place of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1005</td>
<td>Respite Care Services, up to 15 minutes 1 Unit = 15 minutes. Maximum of six hours per day or 24 units.</td>
<td>ICD-10-CM code for the primary diagnosis. Z74.2</td>
<td>12 Home (CFH, participant’s own home, or home of unpaid family)</td>
</tr>
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</tr>
</tbody>
</table>

Respite Care DD Waiver

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- Have received care giving instructions in the needs of the person who will be provided the service
- Demonstrate the ability to provide services according to a plan of service
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<tr>
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</tr>
<tr>
<td>HCPCS</td>
<td>Description</td>
<td>Diagnosis</td>
<td>Place of Service</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>S9125</td>
<td>Respite Care, In the Home, per diem</td>
<td>1 Unit = 1 day</td>
<td>This code should only be used when the participant receives hourly supported living to access the community. All other RES/HAB should be coded as, Home.</td>
</tr>
</tbody>
</table>

18. Supported Employment Services – DD Waiver

18.1. Service Description

Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities, for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disabilities, these individuals need intensive supported employment services or extended services in order to perform such work.

- Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service, verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or by the IDEA.
- Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - Incentive payments made to an employer of waiver participants to encourage or subsidize the employers’ participation in a supported employment program.
  - Payments that are passed through to beneficiaries of supported employment programs.
  - Payments for vocational training that are not directly related to a waiver participant’s supported employment program.

Supported employment includes oversight and training needed to sustain paid work at or above the minimum wage by participants. Service payment is made only for the adaptations, oversight, and training required by participants receiving waiver services as a result of their disabilities, but it does not include payment for the supervisory activities rendered as a normal part of the business setting. Idaho’s Division of Vocational Rehabilitation assists participants to locate a job or develop a job on behalf of the participant.

18.2. Agency Provider Qualifications

Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards; or meet State requirements to be a State approved provider.

Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

For DD waiver participants, this service may only be delivered by an agency provider.
18.3. **Procedure Codes**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>Diagnosis</th>
<th>Place of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2023</td>
<td>Supported Employment, per 15 minutes The maximum allowable units per week are 160. 1 Unit = 15 minutes</td>
<td>ICD-10-CM code Z74.2 for the primary diagnosis.</td>
<td>99 Other (Community)</td>
</tr>
</tbody>
</table>

19. **Non-Medical Transportation – DD Waiver**

19.1. **Service Description**

Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources.

- Non-medical transportation is offered in addition to medical transportation as required in IDAPA 16.03.09, Medicaid Basic Plan Benefits, and will not replace it.
- Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized.

Non-medical transportation is limited to 1,800 miles per year.

As part of non-medical transportation, commercial bus passes may be purchased for a waiver participant. Bus passes are manually priced for the cost of the pass and prior authorized for the public transportation provider if they have a valid contract with the Department.

19.2. **Agency Provider Qualifications**

Providers of non-medical transportation services must:

- Possess a valid driver’s license
- Possess valid vehicle insurance

For DD waiver participants, this service may be delivered by a commercial, agency, or individual transportation provider.

19.3. **Procedure Codes**

Non-Medical Transportation services require prior authorization.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0080</td>
<td></td>
<td>Non-Medical transportation, per mile, vehicle provided by volunteer (individual or organization), with no vested interest. Specify number of miles from pick-up to delivery. Prior Authorization for waiver service required. 1 unit = 1 mile</td>
</tr>
<tr>
<td>A0080</td>
<td>76</td>
<td>Non-Medical Transportation, Commercial Provider</td>
</tr>
<tr>
<td>A0110</td>
<td></td>
<td>Non-Medical Transportation – Commercial Bus Pass</td>
</tr>
</tbody>
</table>
20. Environmental Accessibility Adaptations – DD Waiver

20.1. Service Description

Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety may include:

- The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant
  - but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning.
- Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home which is the participant’s principal residence and is owned by participant or the participant’s non-paid family.
- Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department.

Environmental Accessibility Adaptations are not available to participants receiving residential habilitation – CFH services.

To approve a permanent adaptation to a rental home, the following must be in place:

- A letter from the landlord agreeing with the adaptation
- The lease agreement must be binding for either the participant or the participant’s guardian

20.2. Agency Provider Qualifications

All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification.

For DD waiver participants, this service may be delivered by an Individual or Agency provider.

21. Specialized Medical Equipment and Supplies – DD Waiver

21.1. Service Description

Specialized medical equipment and supplies include devices, controls, or appliances which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.
21.2. **Agency Provider Qualifications**

Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items must meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant’s needs.

For DD waiver participants, this service may only be delivered by an agency provider.

22. **Personal Emergency Response System DD Waiver**

22.1. **Service Description**

Personal Emergency Response System (PERS) is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

This service is limited to participants who:
- Rent or own their home, or live with unpaid caregivers
- Are alone for significant parts of the day
- Have no caretaker for extended periods of time
- Would otherwise require extensive routine supervision

22.2. **Agency Provider Qualifications**

Providers must demonstrate that the devices installed in waiver participants’ homes meet Federal Communications Standards, Underwriter’s Laboratory standards, or equivalent standards.

For DD waiver participants, this service may only be delivered by an agency provider.

23. **Home Delivered Meals – DD Waiver**

23.1. **Service Description**

Meals are designed to promote adequate participant nutrition through the provision and home delivery of one to two meals per day, and are limited to participants who:
- Rent or own their own home
- Are alone for significant parts of the day
- Have no regular caretaker for extended periods of time
- Are unable to prepare a meal without assistance

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
<th>Place of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Delivered Meals (DD)</td>
<td>S5170</td>
<td>Home Delivered Meals, including preparation; per meal This service is restricted to 14 meals per week. No more than</td>
<td>12 Home</td>
</tr>
</tbody>
</table>
### 23.2. Agency Provider Qualifications

Providers must be a public agency or private business and must be capable of:

- Supervising the direct service.
- 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.
- 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.
- A registered dietician documents the review and approval of menus, menu cycles, and any changes and substitutions.
- The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, Idaho Food Code.

For DD waiver participants, this service may only be delivered by an agency provider.

### 24. Adult Day Health – DD Waiver

#### 24.1. Service Description

Adult Day Health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided in a non-institutional, community-based setting and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult Day Care (Health) services provided under this waiver will not include room and board payments.

Adult Day Health cannot exceed thirty (30) hours per week, either alone or in combination with developmental therapy and occupational therapy.

#### 24.2. Agency Provider Qualifications

Adult Day Health services must be delivered through an executed provider agreement with the provider and Medicaid. Providers are reviewed during the initial provider agreement approval and through the renewal process. After the initial provider agreement is approved, providers are reviewed at least every three (3) years, and as needed based on service monitoring concerns.

Providers of Adult Day Health must meet the following:

- Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, Developmental Disabilities Agencies (DDA).
- Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, Certified Family Homes.
  - Standards of home certification relate specifically to “Fire and Life Safety.”
- Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
• Providers of adult day health services must notify the Department, on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan.
• Be free from communicable diseases.

For DD waiver participants, this service may be delivered by an Individual or Agency provider.

25. Consumer-Directed Services – DD Waiver
Participants eligible for the DD waiver may choose to self-direct their individualized budget rather than receive traditional DD waiver services. The requirements for this option are outlined in IDAPA 16.03.13, Consumer-Directed Services.

25.1. Community Supports Workers

25.1.1. Service Description
Community support workers provide goods and supports that are medically necessary and/or minimize the participant's need for institutionalization and address the participant's preferences for:
• Job support to help the participant secure and maintain employment or attain job advancement
• Personal support to help the participant maintain health, safety, and basic quality of life
• Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community
• Emotional support to help the participant learn and practice behaviors consistent with his goals and wishes while minimizing interfering behaviors
• Learning support to help the participant learn new skills or improve existing skills that relate to his identified goals
• Transportation support to help the participant accomplish his identified goals
• Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes his increased independence
• Skilled nursing supports

25.2. Agency Provider Qualifications
Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

Community Supports may be delivered by an individual, agency or vendor.

25.3. Support Broker

25.3.1. Service Definition
Support brokers provide counseling and assistance for participants with arranging, directing, and managing goods and services. They serve as the agent or representative of the participant to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. This includes providing participants
with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Practical skills training is offered to enable participants to remain independent. Examples of skills training include:

- Helping participants understand the responsibilities involved with directing services
- Providing information on recruiting and hiring community support workers
- Managing workers and providing information on effective communication
- Problem-solving

The extent of support broker services furnished to the participant must be specified on the support and spending plan.

Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant’s needs and preferences. At a minimum, the support broker must:

- Participate in the person-centered planning process.
- Develop a written support and spending plan with the participant that includes the supports the participant needs and wants, related risks identified with the participant's wants and preference, and a comprehensive risk plan for each potential risk that includes at least three back up plans should a support fall out.
- Assist the participant to monitor and review his budget through data and financial information provided by the FEA.
- Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department.
- Participate with Department quality assurance measures, as requested.
- Assist the participant with scheduling required assessments to complete the Department's annual determination process as needed, including assisting the participant or his representative to update the support and spending plan and submit it to the Department for authorization.

In addition to the required minimum support broker duties, the support broker must be able to provide the following services when requested by the participant:

- Assist the participant to develop and maintain a circle of support.
- Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports.
- Assist the participant to negotiate rates for paid community support workers.
- Maintain documentation of supports provided by each community support worker, and of the participant’s satisfaction with these supports.
- Assist the participant to monitor community supports.
- Assist the participant to resolve employment-related problems.
- Assist the participant to identify and develop community resources to meet specific needs.

25.4. **Agency Provider Qualifications**

A Support Broker providing services to a participant accessing Consumer Directed Services must meet the following qualifications:

- Be eighteen (18) years of age or older.
- Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field.
- Have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field.
- Successfully pass an application exam.
• Complete a criminal history check, including clearance in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
• Complete an employment agreement with the participant that identifies the specific tasks and services that are required of the support broker.

All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services.

The support broker must not provide or be employed by an agency that provides paid community supports to the same participant, and must not be in a position to both influence a participant’s decision making and receive undue financial benefit from the participant’s decisions.

25.5. Fiscal Employer Agent

25.5.1. Service Description

The Department will offer financial management services through any qualified fiscal employer agent (FEA).

FEA providers will complete financial consultation and services for a participant who has chosen to self-direct their services in order to assure that the financial information and budgeting information is accurate and available to them as is necessary in order for successful self-direction to occur:

• Payroll and Accounting: Providing payroll and accounting supports to participants who have chosen the self-directed community supports option.
• Financial Reporting: Performing financial reporting for employees of each participant.
• Financial information packet: Preparing and distributing a packet of information, including Department approved forms for agreements, for the participant hiring his own staff.
• Time sheets and invoices: Processing and paying timesheets for community support workers and support brokers, as authorized by the participant, according to the participant's Department authorized support and spending plan.
• Taxes: Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker.
• Payments for goods and services: Processing and paying invoices for goods and services, as authorized by the participant, according to the participant's support and spending plan.
• Spending information: Providing each participant with reporting information and data that will assist the participant with managing the individual budget.
• Quality assurance and improvement: Participation in Department quality assurance activities.

FEA providers complete financial services and financial consultation for the participant and/or their representative that is related to a self-directed participant's individual budget. The FEA assures that the financial data related to the participant's budget is accurate and available to them or their representative as necessary in order for successful self-direction to occur. FEA qualifications, requirements, and responsibilities, as well as allowable activities, are described in Idaho Administrative Rules.
25.6. **Agency Provider Qualifications**

The Fiscal Employer Agent (FEA) must meet the requirements outlined in its provider agreement with the Department, and Section 3504 of the Internal Revenue Code.

For DD waiver participants, this service may only be delivered by an Agency provider.

(a) **Procedure Codes**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2040</td>
<td>Financial management self-directed waiver per 15 minutes</td>
<td>Monthly amount based on UCR fee schedule</td>
</tr>
<tr>
<td>T2025</td>
<td>Waiver services not otherwise specified</td>
<td>Pay as billed</td>
</tr>
</tbody>
</table>

26. **Community Crisis Supports**

Community crisis supports is a service available to adults with developmental disabilities delivered by the following waiver providers:

- Residential Habilitation – Agency
- Residential Habilitation – Certified Family Home
- Behavioral Consultation/Crisis Management
- Supported Employment

**Note:** For Agency Provider Qualifications, see IDAPA rules for the specific provider type.

Community crisis supports are interventions for adult participants who have been determined eligible for developmental disability services, and who are at risk of losing housing, employment, or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies.

Community crisis supports may be authorized the following business day after the intervention if there is a documented need for immediate intervention, if no other means of support are available, and if the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period.

Community Crisis Supports are based on a crisis plan that outlines interventions used to resolve the crisis. After Community Crisis Supports are provided, the crisis provider must provide documentation of the crisis outcome, identification of factors contributing to the crisis, and a proactive strategy that will address the factors that resulted in a crisis. The crisis resolution plan must be submitted to the Department for approval within three (3) business days of providing community crisis support.

Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community.

27. **Transition Services – DD Waiver**

27.1. **Service Description**

Transition Services include goods and services that enable a participant residing in a nursing facility, hospital, Institution for Mental Diseases (IMD), or Intermediate Care Facility for
Persons with Intellectual Disabilities (ICF/ID) to transition to a community-based setting where the person is directly responsible for his or her own living expenses. A participant is eligible to receive Transition Services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days.

Transition Service benefits are provided in conjunction with Transition Management. The Transition Management benefit is provided under Enhanced State Plan benefits.

27.2. **Agency Provider Qualifications**

Agencies are responsible for administering Transition Services.

27.3. **Place of Service (POS)**

Transition Services can only be provided in the following POS:

12 Home

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

27.4. **Procedure Codes**

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Services</td>
<td>T2038</td>
<td>Prior Authorized goods and services not to exceed $2,000.</td>
</tr>
</tbody>
</table>

27.5. **References**

27.5.1. **State Regulations**


28. **Aged & Disabled Waiver Services**

Idaho’s elderly and disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the person’s own home and/or community regardless of age, income, or ability. These services should encourage the involvement of natural supports such as family, friends, neighbors, volunteers, religious community, and others. The Idaho Department of Health and Welfare’s (DHW) Medicaid Program requested and obtained approval for a Home and Community-Based Services (HCBS) Aged and Disabled (A&D) waiver from the federal government. The HCBS waiver allows the provision of services that may be provided in a number of community living situations, such as:

- The person’s own home or apartment
- The homes of relatives who are the primary non-paid care providers/certified family homes
- Residential care facilities
- Assisted living facilities
This section addresses all additional services available to qualifying A&D waiver participants, including:

- Adult Day Health
- Non-medical transportation
- Specialized medical equipment and supplies
- Attendant care
- Chore services
- Companion services
- Consultation services
- Homemaker services
- Home delivered meals
- Environmental accessibility adaptations
- Respite care services
- Personal emergency response system
- Supported employment
- Day habilitation
- Residential habilitation
- Skilled Nursing
- Transition Services

See the Adult Residential Care, Idaho Medicaid Provider Handbook for guidance related to the A&D Waiver Adult Residential Care service.

### 28.1. Medicaid Services

In order to better serve the public, the state is organized into seven regions to provide programs that foster a productive, healthful, and independent quality of life for Idaho citizens. Each region serves several counties.

BLTC staff in the region act as the administrative manager for the A&D waiver. They determine unmet needs through the Uniform Assessment Instrument (UAI), authorize waiver services, and participate in development of the Individual Service Plan (ISP).

### 28.2. General Information

This section covers all general claim information for A&D waiver services. It addresses the following:

- Agency Provider Qualifications
- Record keeping
- Participant eligibility
- Prior authorization (PA)
- Billing information
- Place of service delivery and exclusions
- Plan for services
- Change of provider information

#### 28.2.1. Agency Provider Qualifications

All providers of waiver services must have a valid provider agreement or performance contract with Medicaid. Providers must meet the qualifications of IDAPA 16.03.10.329, Aged and Disabled Waiver Services – Agency Provider Qualifications and Duties. BLTC staff in each region will monitor performance under this agreement or contract.
Waiver service providers must obtain a separate provider number for non-medical transportation services.

Non-medical transportation (NMT) services providers must be enrolled as transportation vendors with the Idaho Medicaid program; see the [NMT Agency Provider Qualifications](#) section for more information.

Specialized medical equipment and supplies services providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see [Suppliers](#), Idaho Medicaid Provider Handbook for more information.

Environmental accessibility adaptation providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see [Suppliers](#), Idaho Medicaid Provider Handbook for more information.

Personal emergency response system services providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see [Suppliers](#), Idaho Medicaid Provider Handbook for more information.

Adult Day Health providers must have an Adult Day Health additional terms provider agreement.

Providers of homemaker services, attendant care, chore services, consultation, and skilled nursing services, and Transition Managers must be enrolled or affiliated with a Personal Care Services Agency. The Agency must have an [Aged and Disabled Waiver - Personal Care Services](#) additional terms provider agreement.

Supported employment providers must be enrolled as supported employment agencies with a [Supported Employment](#) additional terms provider agreement.

Residential habilitation and day habilitation providers must be enrolled as residential habilitation agencies with a [Residential Habilitation Agency](#) additional terms provider agreement.

### 28.2.2. Record Keeping

Medicaid requires all providers to meet the documentation requirements listed in the Provider Enrollment Agreement and IDAPA rules. Providers must generate records at the time of service and maintain all service delivery records necessary to fully document the extent of services submitted for Medicaid reimbursement for each participant receiving services. Providers must also retain all medical records to document services submitted for Medicaid reimbursement for at least five (5) years after the date of final payment for the service.

**Note:** Do not attach service delivery documentation to claims submitted to Idaho Medicaid.

**Documentation Requirements**

*For Attendant Care and Homemaker services:* After every visit, the Direct Care Professional must enter, at a minimum, the following information into the service delivery record:

- **Date of visit.**
- **Time the service(s) begins and ends.** The time services are delivered must be identified using A.M. or P.M. unless entered using military time.
- **Services Provided.** All services provided during each visit, including the Activities of Daily Living (ADL) identified on the Universal Assessment Instrument (UAI).
• **Narrative.** Narrative related to the participant’s response to the service(s), any changes noted in the participant’s condition, or any deviations from the Service Plan.

• **Participant’s signature and date.** This may be captured using a signature or unique software login.

• **Direct Care Professional’s signature and date** – this may be captured using a signature or unique software login.

**Records Availability**
Providers must make a copy of the Service Delivery documentation available to each participant at a minimum weekly basis. Service Delivery records must either be printed and placed in the participant’s home or available to the participant and/or legal representative using an electronic record format (e-mail, website with a login, etc.). When Service Delivery records are not printed and maintained in the participant’s home, the provider must document the participant’s preference for receiving Service Delivery documents using a Service Delivery Document Attestation.

**Service Delivery Document Attestation**
When a participant requests to receive service delivery records in an alternate method other than in a printed format kept in their home, the provider must document the participant’s choice using an attestation. The attestation must include the participant’s signature and date, and clearly indicate the method by which the participant chose to receive their documentation (print, email, website with a login, etc.) and the participant’s acknowledgement that their service delivery documentation is available at least on a weekly basis. The provider must keep all attestation forms available at the agency and make them available to the Department if requested.

### 28.2.3. Participant Eligibility
For a participant to be eligible for Medicaid payment of A&D waiver services, Medicaid must determine that all of the following criteria are met:

- The participant requires services due to a physical or cognitive disability, which results in a significant impairment in functional independence as demonstrated by the findings of the UAI.
- The participant is capable of being maintained safely and effectively in a non-institutional setting.
- The participant would need to reside in a nursing facility in the absence of waiver services; Medicaid Program expenditures for the care of the person in the community will be no more than the Medicaid program costs would be for that person’s care in a nursing facility.

### 28.2.4. Prior Authorization (PA)
BLTC must authorize all services reimbursed by Medicaid under the A&D Waiver program before services are rendered.

### 28.2.5. Billing Information
**Determining How to Bill Units for 15-Minute Timed Codes**
Several CPT® codes used for evaluations, therapy modalities, procedures, and collateral contacts specify that one (1) unit equals 15 minutes. Provider’s bill procedure codes for the services they delivered using CPT® codes and the appropriate number of units of service. For any single CPT® code, providers may bill a single 15-minute unit for treatment that is greater than or equal to eight minutes. Two units should be billed when the interaction with the
participant or collateral contact is greater than or equal to 23 minutes but is less than 38 minutes. Time intervals for larger numbers of units are as follows:

<table>
<thead>
<tr>
<th>Units</th>
<th>Time Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>( \geq 38 \text{ minutes} ) to (&lt; 53 \text{ minutes} )</td>
</tr>
<tr>
<td>4</td>
<td>( \geq 53 \text{ minutes} ) to (&lt; 68 \text{ minutes} )</td>
</tr>
<tr>
<td>5</td>
<td>( \geq 68 \text{ minutes} ) to (&lt; 83 \text{ minutes} )</td>
</tr>
<tr>
<td>6</td>
<td>( \geq 83 \text{ minutes} ) to (&lt; 98 \text{ minutes} )</td>
</tr>
<tr>
<td>7</td>
<td>( \geq 98 \text{ minutes} ) to (&lt; 113 \text{ minutes} )</td>
</tr>
<tr>
<td>8</td>
<td>( \geq 113 \text{ minutes} ) to (&lt; 128 \text{ minutes} )</td>
</tr>
</tbody>
</table>

The pattern remains the same for treatment units in excess of two hours. Providers should not bill for services performed for less than eight minutes. The expectation (based on work values for these codes) is that a provider’s time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review. The above schedule of times is intended to provide assistance in rounding time into 15-minute increments for billing purposes. It does not imply that any minute until the eighth should be excluded from the total count because the time that is counted for active treatment includes all time. The beginning and ending time of the treatment must be recorded in the participant’s medical record with a note describing the treatment.

(For additional guidance please consult CMS Program Memorandum Transmittal AB-00-14.)

**Billing Procedure for Date Spanning**

The dates of service billed on a single detail line must be within the same Sunday through Saturday calendar week. Providers can bill consecutive dates of service that fall in one calendar week (Sunday through Saturday) on one detail line. When date spanning, services must have been provided for every day within that span. For example, it would be incorrect to date span the entire week when services were only performed on Thursday and Saturday. Additionally, it would be inappropriate to bill with a date span if services were provided on a Monday and a Friday but there were no services offered between those days.

**Example**

For services provided to the participant on the following days:

Thursday, December 11, 2008
Saturday, December 13, 2008

Enter each date on a separate detail line.

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Procedure Code</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13/2008 – 12/13/2008</td>
<td>XXXXX</td>
<td>$XXX.XX</td>
</tr>
</tbody>
</table>

**Electronic Visit Verification (EVV) Requirement**

As of July 1, 2021, providers of some A&D waiver services must submit Electronic Visit Verification (EVV) data to the state’s MMIS Aggregator (managed by Sandata) in order to be eligible to receive payment for these services. See “Electronic Visit Verification (EVV)” in the General Billing Instructions, Idaho Medicaid Provider Handbook for information related to EVV requirements.

**28.2.6. Healthy Connections (HC)**

HC referrals are not required for services under the A&D Waiver.
28.2.7. Place of Service (POS) Delivery and Exclusions

Participants may choose to receive A&D Waiver services in the following environments:

- Participant’s own home or apartment.
- Certified Family Home.
- Residence of the participant’s family.
- Adult Day Health facility.
- Residential Assisted Living Facilities.
- The community.

The following living situations are specifically excluded as a personal residence for A&D waiver services:

- Licensed, skilled, or intermediate care facility.
- Certified nursing facility (NF) or hospital.
- Licensed intermediate care facility for people with intellectual disabilities (ICF/IID).

28.2.8. Individual Service Plan (ISP)

All services must be prior authorized by BLTC. The services must be based on a written Individual Service Plan (ISP).

BLTC and the participant develop the ISP for the A&D Waiver. In addition, the following persons may be included:

- The RN Supervisor.
- The guardian, family, or current service providers, unless specifically excluded by the participant.
- Others identified by the participant.

The ISP is based on a person-centered, planning and assessment process using the UAI and the participant’s choice of services. It describes the specific types, amounts, frequency, and duration of Medicaid reimbursed services to be provided.

The ISP must include documentation of the participant’s choice between waiver services and institutional placement, and the participant’s or a legal guardian’s signature (if applicable).

The ISP must be revised and updated by BLTC based upon significant changes in the participant’s needs and must be re-authorized at least annually.

The ISP includes all Medicaid allowable services and supports, and all natural or non-paid services and supports. See IDAPA 16.03.10.329, Aged or Disabled Waiver Services – Agency Provider Qualifications and Duties, for supervision requirements for each participant service.

28.2.9. Plan of Care

All services that are provided must be based on a written plan of care. The plan of care is developed by the plan of care team, which includes the participant, the family, guardian, service providers, and others identified by the participant, and in the participant’s home.

The agency must use the BLTC completed UAI Negotiated Services Agreement (NSA). The agency will need to include on the NSA:

- Type, amount, frequency, and duration of services with the provider identified.
- Support and service needs to be met by the participant’s family, friends, other community resources, and the providers of services.
- Health, safety, and personal goals to be addressed.
• Activities to promote progress, maintain functional skills, or delay or prevent regression.
• The signature of the participant or guardian and agency supervisory RN.

The plan of care must be revised and updated by the agency supervisory RN and plan of care team based upon treatment results or a change in the participant’s needs. The plan of care must be reviewed at least annually.

For significant changes in the participant’s functioning, the agency supervising personnel should visit the participant to assess what functioning areas have been impacted and complete the Significant Change Form. The Significant Change Form must be signed by the agency supervisory RN who is responsible for verifying the information on the form is correct. The agency supervisory RN is responsible for updating the NSA. The department will not authorize an RN visit or service plan units for completion of the Significant Change Form or resulting NSA changes.

A copy of the most current NSA must be kept in the participant’s home. Services performed, which are not contained in the NSA, are not eligible for Medicaid payments. Failure to follow the approved NSA may result in loss of payment, provider status for Idaho Medicaid, or other action as deemed necessary by DHW.

28.3. Adult Day Health – A&D Waiver

Adult Day Health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult Day Health services provided under this waiver will not include room and board payments.

28.3.1. Facilities

Facilities that provide Adult Day Health must be maintained in a safe and sanitary manner and meet the requirements of the Adult Day Health provider agreement. Facilities will provide the staff and space necessary to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary to assure the comfort and safety of the participants served.

28.3.2. Provider Home (Certified Family Home)

Providers accepting participants into their homes for services must maintain the home in a safe and sanitary manner and meet the standards of the Adult Day Health provider agreement and home certification identified in IDAPA 16.03.19, Certified Family Homes. The provider must provide supervision as necessary to assure the comfort and safety of the participants served.

28.3.3. Diagnosis Code

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.
28.3.4. Place of Service (POS) Codes

Adult Day Health services can only be provided in the following POS:

12    Home
99    Other (Community)

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.4. Non-Medical Transportation – A&D Waiver

NMT enables a waiver participant to gain access to waiver and other community services and resources.

- NMT is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits", and will not replace it.
- Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized.

NMT is limited to 1,800 miles per year.

As part of NMT, commercial bus passes may be purchased for a waiver participant. Bus passes are manually priced for the cost of the pass and prior authorized for the public transportation provider if they have a valid contract with the Department.

28.4.1. Agency Provider Qualifications

Providers of NMT services must:

- Possess a valid driver’s license,
- Possess valid vehicle insurance,
- Comply with all applicable state laws, and
- Be enrolled as a Medicaid transportation provider.

28.4.2. Payment

Payment for NMT is reimbursed at the per-mile rate established by Medicaid. Providers and participants receive a Notice of Decision that identifies the procedure codes that have been approved and are to be used for billing.

28.4.3. Diagnosis Code

Enter the appropriate ICD-10-CM: R69 – Illness, unspecified code as the primary diagnosis code in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.4.4. Place of Service (POS) Code

NMT can only be provided in the following POS:

99    Other (Community)

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.
### 28.4.5. Procedure Codes

<table>
<thead>
<tr>
<th>HPCS</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0080</td>
<td>Mod 0</td>
<td>Non-Medical transportation, per mile, Agency Provider. Specify number of miles from pick-up to delivery. Prior Authorization for waiver service required. 1 unit = 1 mile</td>
</tr>
<tr>
<td>A0080</td>
<td>Mod 68</td>
<td>Non-Medical Transportation, Commercial Provider. 1st mile of 1st trip of the day.</td>
</tr>
<tr>
<td>A0080</td>
<td>Mod 67</td>
<td>Non-Medical Transportation, Commercial Provider. All additional miles on 1st trip or subsequent miles/trips within the same day.</td>
</tr>
<tr>
<td>A0110</td>
<td></td>
<td>Commercial Bus Pass</td>
</tr>
</tbody>
</table>

### 28.5. Specialized Medical Equipment and Supplies – A&D Waiver

Specialized medical equipment and supplies include:
- Devices, controls, or appliances that enable a participant to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives.
- Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant.

**Note:** Provider responsibilities, payment information, and diagnosis, place of service and procedure codes can be found in the Suppliers, Idaho Medicaid Provider Handbook guidelines.

#### 28.5.1. Agency Provider Qualifications

Providers of this service must:
- Be an authorized dealer of equipment that meets Underwriter’s Laboratory Standards, Federal Drug Administration Standards, or Federal Communication Commission Standards when applicable.
- Must provide the specific product when applicable (i.e., medical supply businesses or organizations that specialize in the design of the equipment).

Specialized medical equipment items over $500.00 require three competitive bids.

#### 28.5.2. Place of Service (POS) Codes

Specialized medical equipment can only be provided in the following POS:

- **11** Office
- **12** Home

#### 28.5.3. Procedure Codes

Specialized medical equipment and supplies for A&D waivered services are covered for Medicaid Enhanced Plan participants.
<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialized Medical Equipment</td>
<td>E1399</td>
<td>Durable Medical Equipment</td>
</tr>
</tbody>
</table>

28.6. **Attendant Care – A&D Waiver**

Attendant care services are services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant’s needs for long-term maintenance, supportive care, or activities of daily living (ADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to an unlicensed person by a licensed health care professional or the participant. Services are based on the participant’s abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task.

28.6.1. **Agency Provider Qualifications**

Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, *Criminal History and Background Checks*. All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with IDAPA 16.03.10.329.03.

As of July 1, 2021, Attendant Care service providers must submit Electronic Visit Verification (EVV) data to the state’s MMIS Aggregator (managed by Sandata) in order to be eligible to receive payment for services provided in the home. See “Electronic Visit Verification (EVV)” in the General Billing Instructions, Idaho Medicaid Provider Handbook for information related to EVV requirements.

28.6.2. **Diagnosis Code**

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.6.3. **Place of Service (POS) Codes**

Attendant care can only be provided in the following POS:

- **03** School
- **12** Home
- **33** Custodial Care Facility (certified family homes, assisted living facilities, residential care facility, and other living situations where care is furnished commercially) when the service plan does not identify this service as the responsibility of the facility
- **99** Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.
28.6.4. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendant Care</td>
<td>S5125</td>
<td>Attendant Care Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unit = 15 minutes</td>
</tr>
</tbody>
</table>

28.7. Chore Services – A&D Waiver

Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment:

- Intermittent assistance may include the following.
  - Yard maintenance
  - Minor home repair
  - Heavy housework
  - Sidewalk maintenance
  - Trash removal to assist the participant to remain in the home

- Chore activities may include the following.
  - Washing windows
  - Moving heavy furniture
  - Shoveling snow to provide safe access inside and outside the home
  - Chopping wood when wood is the participant’s primary source of heat
  - Tacking down loose rugs and flooring

- These services are only available when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and when no other relative, caregiver, landlord, community, volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision.

- In the case of rental property, the landlord’s responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant.

28.7.1. Agency Provider Qualifications

Providers of chore services must meet the following minimum qualifications.

- Be skilled in the type of service to be provided.
- Demonstrate the ability to provide services according to a plan of service.
- Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
- Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff in accordance with IDAPA 16.03.10.329.03.

28.7.2. Diagnosis Code

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.7.3. Place of Service (POS) Code

Chore services can only be provided in the following POS:

12 Home
Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

### 28.7.4. Procedure Code

<table>
<thead>
<tr>
<th>Provider Specialty</th>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBI</td>
<td>S5120</td>
<td>Chore Services, 1 unit = 15 minutes</td>
</tr>
<tr>
<td>PCS Agency</td>
<td>S5120</td>
<td>Chore Services, 1 unit = 1 Hour</td>
</tr>
<tr>
<td>Chore Services Agency</td>
<td>S5120</td>
<td>Chore Services, 1 unit = 15 minutes</td>
</tr>
</tbody>
</table>

### 28.8. Companion Services – A&D Waiver

Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person onsite. The service provider, who may live with the participant, may provide voice cueing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed.

#### 28.8.1. Agency Provider Qualifications

All providers of companion services must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

#### 28.8.2. Diagnosis Code

Enter the appropriate ICD-10-CM: Z74.2 - Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

#### 28.8.3. Place of Service (POS) Code

Companion services can only be provided in the following POS:

12  Home

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

#### 28.8.4. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Companion</td>
<td>S5135</td>
<td>Adult Companion Care Unit = 15 minutes</td>
</tr>
</tbody>
</table>
28.9. Consultation Services – A&D Waiver
Consultation services are services to a participant or family member. Services are provided by a Personal Care Service Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant’s family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver.

28.9.1. Agency Provider Qualifications
Consultation services must be provided through a Personal Care Service Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers.

28.9.2. Diagnosis Code
Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.9.3. Place of Service (POS) Codes
Consultation services can only be provided face-to-face with the participant or family in the following POS:

<table>
<thead>
<tr>
<th>POS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility (certified family home, assisted living facility, residential care facility, or other facility where care is provided commercially)</td>
</tr>
<tr>
<td>99</td>
<td>Other (Community, Adult Day Care, participant’s work location)</td>
</tr>
</tbody>
</table>

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.9.4. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>S5115</td>
<td>Home Care Training – non-family Unit = 15 minutes</td>
</tr>
</tbody>
</table>

28.10. Homemaker Services – A&D Waiver
Homemaker services consist of performing for the participant, and/or assisting him with, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks.

28.10.1. Agency Provider Qualifications
The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks. All providers of homemaker services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with IDAPA 16.03.10.329.03.
As of July 1, 2021, Homemaker service providers must submit Electronic Visit Verification (EVV) data to the state’s MMIS Aggregator (managed by Sandata) in order to be eligible to receive payment for this service. See “Electronic Visit Verification (EVV)” in the General Billing Instructions, Idaho Medicaid Provider Handbook for information related to EVV requirements.

28.10.2. Diagnosis Code

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.10.3. Place of Service (POS) Code

Homemaker Services can only be provided in the following POS:

12 Home

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.10.4. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homemaker Services</td>
<td>S5130</td>
<td>Homemaker Service, NOS Unit = 15 minutes</td>
</tr>
</tbody>
</table>

28.11. Home Delivered Meals – A&D Waiver

Home delivered meals are meals that are delivered to the participant’s home to promote adequate participant nutrition. One to two meals per day may be provided to a participant who:

- Rents or owns a home
- Is alone for significant parts of the day
- Has no caregiver for extended periods of time
- Is unable to prepare a meal without assistance

28.11.1. Agency Provider Qualifications

Providers of home delivered meals must be a public agency or private business, and must exercise supervision to ensure 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
- Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food
- Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served
- The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, Idaho Food Code
- A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions
Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with IDAPA 16.03.10., Subsection 329.03.

28.11.2. Diagnosis Code
Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.11.3. Place of Service (POS) Code
Home delivered meals services can only be provided in the following POS:

12 Home

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.11.4. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Delivered Meals</td>
<td>S5170</td>
<td>Home Delivered Meals, including preparation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unit = 1 meal</td>
</tr>
</tbody>
</table>

Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include:

- The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning.
- Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant’s principal residence and is owned by the participant or the participant’s non-paid family.
- Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department.

28.12.1. Agency Provider Qualifications
All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification.

28.12.2. Payment
Payment for environmental accessibility adaptations will be made as prior-authorized by BLTC. Each item and the allowed payment amount must be authorized. Providers and participants will receive a prior authorization notice, along with a prior authorization number that will
identify the procedure codes, items, and the payment amount that have been approved and are to be used for billing.

28.12.3. Diagnosis Code
Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.12.4. Place of Service (POS) Code
Environmental accessibility adaptation services can only be provided in the following POS:

12 Home

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.12.5. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Accessibility</td>
<td>S5165</td>
<td>Home Modification; per service Environmental Accessibility Adaptations Services, per item and dollar amount as authorized by BLTC.</td>
</tr>
</tbody>
</table>

28.13. Respite Care – A&D Waiver
Respite care includes short-term breaks from caregiving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant’s residence, a certified family home, a developmental disabilities agency, a residential care or assisted living facility, or an Adult Day Health facility.

28.13.1. Agency Provider Qualifications
Providers of respite care services must meet the following minimum qualifications.

- Have received caregiving instructions in the needs of the person who will be provided the service
- Demonstrate the ability to provide services according to a plan of service
- Be free of communicable disease
- Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

As of July 1, 2021, Personal Assistance Agencies (PAA) providing Respite care services must submit Electronic Visit Verification (EVV) data to the state’s MMIS Aggregator (managed by Sandata) in order to be eligible to receive payment for services provided in the home. See “Electronic Visit Verification (EVV)” in the General Billing Instructions, Idaho Medicaid Provider Handbook for information related to EVV requirements.
28.13.2. Diagnosis Code
Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.13.3. Place of Service (POS) Codes
In-home respite can only be provided in the following POS:

12 Home

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.13.4. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Home Respite</td>
<td>T1005</td>
<td>Respite Care Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unit = 15 minutes</td>
</tr>
</tbody>
</table>

Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse licensed to practice in Idaho.

Skilled nursing service providers must be licensed in Idaho as a registered nurse or licensed practical nurse in good standing or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

28.14.2. Provider Responsibilities
- Evaluate changes of condition.
- Immediately notify the physician and plan monitor of any significant changes in the participant’s physical condition or response to the service delivery.
- Provide services in accordance with the nursing plan of care and the waiver plan of service.
- Maintain records of care given to include the date, time of start and end of service delivery, and comments on participant’s response to services delivered.
- In the case of an LPN, skilled nursing providers, and other non-licensed direct care providers, document that oversight of services by a RN is in accordance with the Idaho Nurse Practice Act and the Rules, Regulations, and Policies of the Idaho Board of Nursing.
- An RN can provide either oversight or skilled nursing services.

28.14.3. Nursing Plan of Care
All nursing oversight and skilled nursing services provided must be on a nursing plan of care. The nurse is responsible for the nursing plan of care based upon:
• The nurse’s assessment and observation of the participant.
• The orders of the participant’s physician.
• The ISP.
• Information elicited from the participant.

The nursing plan of care must include all aspects of the medical care necessary to be performed, including the amount, type, and frequency of such services. Certain services can be delegated by an RN.

When nursing services are delegated to a non-licensed provider, the type, amount of supervision and training to be provided must be included in the plan.

28.14.4. Nursing Plan of Care Update
The nursing plan of care must be revised and updated based upon treatment results or as necessary to meet the participant’s changing medical needs, but at least annually. A copy of the plan must remain in the participant’s home.

28.14.5. Diagnosis Code
Enter the appropriate primary diagnosis code in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.14.6. Place of Service (POS) Codes
Nursing Services can only be provided in the following POS:

<table>
<thead>
<tr>
<th>POS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility, if such services are not included in the negotiated service agreement with the facility</td>
</tr>
<tr>
<td>99</td>
<td>Other (Adult Day Care (Health))</td>
</tr>
</tbody>
</table>

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.14.7. Procedure Codes

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Services – R.N.</td>
<td>T1002</td>
<td>RN Services, 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>Nursing Assessment/Evaluation</td>
<td>T1001</td>
<td>RN Services, 1 Unit = 1 visit</td>
</tr>
<tr>
<td>Nursing Services – L.P.N.</td>
<td>T1003</td>
<td>LPN/LVN Services, Unit = 15 minutes</td>
</tr>
</tbody>
</table>

28.15. Personal Emergency Response System (PERS) – A&D Waiver
A PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals. This service is limited to participants who:

• Rent or own a home, or live with unpaid caregivers
• Are alone for significant parts of the day
• Have no caregiver for extended periods of time
• Would otherwise require extensive, routine supervision

28.15.1.  Agency Provider Qualifications

PERS providers must demonstrate that the devices installed in a waiver participant’s home meet Federal Communications Standards, Underwriter’s Laboratory Standards, or equivalent standards. Specific billing instructions for medical equipment vendors can be found in the Suppliers, Idaho Medicaid Provider Handbook guidelines.

28.15.2.  Diagnosis Code

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.15.3.  Place of Service (POS) Code

PERS can only be provided in the following POS:

12  Home

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.15.4.  Procedure Codes

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Installation</td>
<td>S5160</td>
<td>Emergency Response System; installation and testing and first month service rental.</td>
</tr>
<tr>
<td>Monthly Rent</td>
<td>S5161</td>
<td>Emergency Response System; service fee, per month (excludes installation and testing).</td>
</tr>
</tbody>
</table>

28.16.  Day Habilitation Services – A&D Waiver

Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day habilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

28.16.1.  Agency Provider Qualifications

Providers of day habilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
28.16.2. Payment
Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. All day habilitation services must be prior authorized by BLTC before being rendered and must be the most cost-effective way to meet the needs of the participant.

**Note:** The PA number must be included on the claim or the claim will be denied.

28.16.3. Diagnosis Codes
Enter the appropriate primary diagnosis code in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.16.4. Place of Service (POS) Codes
Day Habilitation Services can only be provided in the following POS:

- 11 Office
- 99 Other (Community)

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.16.5. Procedure Codes

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Habilitation (Individual)</td>
<td>T2021</td>
<td>Day Habilitation, waiver; per 15 minutes The limit of hours for day rehab is 30 hrs/wk for both individual and group or in combination. 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>Day Habilitation (Group) limited to not more than six participants</td>
<td>T2021</td>
<td>Day Habilitation, waiver; per 15 minutes Unit = 15 minutes</td>
</tr>
</tbody>
</table>

28.17. Residential Habilitation Services – A&D Waiver
Residential habilitation services consist of an integrated array of individually-tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in Certified Family Homes. The services and supports that may be furnished consist of the following:

- Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities.
- Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations.
- Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures.
- Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in
community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature.

- Mobility consists of training or assistance aimed at enhancing movement within the person’s living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community.
- Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs.
- Personal Care Services, necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person’s primary caregiver(s) are unable to accomplish on his or her own behalf. Personal care activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered; supervision; communication assistance, reporting changes in the waiver participant’s condition and needs; household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence.

28.17.1. Agency Provider Qualifications

When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, Residential Habilitation Agencies, and supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency.

Providers of residential habilitation services must meet the following requirements:

- 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 service
  - Have current CPR and First Aid certifications
  - Be free from communicable diseases
  - Each staff person assisting with participant medications must successfully complete and follow the “Assistance with Medications” course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training.
  - Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
  - 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.

- The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant.

- Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects:
  - Purpose and philosophy of services
Service rules
- Proper conduct in relating to waiver participants
- Handling of confidential and emergency situations that involve the waiver participant
- Participant rights
- Methods of supervising participants
- Working with individuals with developmental disabilities
- Training specific to the needs of the participant
- Working with individuals with traumatic brain injuries

- Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum:
  - Instructional techniques: Methodologies for training in a systematic and effective manner
  - Managing behaviors: Techniques and strategies for teaching adaptive behaviors
  - Feeding
  - Communication
  - Mobility
  - Activities of daily living
  - Body mechanics and lifting techniques
  - Housekeeping techniques
  - Maintenance of a clean, safe, and healthy environment

- The provider agency will be responsible for providing ongoing training specific to the needs of the participant as needed. Residential habilitation must be provided by an agency certified by Medicaid as a RES/HAB services provider under IDAPA 16.04.17, Residential Habilitation Agencies. Residential habilitation agencies must be capable of supervising the direct services provided.

28.17.2. Provider Responsibilities

(a) Training

The provider agency is responsible for training the direct service provider in general education areas of developmental disability. The provider agency must provide supervision to meet the participant’s needs.

A program coordinator must develop skill-training programs. The program coordinator must be employed by the RES/HAB Agency.

Additional training requirements for direct service providers include, at a minimum:
- Instructional technology.
- Behavior technology.
- Feeding.
- Communication/sign language.
- Mobility.
- Assistance with the administration of medications.
- Activities of daily living.
- Body mechanics and lifting techniques.
- Housekeeping techniques and maintenance of a clean, safe, and healthy environment.
(b) **Record Keeping**

A RES/HAB provider must maintain a standardized residential habilitation service record for each participant receiving RES/HAB Services. Residential habilitation agency program coordinators are responsible for establishing a standardized format for record keeping that includes all required information.

A copy of the current six (6) months of service delivery records will be maintained in the participant’s home. It is the provider’s responsibility to ensure the participant maintains the current service delivery records. After every visit, document the following information:

- The date and time of visit; the date is given in MMDDCCYY format:
  
  **Examples:**
  
  02/10/2005; 8:00 A.M. - 11:15 A.M.
  

- The length of visit in decimal form.
  
  **Example**
  
  A visit of three hours and 15 minutes is entered as 3.25 hours.

- A statement of the participant’s response to the services, including any changes noted in the participant’s condition.

- Any changes in the support plan authorized by BLTC as a result of changes in the participant’s condition or skill level.

- The participant’s signature on the service record, unless BLTC determines the participant is unable to sign.

(c) **Records Maintenance**

To provide continuity of services, when a participant moves, selects a different provider, or changes service coordinators, all of the foregoing participant records will be delivered to and held by the provider.

When a participant is no longer involved in the waiver services program, copies of all the records are retained by the provider agency as part of the participant’s closed record. Provider agencies must retain participant records for those to whom they provide services for five years following the last date of service.

(d) **Change in Participant Status**

It is the responsibility of the RES/HAB provider to notify the service coordinator when there is a significant change in the participant’s circumstances, including accidents, injuries, and health related activities.

(e) **Change of Provider Information**

If the provider has a change of name, address, or telephone number, immediately notify HP in writing. Indicating updated provider information on a claim form is not acceptable and the appropriate changes cannot be made.

28.17.3. **Payment**

Medicaid reimburses RES/HAB Services on a fee-for-service basis.

28.17.4. **Diagnosis Code**

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.
28.17.5. Place of Service (POS) Codes
RES/HAB services can only be billed for the following places of service:

12 Home (CFH, participant’s own home, or home of unpaid family)
99 Other (Community) This code should only be used when the participant receives hourly supported living to access the community. All other residential habilitation should be coded as ‘Home.’

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.17.6. Procedure Codes

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Living - Agency</td>
<td>H2015</td>
<td>Comprehensive Community Support Services, per 15 minutes</td>
</tr>
<tr>
<td>Two Participants</td>
<td>HQ</td>
<td>Supported living for two participants who live in their own home/apartment or with a non-paid caregiver. 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>Supported Living - Agency</td>
<td>H2015</td>
<td>Comprehensive Community Support Services; per 15 minutes</td>
</tr>
<tr>
<td>One Participant</td>
<td>HQ</td>
<td>Supported living for one participant who lives in his/her own home/apartment or with a non-paid caregiver. 1 Unit = 15 minutes</td>
</tr>
<tr>
<td>Daily Supported Living – Intense</td>
<td>H2016</td>
<td>Comprehensive Community Support Services, per diem</td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td>1 Unit = 1 day</td>
</tr>
<tr>
<td>Therapeutic Behavioral Services</td>
<td>H2020</td>
<td>Therapeutic Behavioral Services – Agency provider, per diem 1 Unit = 1 Day</td>
</tr>
<tr>
<td>Daily Supported Living – High</td>
<td>H2022</td>
<td>Daily Supported Living – High Support – Agency provider, per diem 1 Unit = 1 Day</td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28.17.7. Billing Restrictions
Hourly procedure codes cannot be billed on the same date of service as daily procedure codes.

28.18. Supported Employment – A&D Waiver
Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work.

- Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not
otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA.

- Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer’s participation in a supported employment program, payments that are passed through to beneficiaries of a supported employment program, or payments for vocational training that is not directly related to a waiver participant’s supported employment program.

### 28.18.1. Agency Provider Qualifications

Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards or meet State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks. Providers must also take a traumatic brain injury training course approved by the Department.

### 28.18.2. Provider Responsibilities

The provider is responsible for supported employment services, including long-term maintenance or job coaching to support the participant at work.

### 28.18.3. Payment

Medicaid reimburses services on a fee-for-service basis.

### 28.18.4. Diagnosis Codes

Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

### 28.18.5. Place of Service (POS) Code

Supported Employment Services can only be billed in the following POS:

- **99** Other (Community)

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

### 28.18.6. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Employment</td>
<td>H2023</td>
<td>Supported Employment, per 15 minutes Maximum allowable – 160 units per week. 1 Unit = 15 minutes</td>
</tr>
</tbody>
</table>
28.19. Transition Services – A&D Waiver

28.19.1. Service Description
Transition Services include goods and services that enable a participant residing in a nursing facility, hospital, Institution for Mental Diseases (IMD), or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) to transition to a community-based setting where the person is directly responsible for their own living expenses. A participant is eligible to receive Transition Services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days.

Transition Service benefits are provided in conjunction with Transition Management. The Transition Management benefit is provided under Enhanced State Plan benefits.

28.19.2. Agency Provider Qualifications
Agencies are responsible for administering Transition Services.

28.19.3. Place of Service (POS) Code
Transition Services can only be provided in the following POS:

- Home (12)
- Custodial Care Facility (certified family homes, assisted living facilities, residential care facility, and other living situations where care is furnished commercially) when the service plan does not identify this service as the responsibility of the facility (33)
- Other (Community) (99)

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

28.19.4. Procedure Code

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Services</td>
<td>T2038</td>
<td>Prior Authorized goods and services not to exceed $2,000.</td>
</tr>
</tbody>
</table>

28.19.5. References

(a) State Regulations

29. Personal Care Services (PCS)
This section covers services provided under Personal Care Services (PCS), which is a state plan service, not a waiver service. For adults receiving services under the State Medicaid Plan Option, service delivery is limited to a maximum of 16 hours per week per participant. For children who meet medical necessity criteria under Early, Periodic Screening, Diagnosis, and Treatment (EPSDT), as found in IDAPA 16.03.09.882, the services must be medically necessary and meet the other program requirements found in IDAPA 16.03.10.300, Personal Care Services (PCS) through 308, Personal Care Services (PCS) – Quality Assurance.
If a child (up to age of 21) needs medically necessary services (PCS) that exceed the Medicaid limitation (16 hours of PCS per week), the state Medicaid program can approve additional services through the Early Periodic Screening, Diagnosis, & Treatment benefit. When a child’s primary care provider (PCP) determines during a well-child check-up that the child needs additional treatment for a health condition, the PCP orders the services for the child.

Prior to obtaining the additional services, the parents or guardians must coordinate with the personal care agency for Medicaid authorization. A Request for Additional Services Form, Service Provider Statement of Need, Primary Care Provider Statement of Need, and other required documentation must be submitted to Medicaid.

All PCS must be provided in accordance with a written plan of care.

Note: Personal Care Services are covered for Medicaid Enhanced Plan participants.

29.1. General Information

This section covers all general claims information for PCS Services. It addresses the following:

- Agency Provider Qualifications
- Record keeping
- Prior authorization (PA)
- Healthy Connections (HC)
- Dates of service
- Service description
- Claim billing

29.2. Agency Provider Qualifications

All providers of services must have a valid provider agreement or performance contract with Medicaid. Providers must meet the qualifications of IDAPA 16.03.10.305, Personal Care Services – Agency Provider Qualifications. Performance under this agreement or contract will be monitored by Medicaid in each region.

A separate transportation provider number must be obtained by PCS providers and agencies.

As of July 1, 2021, Personal Care Service providers must submit Electronic Visit Verification (EVV) data to the state’s MMIS Aggregator (managed by Sandata) in order to be eligible to receive payment for services provided in the home. See “Electronic Visit Verification (EVV)” in the General Billing Instructions, Idaho Medicaid Provider Handbook for information related to EVV requirements.

29.3. Prior Authorization (PA)

Medicaid must authorize all services reimbursed by Medicaid under the PCS program prior to the payment of services. Approved PAs are valid for the dates shown on the authorization.

Adult PCS is limited to a maximum of 16 hours per week.

29.4. Healthy Connections (HC)

HC referrals are not required for services under the PCS program.
29.5. Dates of Service

Dates of service must be within the Sunday through Saturday calendar week on a single claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday. Failure to comply with the Sunday through Saturday billing will result in claims being denied. In addition, a claim cannot span more than one calendar month. If the end of the month falls in the middle of a week, two separate claims must be used.

Example

See the following calendar. The last week in April 2010 begins Sunday, April 25, and ends Saturday, May 1. Two separate claims must be entered for this week. One claim will have service dates of 4/25/2010 through 4/30/2010. The second claim will have service dates of 5/01/2010 through 5/01/2010. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim as long as the same quantity of services has been provided each day.

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
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<td>29</td>
<td>30</td>
<td>May 1</td>
</tr>
</tbody>
</table>

29.6. Service Description

The PCS provider is referred to as a personal assistant and is responsible for medically oriented tasks related to a participant’s physical care provided in the home. Such services must be included in an approved plan of care and include, but are not limited to, the following:

- Medical Services – The personal assistant assists the participant with or performs basic personal care and grooming that may include bathing, hair care, assistance with clothing and dressing, bathroom assistance, and basic skin care; the personal assistant may assist the participant with bladder or bowel requirements, which may include helping the participant to and from the bathroom or assisting the participant with bedpan routines.

- Medications – The personal assistant may assist the participant with physician ordered medications that are ordinarily self-administered in accordance with IDAPA 24.34.01, Rules of the Idaho Board of Nursing, Subsection 200.01.c.

- Meal Preparation – The personal assistant may assist with food, nutrition, and diet activities, including meal preparation if the physician determines the participant has a medical need for such assistance; gastrostomy tube feedings may be performed if authorized by Medicaid, and if the supervising nurse has properly trained the provider personal assistant; personal assistants may be authorized to perform non-nasogastric gastrostomy tube feedings if authorized by Medicaid and if it meets the requirements in IDAPA 16.03.10.303.01, Medical Care and Services.

- Non-Medical Services – The personal assistant may perform such incidental household services Medicaid determines to be essential to a participant’s comfort, safety, and health. For children, these services must be ordered by the physician. The participant must receive one medical service to be eligible to receive non-medical services. Non-medical services include:
  - Changing of bed linens for the participant.
  - Rearranging of furniture to enable the participant to move about more easily.
  - Doing laundry for the participant.
- Cleaning of areas used by the participant when required for the participant’s treatment.
- Accompanying the participant to clinics, a physician’s office, or other medical appointments.
- Shopping for groceries or other household items required specifically for the health and maintenance of the participant.

- Independence Training – The personal assistant may assist the developmentally disabled adult or child participant in the home setting, through the continuation of active treatment training programs to increase or maintain participant independence; independence training is part of the participant's everyday care; a Qualified Intellectual Disabilities Professional (QIDP) must specifically identify such services on the PCS plan of care. Examples of independence training are: personal hygiene, getting dressed, or taking the participant grocery shopping.
- It is the responsibility of the personal assistant provider to notify either the supervising registered nurse or the physician when there is a significant change in the participant’s condition; notification of the physician or registered nurse must be documented in the progress notes; the personal assistant will document any changes noted in the participant’s condition or any deviation from the plan of care.

29.7. Change in Participant Status
The personal assistance agency is responsible to notify Medicaid 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.

29.8. Exclusions
Under no circumstance is the personal assistant authorized to perform any of the following:
- Irrigation or suctioning of any body cavities which require sterile procedures.
- Application of sterile dressings.
- Administration of prescription medication, including injections of fluids into the veins, muscles, or skin.
- Procedures requiring aseptic technique.
- Skin care which requires sterile technique.
- Insertion or irrigation of catheters.
- Cooking, cleaning, or laundry for any other occupant of the participant’s residence.
- Nasogastric feedings.

Note: Personal assistants may not bring children into a participant’s home when providing services.

29.9. Transportation
Non-medical transportation (such as to the grocery store) is not reimbursable to the personal assistant.

29.10. Diagnosis Code
Enter the appropriate ICD-10-CM: Z74.2 – Need for assistance at home and no other household member able to render care code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

29.11. Place of Service (POS) Code
PCS services may only be provided in a participant’s personal residence.
12 Home

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

The following are specifically excluded as personal residences:

- Licensed skilled nursing facilities (SNFs), intermediate care facilities (ICFs), or hospitals.
- Licensed intermediate care facilities for people with intellectual disabilities (ICF/IID).
- Residential Care Facilities for children as described in IDAPA 16.06.01.487, Child and Family Services.
- A home receiving payment for specialized foster care, professional foster care, or group foster care for children.

See the Qualified Intellectual Disabilities Professional (QIDP) section for more on the QIDP and special requirements for individuals with DD.

29.12. Plan of Care (POC)

Delivery of all PCS services is based on a written plan of care. The Personal Assistance Agency supervisory registered nurse (RN) for the participant is responsible to prepare the plan in the participant’s home. The POC is based on:

- The agency must use BLTC’s completed Uniform Assessment Instrument (UAI), generated Negotiated Service Agreement Form, or the Children’s PCS Assessment completed by Medicaid.
- Service hours authorized by Medicaid.
- Information elicited from the participant/parent/guardian.
- Information from the qualified intellectual disabilities professional (QIDP).
- The signature of all individuals and providers responsible for developing the POC with the participant and responsible for its implementation.

A copy of the most current POC must be kept in the participant’s home. The plan must include all aspects of personal care necessary to be performed by the personal assistant, including the amount, type, and frequency of such services. The POC is developed by the POC team, which includes the participant, the family, guardian, the agency supervisory RN, and others identified by the participant, in the participant’s home.

Services performed, which are not contained in the approved POC, are not eligible for Medicaid payments. Failure to follow the approved POC may result in loss of payment, provider status for Idaho Medicaid, or other action as deemed necessary by DHW.

For significant changes in the participant’s functioning, the agency supervising personnel (adults) or supervisory RN (children) should visit the participant to assess what functioning areas have been impacted and complete the Significant Change Form. The Significant Change Form must be signed by all individuals and providers responsible for its implementation. The Department will not be authorizing a RN visit or POC units for completion of the Significant Change Form or the resulting POC revisions.

The POC must be revised and updated based upon treatment results or a participant’s changing needs as necessary, or at least annually. Services performed, which are not contained in the POC, are not covered.
29.13. Registered Nurse (RN) Responsibilities

An RN, who is not functioning as the personal assistant, may supervise the delivery of PCS to the participant. The supervising RN may be an employee or contractor of a personal assistance agency or fiscal intermediary. The supervisory nurse will:

- Supervise the treatment given by the personal assistant.
- Conduct on-site interviews with the participant as specified in the POC.
- Update the POC as necessary, but at least annually.
- Notify the physician immediately of any significant changes in the participant’s physical condition or response to the service delivery.
- Evaluate changes of condition when requested by the personal assistant, case manager, or participant through on-site visits.

Note: PCS Supervisory RN services are covered for Medicaid Enhanced Plan participants.

Note: PCS Supervisory RNs may participate in the development of a POC for the participant, but participation is not required.

29.14. Special Requirements for Individuals with Developmental Disabilities (DD)

In addition to the RN’s supervisory visit, some participants who are developmentally disabled (DD) as determined by Medicaid, receive an assessment and supervision of service delivery from a QIDP as defined in 42 CFR §483.430.

Note: PCS Qualified Intellectual Disabilities Professional (QIDP) services are covered for Medicaid Enhanced Plan participants.

29.15. Qualified Intellectual Disabilities Professional (QIDP)

The QIDP performs the following services:

- Assists in the development of the POC for the participant in conjunction with the supervisory RN.
- Supervises the skills training components of service given by the personal assistant; the skills training is generally the continuation of an active treatment program developed by a Developmental Disabilities Agency (DDA) or special education department of a school system.
- Conducts participant interviews in the home, as specified in the POC.
- Re-evaluates the POC annually or as needed.
- Conducts on-site evaluations of changes in participant condition when requested by the personal assistant, case manager, participant, or RN supervisor.

29.16. Registered Nurse and Qualified Intellectual Disabilities Professional

For children, the Registered Nurse (RN) or Qualified Intellectual Disabilities Professional (QIDP) must submit a report of initial assessment and plan of care to Medicaid to receive prior authorization to submit a claim for the service. Medicaid may also require additional information as necessary. The RN or QIDP does the following:

- Develops the Plan of Care.
- Completes any other forms needed.
- Obtains the attending physician’s signature as required.
- Delivers the packet to Medicaid for review.
The RN supervisor of the personal assistance agency bills for care plan development and placement.

### 29.17. Functional Assessment/Individual Support Plan and Uniform Assessment Instrument (UAI)

For adults, the UAI is the tool used for assessment and care plan development.

The UAI is administered by BLTC to determine the participant’s medical and social history and assess the need for services.

The assessment and Negotiated Service Agreement/Service Plan are sent to the personal assistance agency selected by the participant. The agency and participant complete the NSA/SP. The agency is responsible to develop health and safety and personal goals with the participant to be included in the service plan.

### 29.18. Procedure Codes

Refer to the Idaho Medicaid Fee Schedule library and the Personal Assistance Agency Services fee schedule for covered codes.

<table>
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<tr>
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<th>HCPCS</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Supervisory RN Codes</strong></td>
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<td></td>
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<tr>
<td>PCS Assessment - Participant Evaluation &amp;</td>
<td><strong>G9002</strong></td>
<td>Coordinated Care Fee, Maintenance Rate Initial visit and/or plan development, and annually for the re-evaluation. Prior authorization (PA) Medicaid is required each time this procedure code is used. If additional evaluations are necessary, obtain PA from Medicaid. For initial plans, 8 Units = 1 plan development and placement. For annual plans, 4 Units = 1 development and one plan development and placement.</td>
</tr>
<tr>
<td>Care Plan Development - Agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN Supervising Visit - Agency</td>
<td><strong>T1001</strong></td>
<td>Nursing Assessment/Evaluation The frequency of the supervising visits will be included in Medicaid approved PA. If additional or emergency visits in excess of the approved number are required, they must be prior authorized by Medicaid. 1 Occurrence = 1 visit</td>
</tr>
</tbody>
</table>

| **QIDP Codes**                           |       |                                                                             |
| QIDP Participant Evaluation and Individual Support Plan Development - Agency | **G9001** | Coordinated Care Fee – Initial Rate Initial visit and plan development and the re-evaluation done annually. PA from Medicaid is required each time this procedure code is used. If additional evaluations are necessary, obtain PA from Medicaid. |
| QIDP Supervising Visit - Agency          | **H2020** | Therapeutic Behavioral Services, per diem. The frequency of the supervising visits will be included in the BLTC approved PA. |
If additional or emergency visits in excess of the approved number are required, they must be prior authorized by Medicaid.
1 Unit = 1 day

### Agency PCS Providers

<table>
<thead>
<tr>
<th>Agency Provider PCS</th>
<th>T1019</th>
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</thead>
<tbody>
<tr>
<td>Agency PCS Provider T1019</td>
<td>PCS, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/IID or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse). 1 Unit = 15 minutes</td>
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</table>

### 29.19. Documentation

Medicaid requires all providers to meet the documentation requirements listed in the Provider Enrollment Agreement and IDAPA rules. Providers must generate records at the time of service and maintain all service delivery records necessary to fully document the extent of services submitted for Medicaid reimbursement for each participant receiving services. Providers must also retain all medical records to document services submitted for Medicaid reimbursement for at least (5) years after the date of final payment for the service.

**Note:** Do not attach service delivery documentation to claims submitted to Idaho Medicaid.

#### Documentation Requirements

After every visit, the Direct Care Professional must enter, at a minimum, the following information into the service delivery record:

- **Date of visit.**
- **Time the service(s) begins and ends.** The time services are delivered must be identified using A.M. or P.M. unless entered using military time.
- **Services provided.** Services provided during each visit, including the Activities of Daily Living (ADL) identified on the Universal Assessment Instrument (UAI).
- **Narrative.** Narrative related to the participant’s response to the service(s), any changes noted in the participant’s condition, or any deviations from the Service Plan.
- **Participant’s signature and date.** This may be captured using a signature or unique software login.
- **Direct Care Professional’s signature and date.** This may be captured using a signature or unique software login.

#### Records Availability

Providers must make a copy of the service delivery documentation available to each participant on at a minimum weekly basis. Service delivery records must either be printed and placed in the participant’s home or available to the participant and/or legal representative using an electronic record format (email, website with a login, etc.). When service delivery records are not printed and maintained in the participant’s home, the provider must document the participant’s preference for receiving service delivery documents using a Service Delivery Document Attestation.

#### Service Delivery Document Attestation

When a participant requests to receive service delivery records in an alternate method other than in a printed format kept in their home, the provider must document the participant’s choice using an attestation. The attestation must include the participant’s signature and date, and clearly indicate the method by which the participant chose to receive their documentation.
(print, email, website with a login, etc.) and the participant’s acknowledgement that their service delivery documentation is available at least on a weekly basis. The provider must keep all attestation forms available at the agency and make them available to the Department if requested.

30. **Dental Services**
This section covers Dental Services, which is a state plan service, not a waiver service.

Dental Services and providers are managed by [MCNA Dental](#) under the Idaho Smiles program. See the [DHW Dental Services](#) for providers and [Idaho Smiles](#) for program and provider information.

31. **Transition Management**
This section covers the Transition Management benefit, which is a state plan service, not a waiver service. A maximum of seventy-two (72) hours of Transition Management services are allowed per participant per qualifying transition.

Medicaid participants who are also eligible to receive A&D or DD waiver services receive Transition Management in conjunction with Transition Service waiver benefits. **Note:** Transition Management services are only covered for Medicaid Enhanced Plan participants.

31.1. **Agency Provider Qualifications**
Transition Managers employed by a Personal Assistance Agency (PAA) are responsible for administering Transition Management Services.

31.2. **Record Keeping**
Medicaid requires all providers to meet the documentation requirements listed in the Provider Enrollment Agreement and IDAPA rules. Providers must generate records at the time of service and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. Retain all receipts to document goods and services submitted for Medicaid reimbursement for at least five years after the date of service.

A copy of all service delivery records must be maintained by the provider. It is the provider’s responsibility to ensure that all service delivery records are maintained in the participant’s home whenever possible. When it is not possible to do so, the provider must maintain these records in the provider agency and must produce them upon request from Medicaid.

31.3. **Prior Authorization (PA)**
BLTC must authorize all goods and services reimbursed by Medicaid under the Transition Management benefit prior to the payment of services. Approved PAs are valid for the dates shown on the authorization.

Transition Management is limited to a maximum of seventy-two (72) hours per participant per qualifying transition.

31.4. **Dates of Service**
Dates of service must be within the Sunday through Saturday calendar week on a single detail line on the claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m.
on Saturday. Failure to comply with the Sunday through Saturday billing will be considered inappropriate/fraudulent billing. In addition, a claim cannot span more than one calendar month. If the end of the month falls in the middle of a week, two separate claims must be used.

**Example**
See the following calendar. The last week in April 2019 begins Sunday, April 28, and ends Saturday, May 4. Two separate claims must be entered for this week. One claim will have service dates of 4/28/2019 through 4/30/2019. The second claim will have service dates of 5/01/2019 through 5/04/2019. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim detail line as long as the same quantity of services has been provided each day.

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<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
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<td>30</td>
<td>May 1</td>
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</tbody>
</table>

### 31.5. Service Description
Transition Management provides relocation assistance and intensive service coordination activities to assist nursing facility, IMD and ICF/ID residents to transition to community settings of their choice. Transition Managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to the community and function as a liaison between the participant, institutional, or facility discharge staff, other individuals as designated by the participant, and the Department to support a successful and sustainable transition to the community. A participant is eligible to receive Transition Management benefits when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days.

### 31.6. Procedure Code

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<tr>
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<th>HCPCS</th>
<th>Description</th>
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<tbody>
<tr>
<td>Transition Management</td>
<td>T2022UD</td>
<td>1 Unit = 15 minutes.</td>
</tr>
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</table>

### 31.7. References

#### 31.7.1. State Regulations
## Appendix A. Agency Professional, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date.

<table>
<thead>
<tr>
<th>Version</th>
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<th>Modification Description</th>
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<td>1. Payment</td>
<td>Updated behavioral health contact information</td>
<td>6/26/2024</td>
<td>M Payne, W Deseron</td>
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<td>42.0</td>
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<td>2/5/2024</td>
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<td>41.51</td>
<td>31.1 Agency Provider Qualifications</td>
<td>Clarified agency requirement</td>
<td>2/5/2024</td>
<td>W Deseron, E Garibovic</td>
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<td>30. Dental Services</td>
<td>Updated broken links</td>
<td>2/5/2024</td>
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<td>29.14 Special Requirements for Individuals with Developmental Disabilities (DD)</td>
<td>Updated incorrect CFR reference.</td>
<td>2/5/2024</td>
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<td>29.11. Place of Service (POS) Code</td>
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<td>28.19.4. References</td>
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<td>28.17.1. Agency Provider Qualifications</td>
<td>Updated outdated IDAPA chapter title; removed statement related to phasing in requirements that had to be met by 2007.</td>
<td>2/5/2024</td>
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<td>28.13. Respite Care - A&amp;D Waiver</td>
<td>Updated outdated service terminology</td>
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<td>Updated outdated service terminology &amp; IDAPA chapter titles</td>
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<td>W Deseron, E Garibovic</td>
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<td>41.36</td>
<td>28.2.7. Place of Service (POS) Delivery and Exclusions</td>
<td>Updated outdated service/facility terminology</td>
<td>2/5/2024</td>
<td>W Deseron, E Garibovic</td>
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<td>41.35</td>
<td>28. Aged &amp; Disabled Waiver Services</td>
<td>Updated Adult Residential Care to match Handbook.</td>
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## Agency Professional, Provider Handbook Modifications

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<td>Clarified transportation type allowed and updated contact information to match website.</td>
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<td>Update &quot;Adult Day Care&quot; Service to &quot;Adult Day Health&quot; to match current waiver/rule terminology.</td>
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<td>1.27 3 Adult Day Care – A&amp;D Waiver</td>
<td>Renamed section Adult Day Health. Update &quot;Adult Day Care&quot; Service to &quot;Adult Day Health&quot; to match current waiver/rule terminology.</td>
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<td>Remove Electronic Visit Verification (EVV) requirement statement for Private Duty Nursing (PDN).</td>
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