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1. Section Modifications

Version	Section / Column	Modification Description	Date	SME
27.0	All	Published version	7/14/16	TQD
26.1	2.4.9 Payment for Services	Added information regarding "payer of last resort"	7/14/16	C Burt D Baker
26.0	All	Published version	7/1/16	F Trenkle D Baker
25.20	2.4.12.7 Therapy Services	New section	7/1/16	F Trenkle D Baker
25.19	2.4.12.6 Medical Equipment and Supplies/School-Based Service	Removed "or natural learning environment"	7/1/16	F Trenkle D Baker
25.18	2.4.12.5 Transportation/School-Based Service	Major content updates	7/1/16	F Trenkle D Baker
25.17	2.4.12.4 PCS/School-Based Service	Removed bullet for recommended/referred by physician; added info about PCS not requiring goal on IEP	7/1/16	F Trenkle D Baker
25.16	2.4.12.3 Nursing Services/School-Based Service	Added statement about health care plan	7/1/16	F Trenkle D Baker
25.15	2.4.12.2 CBRS/School-Based Service	Changed section title; major content updates	7/1/16	F Trenkle D Baker
25.14	2.4.12.1 Behavioral Intervention/Behavioral Consultation	Major content updates	7/1/16	F Trenkle D Baker
25.13	2.4.12 Medicaid Reimbursable Health Related Services	New section heading	7/1/16	F Trenkle D Baker
25.12	2.4.11 Procedure Codes	Minor update to evaluations information	7/1/16	F Trenkle D Baker
25.11	2.4.7.1 Paraprofessionals	Updates for ISDE standards, speech-language pathology, and documentation of supervision	7/1/16	F Trenkle D Baker
25.10	2.4.6.5 Excluded Services	Added bullet for services provided to students in nursing homes or hospitals	7/1/16	F Trenkle D Baker
25.9	2.4.6.4 Other Required Documentation	Minor clarifications	7/1/16	F Trenkle D Baker
25.8	2.4.6.3 Service Detail Report (SDR)	Updated bulleted list	7/1/16	F Trenkle D Baker
25.7	2.4.6.2 IEP/IFSP Services Plan	Minor clarifications	7/1/16	F Trenkle D Baker
25.6	2.4.6.1 Order/Recommendations	Changed section title; changed "referral" to "order" and added IDAPA reference	7/1/16	F Trenkle D Baker
25.5	2.4.6 Record Keeping	Added information about service detail report	7/1/16	F Trenkle D Baker
25.4	2.4.4 School Districts and Charter Schools Eligibility	Added statement about one-time consent to access benefits/insurance	7/1/16	F Trenkle D Baker
25.3	2.4.3 Related Services Definition	Added information about reimbursements	7/1/16	F Trenkle D Baker
25.2	2.4.2 Interpretive Services	Added statement about documentation	7/1/16	F Trenkle D Baker
25.1	2.4.1 Overview (School-Based Services)	Updated bulleted list; added paragraph for supporting documentation for supervision requirements	7/1/16	F Trenkle D Baker
25.0	All	Published version	5/19/16	TQD
24.2	2.10.4 Family-Directed Services Option – Children's DD Waiver	Updated name of reference material	5/19/16	C Burt D Baker

Version	Section / Column	Modification Description	Date	SME
24.1	2.9.4 Family-Directed Services Option – HCBS State Plan	Updated name of reference material	5/19/16	C Burt D Baker
24.0	All	Published version	4/14/16	TQD
23.1	2.40.1 Overview	Deleted last sentence about Home Health visits	4/14/16	D Baker
23.0	All	Published version	1/19/2016	TQD
22.2	2.8.8 Place of Service (POS)	Added new section	1/22/2016	D Baker C Brock C Loveless
22.1	2.8.7 Children's DD Benefit Packages	Added reference to GP&P handbook	1/22/2016	D Baker C Brock C Loveless
22.0	All	Published version	11/5/15	TQD
21.1	2.33.5 Procedure Code	Added new table for Chore Services procedure codes	11/5/15	D Baker
21.0	All	Published version	9/25/15	TQD
20.1	2.44.1 Overview [PCS]	Added link to Request for Additional Services Form	9/25/15	K Gillette D Baker
20.0	All	Published version	8/28/15	TQD
19.1	2.1.1 General Policy 2.9.3.1 Respite 2.28.3 Diagnosis Code 2.29.4 Diagnosis Code 2.31.3 Diagnosis Code 2.33.3 Diagnosis Code 2.34.3 Diagnosis Code 2.35.3 Diagnosis Code 2.36.3 Diagnosis Code 2.37.3 Diagnosis Code 2.38.4 Diagnosis Code 2.39.3 Diagnosis Code 2.40.12 Diagnosis Code 2.42.5 Diagnosis Code 2.43.5 Diagnosis Codes 2.45.3 Diagnosis Code	Updated for ICD-10	8/28/15	J Siroky A Fernandez C Burt C Taylor D Baker
19.0	All	Published version	1/16/15	TQD
18.2	2.4.11.1 Place of Service (POS) Codes	Added section	1/16/15	F Trenkle-MacAllister T Kinzler

Version	Section/ Column	Modification Description	Date	SME
18.1	2.4.1 Overview 2.4.2 Interpretive Services 2.4.4 School Districts and Charter Schools Eligibility 2.4.4.1 Evaluations 2.4.5 Evaluation and Diagnostic Services 2.4.6.1 Referrals/Recommendations 2.4.6.2 IEP/IFSP/SP 2.4.6.3 Service Detail Report 2.4.6.4 Other Required Documentation 2.4.6.5 Excluded Services 2.4.7.1 Paraprofessionals 2.4.11.2 Behavioral Intervention/Behavioral Consultation 2.4.11.3 PSR/School-Based Service 2.4.11.5 PCS/School-Based Service 2.4.11.6 Transportation/School-Based Service 2.10.3.3 Interdisciplinary Training	Updated for clarity	1/16/15	F Trenkle-MacAllister T Kinzler
18.0	All	Published version	09/02/14	TQD
17.4	2.15.1 Service Description	Added last sentence to last bullet	09/02/14	C Burt C Taylor
17.3	2.7 Mental Health Service Coordination	Removed entire section	09/02/14	C Burt C Taylor
17.2	2.4.1 Overview	Added last sentence indicating school-based services must be provided by qualified professionals as indicated for each service.	09/02/14	C Burt C Taylor
17.1	All	Removed blue italicized text that was no longer appropriate for mental health.	09/02/14	C Burt C Taylor
17.0	All	Published version	08/15/14	TQD
16.1	2.4.11.1 Behavioral Intervention/Behavioral Consultation	Updated for Correct Coding Initiative (CCI).	08/15/14	F Trenkle-MacAllister C Taylor D Baker
16.0	All	Published version	07/07/14	TQD
15.1	Multiple	Updated ICD-9/10 dates to 2015	07/07/14	C Taylor
15.0	All	Published version	2/21/14	TQD
14.1	Multiple	Updated “Adult Day Care” to “Adult Day Care (Health)”	2/21/14	D Baker
14.0	All	Published version	2/14/14	TQD
13.2	2.10.3.1 Respite	Updated for clarity	2/14/14	B Hamilton D Baker
13.1	Multiple	Added ICD-10 information for DOS on or after October 1, 2014.	2/14/14	L Neal C Taylor D Baker
13.0	All	Published version	1/31/14	TQD
12.3	2.28 A&D Waiver Services – 2.45 Personal Care Services	Updated information in all sections in this range to align with current IDAPA rules.	1/31/14	M Wasserman D Baker

Version	Section/ Column	Modification Description	Date	SME
12.2	2.7 MH Service Coordination, and 2.8 Service Coord. For Children with Special Health Care Needs	Modified organization of information; in Section 2.8, updated PA information for children's service coordination.	1/31/14	C Brock C Taylor
12.1	2.3 District Health Department Services	Added section	1/31/14	J Siroky C Taylor
12.0	All	Published version	10/04/13	TQD
11.1	2.3.7.1 Paraprofessionals	Added/removed information in second and third paragraphs for clarification and to align with IDAPA rule.	10/04/13	F Trenkle-MacAllister C Taylor
11.0	All	Published version	8/30/12	TQD
10.10	2.7.4 Crisis Service Coordination	Removed outdated information	8/30/12	C Burt C Taylor
10.9	2.7.3.2 Supervision of Service Coordination	Updated requirements	8/30/12	C Burt C Taylor D Baker
10.8	2.7.3.1 Service Coordinators	Updated third bullet regarding mental health	8/30/12	C Burt C Taylor
10.7	2.7.2 MH Service Coordination Eligibility	Changed mentally retarded to intellectually disabled, severe to serious.	8/30/12	C Burt C Taylor
10.6	2.7.1 Definition	Changed severe to serious and added acronym (SPMI). Deleted outdated material and added information for clarity.	8/30/12	C Burt C Taylor
10.5	2.6.3.3 Supervision of Service Coordination	Updated information	8/30/12	C Burt C Taylor
10.4	2.6.3.1 Service Coordinators	Removed "and service coordination for adults with severe and persistent mental illness" from third bullet.	8/30/12	C Burt C Taylor
10.3	2.6.2 Children's Service Coordination Eligibility	Changed the following terms: Mentally retarded to intellectually disabled Severe to serious Disorder to disturbance Changed bullet point to blue italicized text.	8/30/12	C Burt C Taylor
10.2	2.1.1, 2.6.1, 2.6.2, 2.6.3.2, 2.7	Changed portions of text to blue/italicized to indicate information that is obsolete as of 9/1/13 for mental health.	8/30/12	C Burt C Taylor
10.1	2.6 Children's Service Coordination	Added information regarding Optum	8/30/13	C Burt C Taylor
10.0	All	Published version	7/19/2013	D Baker
9.2	2.3.11.4 Personal Care Services (PCS)/School-Based Services	Updated for clarity	7/19/2013	F Trenkle-MacAllister
9.1	2.3.6. Service Detail Report (SDR)	Updated for clarity	7/15/2013	F Trenkle-MacAllister
9.0	All	Published version	7/1/2013	D Baker
8.37	2.1.1 – General Policy	Updated for clarity	7/1/2013	S Perry
8.36	2.1.2 – Payment	Added information related to interpretation services	7/1/2013	S Perry
8.35	2.2 – DD Agencies	Updated based on changes to IDAPA and to provide clarity	7/1/2013	S Perry
8.34	2.2.5 – Deleted	Deleted section on Psychotherapy based on changes to IDAPA	7/1/2013	S Perry
8.33	2.2.4 – Program Requirements	Added a section on general program requirements to add clarity.	7/1/2013	S Perry
8.32	2.2.6 – Moved	Moved information on Community Crisis Services to 2.26.	7/1/2013	S Perry
8.31	2.2.7 - Deleted	Deleted section on Speech-Language Pathology Services based on changes to IDAPA	7/1/2013	S Perry

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8.30	2.2.8 - Deleted	Deleted section on PT and OT based on changes to IDAPA	7/1/2013	S Perry
8.29	2.2.9 - Moved	Moved Developmental Therapy information to 2.2.3	7/1/2013	S Perry
8.28	2.2.10 - Deleted	Deleted section on IBI based on changes to IDAPA	7/1/2013	S Perry
8.27	2.2.11 - Deleted	Deleted section on Specialized Services to Nursing Facility Participants based on changes to IDAPA	7/1/2013	S Perry
8.26	2.3 – School Based Services	Removed Infant Toddler Program, Developmental Therapy & IBI, added new programs, updated to match policy	7/1/2013	F Trenkle-MacAllister
8.25	2.3.11.2 - Deleted	Deleted section on Intensive Behavior Intervention based on changes to IDAPA	7/1/2013	F Trenkle-MacAllister
8.24	2.5 – DD Targeted Service Coordination	Updated wording for clarity and removed outdated content	7/1/2013	S Perry
8.23	2.6.1, 2.6.2 Children's Service Coordination	Removed reference to developmental disability	7/1/2013	F Trenkle-MacAllister
8.22	2.8, 2.8.1, 2.8.5, 2.8.7 – Children's DD Services	Changed redesign to children's DD services	7/1/2013	F Trenkle-MacAllister
8.21	2.9.3.3 – Family Education	Updated to current qualifications for provider	7/1/2013	F Trenkle-MacAllister
8.20	2.10.3.1 – Habilitative Intervention	Updated to current qualifications for provider	7/1/2013	F Trenkle-MacAllister
8.19	2.11 – Waiver Services for Adults with DD	Updated outdated content and provided additional information for clarity	7/1/2013	S Perry
8.18	2.11.3.2 - Deleted	Deleted section on service supervision. Material duplicative of information found in other sections of the provider handbook	7/1/2013	S Perry
8.17	2.11.3.2 – Addendum to the Plan of Service	Added a section on Addendums to provide clarity	7/1/2013	S Perry
8.16	2.11.4 - Deleted	Deleted section on provider qualifications. Material duplicative of information found in other sections of the provider handbook	7/1/2013	S Perry
8.15	2.11.4 – Implementation Plans	Added a section on Implementation Plans to provide clarity	7/1/2013	S Perry
8.14	2.11.6 - Deleted	Deleted section on Adult Care Management. Material duplicative of information found in other sections of the provider handbook	7/1/2013	S Perry
8.13	2.11.6 - Payment	Added a section on Payment to provide clarity	7/1/2013	S Perry
8.12	2.11.7 – Moved	Moved information on Community Crisis Services to 2.26.	7/1/2013	S Perry
8.11	2.11.7 – Share of Cost	Added a section on Share of Cost to provide clarity	7/1/2013	S Perry
8.10	2.11.8 - Deleted	Deleted section on Medical Care Evaluation for Assessment. Material duplicative of information found in other sections of the provider handbook	7/1/2013	S Perry
8.9	2.11.7.1 – Record Keeping	Added a section on Record Keeping to provide clarity	7/1/2013	S Perry
8.8	2.11.9 - Deleted	Deleted section on Plan Development. Material duplicative of information found in other sections of the provider handbook	7/1/2013	S Perry
8.7	2.11.9 – Change of Provider Information	Added a section on Change of Provider Information to provide clarity	7/1/2013	S Perry
8.6	2.11.10 - Deleted	Deleted section on Monitoring. Material duplicative of information found in other sections of the provider handbook	7/1/2013	S Perry

Version	Section / Column	Modification Description	Date	SME
8.5	2.12 through 2.23 – DD Waiver	Updated based on changes to IDAPA. Removed sections that were duplicative of material found in other sections of the provider handbook	7/1/2013	S Perry
8.4	2.24 – Dental Services – DD Waiver	Added a section on Dental Services	7/1/2013	S Perry
8.3	2.25 – Consumer Directed Services	Added a section on Consumer Directed Services	7/1/2013	S Perry
8.2	2.26 – Community Crisis Supports	Combined previous sections for single information source on Community Crisis Supports	7/1/2013	S Perry
8.1	2.46.7.2 – RN and QIDP	Updated for clarity	7/1/2013	S Perry
8.0	All	Published version	5/23/2012	TQD
7.2	2.1.2.1 Share of Cost (SOC)	Added information for SOC Review Request Form	5/23/2012	T Kinzler
7.1	2.9.3.1 Respite	Added ICD-9 diagnosis code	5/23/2012	L Ertz
7.0	All	Published version	02/28/12	TQD
6.9	2.2.11.3 Intensive Behavioral Intervention (IBI) to Nursing Facility Participants	Section was 2.2.11.5 but now is 2.2.11.3	02/28/12	J Siroky
6.8	2.2.11.2 Psychotherapy Treatment to Nursing Facility Participants	Section was 2.2.11.4 but now is 2.2.11.2	02/28/12	J Siroky
6.7	2.2.11.2 Physical Therapy (PT) to Nursing Facility Participants	Section deleted	02/28/12	J Siroky
6.6	2.2.11.1 Developmental Therapy (DT) to Nursing Facility Participants	Section was 2.2.11.3 but now 2.2.11.1 plus updated the name to Developmental Therapy (DT) to Nursing Facility Participants. Also changed the responsibility for participants physical therapy	02/28/12	J Siroky
6.5	2.2.11.1 Speech-Language Pathology Services to Nursing Facility Participants	Section deleted	02/28/12	J Siroky
6.4	2.2.8.1 Prior Authorization (PA) of Physical Therapy (PT) and Occupational Therapy (OT) Services	Section deleted	02/28/12	J Siroky
6.3	2.2.8 Physical Therapy (PT) and Occupational Therapy (OT) Services	Removed service limit with PA requirement verbiage	02/28/12	J Siroky
6.2	2.2.7.1 Prior Authorization (PA) for Speech-Language Pathology Service	Section deleted	02/28/12	J Siroky
6.1	2.2.7 Speech-Language Pathology Services (SLP)	Removed services limit with PA requirement verbiage	02/28/12	J Siroky
6.0	All	Published version	10/3/2011	TQD
5.3	2.10 Waiver Services for Children with Developmental Disabilities (DD)	Add information for Waiver Services for Children with DD (CCF 10462)	10/3/2011	L Ertz
5.2	2.9 Children's Home and Community Based Services State Plan Option	Added information for Children's Home and Community Based Services State Option Plan (CCF 10462)	10/3/2011	L Ertz

Version	Section / Column	Modification Description	Date	SME
5.1	2.8 Children's Developmental Disabilities Redesign Services	Added information for Children's DD Redesign Services (CCF 10462)	10/3/2011	L Ertz
5.0	All	Published version	7/29/2011	TQD
4.15	2.23.3 Service Locations	Updated IDAPA information	7/29/2011	L Ertz
4.14	2.3.7.1 Paraprofessionals	Updated IDAPA information for Developmental therapy	7/29/2011	L Ertz
4.13	2.3.7 Collateral Contact	Removed section	7/29/2011	L Ertz
4.12	2.3.1 Overview	Removed Collateral contact	7/29/2011	L Ertz
4.11	2.2.12.5 Supportive Counseling to Nursing Facility Participants	Section deleted	7/29/2011	L Ertz
4.10	2.2.11.2 Psychotherapy Treatment to Nursing Facility Participants	Updated IDAPA information	7/29/2011	L Ertz
4.9	2.2.9 Developmental Therapy (DT)	Updated IDAPA information	7/29/2011	L Ertz
4.8	2.2.6 Community Crisis Supports	Community Crisis Supports was 2.2.7 is now 2.2.6.	7/29/2011	L Ertz
4.7	2.2.6.1 Supportive Counseling	Section deleted	7/29/2011	L Ertz
4.6	2.2.5 Psychotherapy	Psychotherapy section was 2.2.6 is now 2.2.5 Updated IDAPA information, last sentence	7/29/2011	L Ertz
4.5	2.2.5 Collateral Contact	Deleted section	7/29/2011	L Ertz
4.4	2.2.3 Covered Service Limits	Changed number of hours from 12 to 4	7/29/2011	L Ertz
4.3	2.2.2 Program Requirements	Updated first sentence with additional information	7/29/2011	L Ertz
4.2	2.2.1 Overview	Changed IDAPA 16.04.11 to 16.03.21	7/29/2011	L Ertz
4.1	2.1.1 General Policy	Changed Centers to Agencies	7/29/2011	L Ertz
4.0	All	Published version	6/27/2011	TQD
3.5	2.43.10 Record Keeping	Updated wording or outdated content	6/27/2011	S Scheuerer
3.4	2.42.2.2 Record Keeping	Updated wording or outdated content	6/27/2011	S Scheuerer
3.3	2.40.7.2 Record Keeping	Updated wording or outdated content	6/27/2011	S Scheuerer
3.2	2.28.1 Overview	Updated wording or outdated content	6/27/2011	S Scheuerer
3.1	2.24.2.2 Record Keeping	Updated wording or outdated content	6/27/2011	S Scheuerer
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2.57	2.21.2.9	Updated wording or outdated content	3/11/2011	S Choules
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2.55	2.40.5	Deleted and updated outdated wording	3/11/2011	S Choules
2.54	2.40.8	Updated wording or outdated content	3/11/2011	S Choules
2.53	2.40.4 – 2.41.10	Updated to meet HB701 legislative direction	3/11/2011	S Scheuerer
2.52	2.41.8 Functional Assess/UAI	Updated to meet HB701 legislative direction	3/11/2011	S Scheuerer
2.51	2.41.5 A&D POC	Updated to meet HB701 legislative direction	3/11/2011	S Scheuerer
2.50	2.22.9 A&D SP	Updated to meet HB701 legislative direction	3/11/2011	S Scheuerer
2.49	2.35.1 A&D Nsg	Updated to meet HB701 legislative direction	3/11/2011	S Scheuerer
2.48	2.39.7.3 A&D TBI Records	Updated to meet HB701 legislative direction	3/11/2011	S Scheuerer
2.47	2.28 A&D SC	Deleted to meet HB701 legislative direction	3/11/2011	S Scheuerer
2.46	2.22.2.8 A&D ISP	Updated to meet HB701 legislative direction	3/11/2011	S Scheuerer
2.45	2.39.11.1 A&D Res hab TBI Proc Codes	Updated wording and outdated content	3/11/2011	S Scheuerer
2.44	2.39.6 A&D Res Hab Prov Qual	Updated wording and outdated content	3/11/2011	S Scheuerer

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2.43	2.31.1 A&D Consultation Services Overview	Updated wording or outdated content	3/11/2011	S Scheuerer
2.42	2.30.5 A&D Companion Procedure Code	Updated wording or outdated content	3/11/2011	S Scheuerer
2.41	2.30.2 A&D Companion Provider Qualifications	Updated wording or outdated content	3/11/2011	S Scheuerer
2.40	2.29.2 A&D Chore	Updated wording or outdated content	3/11/2011	S Scheuerer
2.39	2.29.1 Chore Services Overview	Updated wording or outdated content	3/11/2011	S Scheuerer
2.38	2.28.9 Procedure Codes	Updated wording or outdated content	3/11/2011	S Scheuerer
2.37	2.28.8 Payment & Limitations	Updated wording or outdated content	3/11/2011	S Scheuerer
2.36	2.28.3.2 SP Development	Updated wording or outdated content	3/11/2011	S Scheuerer
2.35	2.28.3.1 Assessing Participant's Needs	Updated wording or outdated content	3/11/2011	S Scheuerer
2.34	2.28.3 Service Coordinator's Responsibilities	Updated wording or outdated content	3/11/2011	S Scheuerer
2.33	2.28.2.3 A&D Supervision of Service Coordination	Updated wording or outdated content	3/11/2011	S Scheuerer
2.32	2.28.2.2 A&D SC Paraprofessional Qualifications	Updated wording or outdated content	3/11/2011	S Scheuerer
2.31	2.28.2.1 A&D SC Provider Qualifications	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.30	2.26.4 A&D POS Codes	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.29	2.26.2 A&D Provider Qualifications	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.28	2.26.1 A&D Attendant Overview	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.27	2.25.4 A&D Procedure Codes	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.26	2.25.1 SME & Supplies A&D Waiver Overview	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.25	2.24.3 A&D Payment	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.24	2.24.1 Non-Med Trans A&D Overview	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.23	2.23.4 A&D POS Codes	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.22	2.23.2.1 A&D Provider Home	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.21	2.23.2 A&D Facilities	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.20	2.22.2.9 A&D SP	Corrected formatting and deleted outdated wording, removed outdated information	3/11/2011	S Scheuerer
2.19	2.22.2.8 A&D ISP	Corrected formatting and outdated wording	3/11/2011	S Scheuerer
2.18	2.22.2.4 A&D PA	Corrected formatting and outdated wording	3/11/2011	S Scheuerer
2.17	2.22.2.1 A&D Provider Qualifications	Corrected formatting and outdated wording	3/11/2011	S Scheuerer
2.16	2.22.1 A&D Overview	Corrected formatting and outdated wording	3/11/2011	S Scheuerer
2.15	2.4.1.3 Provider Agency	Removed paragraph that agency must indicate if RN or LPN provided service.	3/11/2011	S Scheuerer
2.14	2.42.10 Record Keeping	Deleted Change in Participant Status	3/11/2011	S Scheuerer
2.13	2.42.9 Procedure Codes	Updated descriptions	3/11/2011	S Scheuerer
2.12	2.42.8 Functional Assessment/ISP and UAI	Updated for clarity	3/11/2011	S Scheuerer
2.11	2.42.7.2 RN and QIDP	Updated section name and section with QIDP and for clarity.	3/11/2011	S Scheuerer
2.10	2.42.7.1	Updated section with QIDP	3/11/2011	S Scheuerer

Version	Section / Column	Modification Description	Date	SME
2.9	2.42.7 Special Requirements for Ind w/DD	Updated QMRP to QIDP/QMRP	3/11/2011	S Scheuerer
2.8	2.42.6 RN Responsibilities	Updated plan of care with POC	3/11/2011	S Scheuerer
2.7	2.42.5 Plan of Care (POC)	Updated for clarity	3/11/2011	S Scheuerer
2.6	2.42.1 Change in Participant Status	Moved from 2.42.10 to 2.42.1	3/11/2011	S Scheuerer
2.5	2.42 Service Description	Updated for clarity	3/11/2011	S Scheuerer
2.4	2.41.2.1 Provider Qualifications	Updated for clarity	3/11/2011	S Scheuerer
2.3	2.4.1 Overview	Replaced RMS with Medicaid	3/11/2011	S Scheuerer
2.2	2.4	Removed "/School-based Services" from heading	3/11/2011	L Ertz
2.1	2.3.10	Removed "Third party recovery (TPR), such as private insurance, must be exhausted before DHW is billed. Proof of billing other third party payers is required."	3/11/2011	L Ertz
2.0	All	Published version	8/27/2010	TQD
1.11	2.15	Added Transportation DD Waiver	8/27/2010	P Grooms
1.10	2.16	Added Environmental Accessibility Adaptations DD Waiver	8/27/2010	P Grooms
1.9	2.17	Added Specialized Equipment and Supplies DD Waiver	8/27/2010	P Grooms
1.8	2.18	Added Personal Emergency Response System DD Waiver	8/27/2010	P Grooms
1.7	2.19	Added Home Delivered Meals DD Waiver	8/27/2010	P Grooms
1.6	2.20	Added Adult Day Care DD Waiver	8/27/2010	P Grooms
1.5	2.21	Added Self Directed Supports DD Waiver	8/27/2010	P Grooms
1.4	Various	Updated to match policy	8/27/2010	P Grooms
1.3	2.2.4	Updated to: Do not put PA on claim form	8/27/2010	D Baker
1.2	2.6.1, 2.7.1, 2.8.1, 2.9.1	Updated to match policy	8/27/2010	T Kinzler
1.1	All	Sections were renumbered to accommodate additional information	8/27/2010	C Stickney
1.0	All	Initial document – Published version	5/7/2010	Molina / TQD

2. Agency – Professional

2.1. Introduction

2.1.1. General Policy

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.

This section covers all Medicaid options and health related Infant Toddler Programs (ITP) services provided by therapists, school districts, charter schools, and Infant Toddler Programs (ITPs), developmental disabilities agencies (DDAs), DD Waiver service providers, and A&D Waiver service providers as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following areas:

- Developmental Disability Agencies
- School-Based Services
- Nursing Agency-PDN
- DD Targeted Service Coordination
- Children's Service Coordination
- Personal Care Services (PCS)Service Coordination
- DD Waiver Services
- Aged and Disabled Waiver Services

Note: Services limitations are not applicable to school-based services. 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 Optum Idaho. Please see www.optumidaho.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-9-CM or ICD-10-CM code is used for the diagnosis code based on dates of service. For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*. 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 General Provider and Participant Information 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.

2.1.1.1. Share of Cost

The Nursing Home and Waiver Share of Cost (SOC) Review Request form is available online under Forms. The form can be filled out online, saved, and e-mailed to idnursinghome@molinahealthcare.com. The instructions to fill out the form are in the same location. All fields in the forms are ***required***.

2.1.1.2. 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. Providers 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.

3 units ≥ 38 minutes to < 53 minutes
4 units ≥ 53 minutes to < 68 minutes
5 units ≥ 68 minutes to < 83 minutes
6 units ≥ 83 minutes to < 98 minutes
7 units ≥ 98 minutes to <113 minutes
8 units ≥ 113 minutes to < 128 minutes

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.) http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/CMS-Program-Memoranda.html.

2.2. Developmental Disability Agencies

2.2.1. Overview

Developmental disabilities agencies provide:

- Developmental therapy services to adults with developmental disabilities
- Children's Developmental Disabilities Waiver services
- Children's Act Early Waiver services
- 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).

2.2.2. DDA Services

2.2.2.1. 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.

2.2.2.2. Children's DDA Services

For information on Children's services that are provided by a DDA, see *Section 2.8 Children's Developmental Disabilities Services* in this provider handbook.

2.2.3. 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.* See *CMS 1500 Instructions, Appendices* for covered services.

Only one 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.

For limitations specific to Children's DDA services, see *Section 2.8 Children's Developmental Disabilities Services* in this provider handbook.

2.2.3.1. 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

2.2.4. 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* for more information on billing services that require PA.

2.2.5. 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.

2.2.5.1. 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).

2.2.5.2. 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.

2.3. District Health Department Services

2.3.1. Overview

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.

2.3.2. Family Planning Services

2.3.2.1. Overview

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

2.3.2.2. Contraceptive Supplies

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

2.3.2.3. 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.

Some physician administered drugs require prior authorization and can be found on the *Physician Administered Drugs Requiring PA* list.

2.3.2.4. 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.

2.3.2.5. Diagnosis Codes

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

2.3.3. Child Wellness Exams

Complete information regarding child wellness exams is located in the *General Provider and Participant* handbook. Child wellness exams are often referred to as EPSDT screens.

2.3.4. Immunization Program

2.3.4.1. Overview

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 *Allopathic and Osteopathic Guidelines* or http://www.cdc.gov/vaccines/acip/ for more information.

2.3.4.2. 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.

2.3.4.3. 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.).

2.3.5. 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. See *CMS 1500 Instructions*, *Pregnant Women Clinic* for covered services.

2.3.6. Sexually Transmitted Disease (STD)

2.3.6.1. Overview

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.

2.3.6.2. Payment

Services should be billed using the proper CPT codes for E/M, treatment, and diagnostic services. Usual and customary charges should be used.

2.4. School-Based Services

2.4.1. Overview

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
- Evaluation and Diagnostic services; evaluations completed for educational services only cannot be billed
- Interpreter services: For assistance with finding an interpreter, call the Idaho Careline at 1 (800) 926-2588
- 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
- 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.

2.4.2. 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 Billing Instructions* for more information. Interpretative Services means those interpretive services (sign language or non-English language interpretation) that are necessary to allow a participant to benefit from health related services that are Medicaid reimbursable and provided by a school. Payment for interpretive services is limited to the specific time that the participant is receiving the covered health-related service. Both the Medicaid-covered service and the need for interpretive services must be included on the participant's plan.

Payment for interpretive services will not be made for the following:

- Interpretive services to assist the participant to understand information or services that are not reimbursed by Medicaid..
- Interpretive services provided by the provider of the direct service.
- Interpretive services not identified on the IEP or other service plan.

The interpreter must generate documentation as identified in *IDAPA 16.03.09.854.03: Service Detail Reports*. Documentation for interpretive service must include the Medicaid reimbursable health-related service being provided while the interpretive service is provided. A student response is not required for this service.

2.4.3. 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.

2.4.4. 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.

2.4.4.1. 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

2.4.5. 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).

2.4.6. 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 Section *2.4.6.4 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.

2.4.6.1. 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*.

2.4.6.2. 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.

2.4.6.3. 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.

2.4.6.4. 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 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.

2.4.6.5. 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

2.4.7. 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 – Provider Qualifications and Duties*.

2.4.7.1. 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, Rule of the Speech and Hearing 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.

2.4.8. 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.

2.4.9. 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).

2.4.10. Prior Authorization (PA)

Prior authorization is required for certain medical equipment and supplies. See the *Suppliers* 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* for more information on billing services that require PA.

2.4.11. Procedure Codes

All claims submitted must contain a 5-digit health related service procedure code for billing. Please see *CMS 1500 Instructions*, *Appendices* for covered services. 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.

2.4.11.1. Place of Service (POS) Codes

School-based services can only be provided in the following POS:
03 School
99 Other

2.4.12. Medicaid Reimbursable Health Related Services

2.4.12.1. 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.

2.4.12.2. 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.

See *CMS 1500 Instructions*, *Appendices* for covered services. 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.

2.4.12.3. 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.

2.4.12.4. 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 amount 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.

2.4.12.5. 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.

2.4.12.6. 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.

2.4.12.7. Therapy Services

Requirements for Speech-Language Pathology and Audiology professional services: please refer to the *Speech, Language, and Hearing* section of the handbook.

Requirements for Occupational Therapy and Physical Therapy services: please refer to the *Respiratory, Developmental, Rehab, Restorative Services* section of the handbook.

2.5. Nursing Agency-PDN

2.5.1. Overview

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.

2.5.1.1. Family Participation

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

2.5.1.2. 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.

2.5.1.3. 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.

2.5.2. 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.

See *CMS 1500 Instructions*, *Appendices* for covered services.

2.5.2.1. 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.

2.5.2.2. 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* for the current regional address and phone number.

2.5.2.3. 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 an RN or 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 but (s)he will take the opinion or input of the agency nurse into consideration before making the final decision.

Functions of a Licensed Practical Nurse (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 State Board of Nursing, *IDAPA 23.01.01.400.01, Determining Scope of Practice* and *IDAPA 23.01.01.460, Licensed Practical Nurse (LPN)*.

2.5.2.4. 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 Transportation section of Idaho Medicaid.

Contact Medicaid Transportation for transportation questions at 1 (800) 296-0509 or 1 (208) 334-4990.

2.5.3. 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.

2.5.4. 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.

2.5.5. 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.

2.5.6. Reimbursement

2.5.6.1. Overview

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.

2.5.6.2. Registered Nurse (RN)

An RN can provide either oversight of an LPN or direct care.

2.5.6.3. Private Duty Nursing (PDN) Provider

Payments are limited to the services specified on the POC on file with Medicaid.

2.5.7. Record Keeping

Private duty nurses or nursing agencies maintain service records on each participant receiving nursing services. The record will be maintained 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.

2.5.7.1. 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.

2.5.7.2. 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.

2.5.8. Place of Service (POS) Codes

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/ID)
- Licensed shelter homes
- Licensed professional foster homes
- Licensed hospital

2.6. DD Targeted Service Coordination

2.6.1. 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.

For a participant enrolled in Healthy Connections, a targeted service coordinator must receive a referral for assessment and provision of services from the participant's Healthy Connections provider. The Healthy Connections referral must cover the dates of service delivery.

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.

2.6.1.1. Procedure Codes

All targeted service coordination claims submitted must contain a 5-digit health related service procedure code for billing. See *CMS 1500 Instructions, Appendices* for covered services.

2.6.2. 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.

2.6.3. Provider Qualifications

2.6.3.1. 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.*

2.6.3.2. 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.

2.6.3.3. 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.

2.6.4. 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.

2.7. 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 in the *Forms* folder on https://www.idmedicaid.com or at http://healthandwelfare.idaho.gov on the Medical Care

homepage under **Forms** . Utilizing and correctly completing the MEDICAID APPROVED packet will expedite the prior authorization review process.

2.7.1. 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 *2.7.5.1 Required Documentation* in this handbook or refer to *IDAPA 16.03.10.730-736*.

2.7.2. 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.

2.7.3. Provider Qualifications

2.7.3.1. 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*.

2.7.3.2. 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.*

2.7.3.3. 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 *2.7.3.1 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.

2.7.4. 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.

2.7.5. 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 section *2.7.5.1 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.

2.7.5.1. 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.

2.7.6. Notice of Decision (NOD)

Providers can access the Molina 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*.

2.7.7. Billing Procedures

All service coordination services must be billed using the appropriate HCPCS. See CMS 1500 Instructions, *Appendices* for covered services.

2.7.7.1. 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.

2.7.7.2. 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.

2.7.7.3. 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.

2.7.7.4. 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.

2.8. Children's Developmental Disabilities Services

2.8.1. Overview

Children's developmental disabilities (DD) services system includes an array of benefits that includes an independent assessment process, and offers case management for families.

Individuals and agencies can enroll under different provider specialties other than Developmental Disabilities Agencies (DDA). The following is a list of providers able to enter into a Medicaid provider agreement and deliver children's DD services:

- Developmental Disabilities Agencies
- Developmental Disabilities Agencies, Support Only
- Independent Respite Provider
- Independent Therapeutic Consultation Provider
- Independent Crisis Professional Provider

DDAs who are currently under a provider agreement can continue to operate under their same provider specialty. At the time of recertification (or earlier if desired), agencies can decide to continue as a DDA and offer all of the children's DD services, or they can choose to only offer support services and change their provider specialty to DDA – Support Only.

Be sure to visit the Children's DD Services website for forms, processes, contact information, and ongoing updates.

Under children's developmental disabilities program, there are three benefit packages available for families:

- Children's Home and Community-Based Services State Plan Option (Children age 0 - 17 meeting DD criteria)
- Children's Developmental Disabilities Waiver (Children age 0 – 17 meeting DD criteria and institutional level of care)
- Children's Act Early Waiver (Children age 3 – 6 meeting DD criteria and institutional level of care who have autism or maladaptive behaviors)

2.8.2. Department Prior Authorization Process

Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of service, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization, as well as rules for the specific service. The Department's prior authorization process is outlined in *IDAPA 16.03.10, Medicaid Enhanced Plan Benefits,* Sections 520 through 528.

2.8.3. Eligibility Determination and Assessments

Initial and annual assessments must be performed by the independent assessment provider under contract with the Department. The purpose of the eligibility assessment is to determine a child's eligibility for developmental disabilities services and his or her level of care. When a child is determined eligible, the independent assessor will assign the child an annual budget amount that will be used for their DD services.

The child's budget amount covers services that are a part of the children's developmental disabilities program, including: respite, habilitative supports, family education, habilitative intervention evaluation, habilitative intervention, family training, and interdisciplinary training.

Services under the children's DD program that are not included in the budget include therapeutic consultation and crisis intervention. These services are subject to prior authorization and have separate limitations. Also not included in the child's budget is children's DD case management.

The child's budget does not include services outside of the children's DD program that are otherwise covered by the child's Medicaid card. Examples of services not included in the child's budget: Occupational therapy, physical therapy, speech-language pathology, personal care services, mental health services, medical services, transportation, etc.

Prior to receiving developmental disabilities services, children must be determined eligible by the independent assessment provider. See *IDAPA 16.03.10, Medicaid Enhanced Plan Benefits,* Section 522 for a description of the requirements for eligibility determinations.

2.8.4. Family-Centered Planning

The family-centered planning process involves the collaboration of a family-centered planning team to develop the plan of service for the child. The process is facilitated by a case manager (in IDAPA rule, the case manager is referred to as the paid plan developer and paid plan monitor). The family-centered planning team includes, at a minimum, the child (unless otherwise determined by the team), the parent or legal guardian, and the child'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.

2.8.5. Plan Development

In collaboration with the family and child, the Department must ensure that the child has one plan of service. The services and supports on the plan of service must be written within the child's budget. The plan must include all services and supports, including services not funded by Medicaid.

The family may use the Department's case manager or develop their own plan. Non-paid plan development may be provided by the family or a person of their choosing when this person is not a paid provider of services identified on the child's plan of service. The plan of service must always be authorized by the Department prior to implementing services.

The child's plan of service includes a planning assessment, and identifies the following:

- Family's identified needs
- Goals to be addressed within the plan year
- Type of supports and services (including services not funded by Medicaid)
- Service provider
- Frequency and costs for services
- Budget utilization
- Target dates
- Methods for collaboration

Families are provided with a list of all willing and qualified providers for children's DD services in the State of Idaho. If the family has not selected a provider at the time of plan development, they will need to identify a provider shortly after the planning meeting. Once a provider has been identified, the provider must contact the Department to validate that they will be the child's provider for services. DDA providers are to use the DDA Choice Form, located on the Children's DD Services website, and cannot deliver services until the form has been submitted and authorization has been obtained from the Department.

2.8.6. Plan Monitoring

The family-centered planning team must identify the frequency of monitoring. Monitoring of the plan of service must take place at least every six (6) months, and must be a face-to-face meeting with the child and family at least annually.

Plan monitoring includes the following:

- Review of the plan of service with the parent or legal guardian to identify the current status of programs and changes if needed
- Contact with service providers to identify barriers to service provision
- Discussion with parent or legal guardian about their satisfaction regarding quality and quantity of services
- Review of provider status reviews

Providers of habilitative supports, habilitative intervention, and family training must complete a six (6) month and annual provider status review. The provider status review must be submitted to the plan monitor within forty-five (45) calendar days prior to the expiration of the existing plan of service.

The child's plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in the child's need or demonstrated outcomes. Adjustment of the plan of service requires a parent's or legal guardian's signature, and providers will need to obtain a newly authorized plan of service before adjustments can be made to service delivery.

The child's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. At least 45 calendar days prior to the expiration of the existing plan of service, the case manager will:

- 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 from each provider for use by the family-centered planning team.
- Convene the family-centered planning team to develop a new plan of service.

If the family is reapplying for waiver services after at least a thirty (30) calendar day lapse in service, the independent assessment provider must evaluate whether assessments are current and accurately describe the status of the child prior to developing a new plan of service.

2.8.7. Children's DD Benefit Packages

Under the children's DD system, there are three benefit packages available for families:

- Children's Home and Community Based Services State Plan Option
- Children's Developmental Disabilities Waiver
- Children's Act Early Waiver

Note: See section 2.7.4 of the *General Provider and Participant Information* handbook for EPSDT Services.

2.8.8. Telehealth

Children's DD Telehealth services are reimbursable if provided and billed in accordance with the Idaho Medicaid Telehealth Policy and applicable handbooks.

2.9. Children's Home and Community Based Services State Plan Option

2.9.1. Eligibility

The Children's Home and Community Based Services (HCBS) State Plan Option offers services for children age birth through seventeen (17), and with a developmental disability as defined in *16.03.10 Medicaid Enhanced Plan Benefits,* Sections 500 through 506.

2.9.2. Program Requirements

2.9.2.1. General Requirements for Program Documentation

The provider must maintain records for each child served. Each child's record must include documentation of the child's involvement in and response to the services provided. The direct service provider must include written documentation of the service provided during each visit made to the child, which contains, at a minimum, the following information:

- Date and time of visit.
- Intervention or support services provided during the visit.
- A statement of the child's response to the service.
- Length of visit, including time in and time out.
- Specific place of service.

A copy of the above information will be maintained by the provider. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services.

2.9.2.2. Requirements for Following the Plan of Service

Providers of home and community-based services must coordinate with the family-centered planning team as specified on the plan of service. Providers must be identified as the family's selected provider, and can only deliver services in accordance with the type, amount, duration, and frequency specified on the plan of service. Services delivered that are not authorized on the plan of services may be subject to recoupment by the Department.

2.9.2.3. Records Maintenance

Providers must retain participant records for those to whom they provide services for five (5) years following the last date of service.

2.9.2.4. Payment

Medicaid reimburses children's HCBS state plan services on a fee-for-service basis. See the *CMS 1500 Instructions* for the list of billing codes for the covered services.

2.9.2.5. Services Delivered by a Developmental Disabilities Agency (DDA)

In order for a DDA to provide respite, habilitative supports, and family education, the DDA must be certified to provide support services in accordance with *IDAPA 16.03.21, Developmental Disabilities Agencies.* Each DDA is required to provide habilitative supports.

2.9.2.6. Clinical Supervision

A clinical supervisor must be employed by a DDA on a continuous and regularly scheduled basis and be readily available on-site to provide for:

- The supervision of service elements of the agency, including face-to-face supervision of agency staff providing direct care services.
- The observation and review of the direct services performed by all staff on at least a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the DDA services.
- The completion of provider status reviews.

Clinical supervisor qualifications are found in *IDAPA 16.03.21, Developmental Disabilities Agencies.*

2.9.3. Traditional Option Benefits

All children's HCBS state plan services must be identified on a plan of service developed by the family-centered planning team, and must be recommended by a physician or other practitioner of the healing arts. The following services are reimbursable when provided in accordance with *IDAPA 16.03.10, Medicaid Enhanced Plan Benefits,* Sections 660-666.

2.9.3.1. Respite

Service Description

Respite provides supervision to the child on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is also available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver.

The following limitations apply for respite services:

- Payment cannot be made for room and board.
- Must only be offered to children living with an unpaid caregiver who requires relief.
- Cannot exceed fourteen (14) consecutive days.
- Cannot be provided at the same time other Medicaid services are being provided.
- Cannot be provided on a continuous, long-term basis as a daily service to enable an unpaid caregiver to work.
- The respite provider must not use restraints on the child, other than physical restraints in the case of an emergency. Physical restraints may only be used in an emergency to prevent injury to the child or others, and must be documented in the child's record.
- When respite is provided by a DDA as group respite, the following applies:
  - When group respite is center-based, there must be a minimum of 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.
  - When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every three (3) 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 may provide respite in the child's home, the private home of the respite provider, or the community, and the respite can only be provided in an individual setting.

- Group or center based respite cannot be provided by an independent respite provider.

Provider Qualifications

Respite may be provided by a certified Developmental Disabilities Agency (DDA), or by an independent respite provider. An independent respite provider is an individual who has entered into a provider agreement with the Department. To enroll as a Medicaid provider, go to the Molina Medicaid website and follow the steps for provider enrollment.

Providers of respite services must meet the following minimum qualifications:

- Must be at least sixteen (16) years of age when employed by a DDA or at least eighteen (18) years of age and be a high school graduate or have a GED, to act as an independent respite provider.
- Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the child, the family, or the child's guardian.
- Have received instructions in the needs of the child who will be provided the service.
- Demonstrate the ability to provide services according to a plan of service.
- Must satisfactorily complete DHW's criminal history background check process.
- When employed by a DDA, must be certified in CPR and first aid in accordance with the general training requirements in accordance with *16.03.21 "Developmental Disabilities Agencies."* When acting as an independent respite provider, must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.

Record Keeping

The respite provider must maintain records for each child served as described in this handbook under *2.9.2.1 General Requirements for Program Documentation*.

Diagnosis Codes

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.9.3.2. Habilitative Supports

Service Description

Habilitative Supports provides assistance to a child with a disability by facilitating the child's independence and integration into the community. This service provides an opportunity for children to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities.

Integration into the community enables children 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.

Habilitative Supports ensures the child is involved in age-appropriate activities and is engaging with typical peers according to the ability of the child.

The following limitations apply for Habilitative Supports:

- Cannot be used to supplant services provided in school or therapy, or to supplant the role of the primary caregiver.
- When habilitative supports is provided as group supports, there must be a minimum of one (1) qualified staff providing direct services to every three (3) children when provided as group habilitative supports. As the number and severity of children with functional impairments increases, the staff-to-child ratio will be adjusted accordingly.

Provider Qualifications

Habilitative supports must be provided by a certified DDA.

Providers of habilitative supports must meet the following minimum qualifications:
Must be at least eighteen (18) years of age.

- Must be a high school graduate or have a GED.
- Have received instructions in the needs of the child who will be provided the service.
- Demonstrate the ability to provide services according to a plan of service.
- Must have six (6) months supervised experience working with children with developmental disabilities, which can be achieved in at least one of the following ways:
    - **Previous Work Experience.** Have previous work experience gained through paid employment, university practicum experience, or internship
    - **On-the-Job Supervision.** Have on-the-job supervised experience gained through employment at a DDA 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 a minimum of weekly face-to-face supervision with the clinical supervisor for a period of six (6) months while delivering services.
- Must complete competency coursework approved by the Department prior to the delivery of the service, to demonstrate competencies related to the requirements to provide habilitative supports.
    - The competency coursework approved by the Department is an on-line competency training consisting of 4 modules.
    - For competency coursework, go to the Idaho Center on Disabilities and Human Development website to access the training modules.

In addition to the habilitative support qualifications listed above, habilitative support staff serving children birth to three (3) years of age must meet at least one of the following qualifications:

- Have completed courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework.
- Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development.

Record Keeping

The habilitative supports provider must maintain records for each child served as described in this handbook under *2.9.2.1 General Requirements for Program Documentation*.

In addition to the general requirements, the following must also be completed.
On a monthly basis, the habilitative support staff must complete a summary of the child's response to the support service and submit the monthly summary to the clinical supervisor. The clinical supervisor reviews the summary on a monthly basis and when recommendations for changes to the type and amount of support are identified, submits the recommendations to the child's case manager.

Reporting Requirements

The clinical supervisor must complete, at a minimum, 6 month and annual provider status reviews for habilitative support services provided, or more frequently as required on the plan of service.

- Documentation of the 6 month and annual reviews must be submitted to the child's case manager. Status reviews must be submitted forty-five (45) calendar days prior to the expiration of the existing plan of service.
- The provider must use Department-approved forms for provider status reviews. Department forms are available at Children's DD Services.

2.9.3.3. Family Education

Service Description

Family education is professional assistance to families to help them better meet the needs of the child. It offers education to the parent or legal guardian that is specific to the individual needs of the family and child as identified on the plan of service.
Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. It may also provide assistance to the parent or legal guardian in educating other unpaid caregivers regarding the needs of the child.

When family education is provided in a group setting, the group must not exceed five (5) families of children with developmental disabilities receiving services.

Provider Qualifications

Family education must be provided by a certified DDA.

Providers of family education must meet the following minimum qualifications:

- Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college. A human services field is a particular area of academic study in health care, social services, education, behavioral science or counseling.
- Have one (1) year experience providing care to children with developmental disabilities.
- Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education. The requirements (Figure 2-1) for competency coursework are as follows:

- Transcript must contain the nine (9) credit hours of required courses listed in the table below from an accredited university or college.
- The nine credits must be equivalent to three (3) credit hours from each of the three (3) areas, and the course must contain at least the minimum course content listed in the table.
- **Note:** Professional Development courses from an accredited university are accepted if they are the equivalent to a three (3) credit university or college course.

Figure 2-1: Habilitative Intervention Coursework Requirements

Habilitative Intervention Coursework Requirements	
Required Course	**Course content must include the following components:**
ABA	Scientifically based behavior change methods, functional assessments, observation methods, goal and objective writing, various reinforcement techniques, data collection and interpretation, development and monitoring of an appropriate intervention based on the function of the problem behavior.
Child Development	Child development, learning and cognitive development (the majority of the course must contain materials focusing on infancy through adolescence).
Learning Theory Or Psychology of Learning	Development of learning and understanding, including developmental stages, principles of learning, learning styles and processes that lead to comprehension.

In addition to the family education qualifications above, family education staff serving children birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities, as well as must meet one (1) of the qualifications listed in *IDAPA 16.03.10.665.04*.

Ongoing Training

Professionals providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.

If the individual has not completed the required training during any yearly training period, they cannot provide family education beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated.

As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period.

Record Keeping

The family education provider must maintain records for each child served as described in this handbook under *2.9.2.1 General Requirements for Program Documentation*.

In addition to the general requirements, the DDA must survey the parent or legal guardian's satisfaction of the service following each family education session.

2.9.4. Family-Directed Services Option – HCBS State Plan

Families of children eligible for the children's home and community based state plan option may choose to direct their individual budget rather than receive the traditional services. The requirements for the family-directed services option are outlined in *IDAPA 16.03.13, Consumer-Directed Services.*

For additional guidance, refer to the *Family Directed Services Workbook* at www.familydirected.dhw.idaho.gov.

2.9.5. Covered Service Limit

Traditional and Family-Directed HCBS state plan services are limited by the child's individual budget amount. The budget amounts are available at Children's DD Services.

Non-Covered Services

Vocational and educational services are excluded from Medicaid payment for HCBS state plan services. Family education is not considered educational because it does not provide for the payment of services that are mandated under the Individuals with Disabilities Education Improvement Act (IDEA).

2.10. Waiver Services for Children with Developmental Disabilities (DD)

Idaho has two waiver benefit packages for children:

- Children's DD Waiver
- Act Early Waiver

2.10.1. Eligibility

For a child to be eligible for the Children's DD Waiver, the Department's independent assessor must determine that the child meets all of the following criteria:

- Age birth through seventeen (17).
- Has a developmental disability as defined in *16.03.10 Medicaid Enhanced Plan Benefits,* Sections 500 through 506.
- Meets intermediate care facility for persons with intellectual disabilities (ICF/ID) level of care as defined in *16.03.10 Medicaid Enhanced Plan Benefits,* Section 584.
- Is capable of being maintained safely and effectively in a non-institutional setting.
- Needs to reside in an ICF/ID in the absence of such services.

For a child to be eligible for the Act Early Waiver, in addition to the requirements for the Children's DD Waiver, the Department's independent assessor must determine that the child meets the following criteria:

- Age three (3) through six (6)
- Have an autism spectrum diagnosis; or
- Have a self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified by the Department, and a severe deficit defined as having a composite full scale functional age equivalency of fifty percent (50%) or less of the child's chronological age.

2.10.2. Program Requirements

2.10.2.1. General Requirements for Program Documentation

The provider must maintain records for each child served. Each child's record must include documentation of the child's involvement in and response to the services provided. The direct service provider must include written documentation of the service provided during each visit made to the child, which contains, at a minimum, the following information:

- Date and time of visit.
- Intervention and support services provided during the visit.
- A statement of the child's response to the service.
- Length of visit, including time in and time out.
- Specific place of service.
- A copy of the above information must be maintained by the provider. Failure to maintain such documentation will result in the recoupment of funds paid to the provider for undocumented services.

2.10.2.2. Requirements for Following the Plan of Service

Providers of home and community based waiver services must coordinate with the family-centered planning team as specified on the plan of service. Providers must be identified as the family's selected provider, and can only deliver services in accordance with the type, amount, duration, and frequency specified on the plan of service. Services delivered that are not authorized on the plan of services may be subject to recoupment by the Department.

2.10.2.3. Records Maintenance

Providers must retain participant records for those to whom they provide services for five (5) years following the last date of service.

2.10.2.4. Payment

Medicaid reimburses children's waiver services on a fee-for-service basis. See the *CMS 1500 Instructions* for a list of billing codes for the covered services.

2.10.2.5. Services Delivered by a Developmental Disabilities Agency (DDA)

In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services in accordance with *IDAPA 16.03.21, Developmental Disabilities Agencies.* Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training.

2.10.2.6. Clinical Supervision

A clinical supervisor must be employed by a DDA on a continuous and regularly scheduled basis and be readily available on-site to provide for:

- The supervision of service elements of the agency, including face-to-face supervision of agency staff providing direct care services.
- The observation and review of the direct services performed by all staff on at least a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the DDA services.
- The completion of provider status reviews.

Clinical supervisor qualifications are found in *IDAPA 16.03.21, Developmental Disabilities Agencies.*

2.10.2.7. Ongoing Training Requirements for Waiver Providers

Professionals providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.

If the individual has not completed the required training during any yearly training period, they cannot provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated.

As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period.

2.10.3. Traditional Option – Children's Waiver Services

All children's waiver services must be identified on a plan of service developed by the family-centered planning team, and must be recommended by a physician or other practitioner of the healing arts.

Children enrolled in the waiver program have access to respite, habilitative supports, and family education as described in *2.9 Children's Home and Community Based Services State Plan Option*. Children enrolled in a waiver program have the ability to receive greater amounts of these services compared to children enrolled in the HCBS State Plan option.

For children enrolled in the Act Early waiver, the cost of respite services cannot exceed ten (10) percent of the child's individual budget amount to ensure the child receives the recommended amount of intervention based on evidence-based research.

In addition to respite, habilitative supports, and family education, the following services are reimbursable when provided in accordance with *IDAPA 16.03.10, Medicaid Enhanced Plan Benefits,* Sections 680–686.

2.10.3.1. Habilitative Intervention

Evaluation

The purpose of the habilitative intervention evaluation is to guide the formation of developmentally-appropriate objectives and intervention strategies related to goals identified through the family-centered planning process. The habilitative interventionist must complete an evaluation prior to the initial provision of habilitative intervention services. The evaluation must include the following:

- Specific skills assessments for deficit areas identified through the eligibility assessment.
- Functional behavioral analysis.
- Review of all assessments and relevant histories obtained from the child's case manager.
- Clinical opinion, which is a professional summary that interprets and integrates the results of the testing. This summary includes functional, developmentally appropriate recommendations to guide treatment.

Service Description

Habilitative intervention services must be consistent, aggressive, and continuous, and are provided to improve a child's functional skills and minimize problem behavior. Services include individual or group behavioral interventions and skill development activity.

Habilitative intervention must be provided to meet the intervention needs of the child by developing adaptive skills for all children, and addressing maladaptive behaviors for children who exhibit them.

- When goals to address maladaptive behavior are identified on the plan of service, the intervention must include the development of replacement behavior, rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community, and social participation.
- When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of skills that are functional.

Habilitative intervention must be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems.

A list of current evidence-based treatment strategies, along with training modules and briefs, are available at:

- Autism Internet Modules
- National Professional Development Center for Autism Spectrum Disorders

The following limitations apply for habilitative intervention:

- Must be provided in the child's home or community setting, and in addition may be provided in a center.
- Group intervention may be provided in the community and in a center.
- When habilitative intervention is provided as group intervention, there must be a minimum of one (1) qualified staff providing direct services for every three (3) children. As the number and severity of children with functional impairments or behavioral issues increases, the staff to child ratio must be adjusted accordingly.
- The child must be integrated in the community in a natural setting with typically developing peers.

Provider Qualifications

Habilitative intervention must be provided by a certified DDA.

Providers of habilitative intervention must meet the following minimum qualifications:

- Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college. A human services field is a particular area of academic study in health care, social services, education, behavioral science or counseling.
- Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship.
- Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention. The requirements for competency coursework (Figure 2-1) are as follows:

- Transcript must contain the nine (9) credit hours of required courses listed in the table on page Error! Bookmark not defined. from an accredited university or college.
- The nine (9) credits must be equivalent to three (3) credit hours from each of the three (3) areas, and the course must contain at least the minimum course content listed in the table.

Note: Professional Development courses from an accredited university are accepted if they are the equivalent to a three (3) credit university or college course.

In addition to the habilitative intervention qualifications above, habilitative intervention staff serving children birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities, as well as must meet one (1) of the qualifications listed in *IDAPA 16.03.10.665.04*.

Record Keeping

The habilitative intervention provider must maintain records for each child served as described in this handbook under *2.10.2.1 General Requirements for Program Documentation*.

In addition to the general requirements, the DDA must determine objectives to be included on the child's required program implementation plan. All objectives must be related to a goal on the child's plan of service and have a corresponding program implementation plan.

The program implementation plan must be written and submitted to the child's case manager within fourteen (14) days after the first day of ongoing programming and be revised whenever the child's needs change. If the program implementation plan is not completed within this time frame, the child's records must contain documentation justifying the delay.

The program implementation plan must be completed by the habilitative interventionist, and must include the following requirements:

- The child's name.
- A baseline statement (must be measureable).
- Measurable, behaviorally-stated objectives that correspond to those goals, or objectives previously identified on the required plan of service.
- Written instructions to the staff that may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote the child's progress toward the stated objective.
- Identification of the type of environment(s) and specific location(s) where services will be provided.
- A description of the evidence-based treatment approach used for the service provided.
- When the child has a current positive behavior support plan, it must be incorporated into the program implementation plan.
- When interdisciplinary training is provided, identification of the type of interdisciplinary training and the objectives related to the training must be included on the program implementation plan.
- Target date for completion of objectives, not to exceed one (1) year.

- The program implementation plan must be reviewed and approved by the DDA clinical supervisor, as indicated by signature, credential, and date on the plan.

Reporting Requirements

The clinical supervisor must complete, at a minimum, six (6) month and annual provider status reviews for habilitative intervention provided. These provider status reviews must be completed more frequently when so required on the plan of service.

- Documentation of the six (6) month and annual reviews must be submitted to the child's case manager. Status reviews must be submitted forty-five (45) calendar days prior to the expiration of the existing plan of service.
- The provider must use Department-approved forms for provider status reviews. Department forms are available at www.childrensDDservices.dhw.idaho.gov.

It is the responsibility of the service provider to notify the child's case manager when any significant changes in the child's condition are noted during service delivery. Such notification will be documented in the service record.

2.10.3.2. Family Training

Service Description

Family training is professional one-on-one instruction to families to help them better meet the needs of the child receiving intervention services.

Family training is limited to training in the implementation of intervention techniques as outlined in the plan of service, and must be provided to the child's parent or legal guardian when the child is present.

If a child is receiving habilitative intervention, the parent or legal guardian of the child must participate in family training. The following limitations apply for each waiver program:

- For children enrolled in the Children's DD Waiver, the amount, duration, and frequency of the training must be determined by the family-centered planning team and the parent or legal guardian, and must be listed as a service on the plan of service.
- For children enrolled in the Act Early Waiver, the parent or legal guardian will be required to be present and actively participate during the intervention service session for at least twenty percent (20%) of the intervention time provided to the child.

Provider Qualifications

Family training must be provided by a certified DDA. To deliver family training, the provider must meet the minimum qualifications required for a habilitative intervention provider, as described in this handbook under *2.10.3.1 Habilitative Intervention – Provider Qualifications.*

Record Keeping

Providers delivering family training must maintain records for each child served as described in this handbook under *2.10.2.1 General Requirements for Program Documentation.*

In addition to the general requirements, the DDA must develop a program implementation plan to determine objectives to be included on the child's required plan of service, as described in this handbook under *2.10.3.1 Habilitative Intervention – Record Keeping.*

Reporting Requirements

The clinical supervisor must complete, at a minimum, six (6) month and annual provider status reviews for family training provided. These provider status reviews must be completed more frequently when so required on the plan of service.

- Documentation of the six month and annual reviews must be submitted to the child's case manager. Status reviews must be submitted forty-five (45) calendar days prior to the expiration of the existing plan of service.
- The provider must use Department-approved forms for provider status reviews. Department forms are available at Children's DD Services.

It is the responsibility of the service provider to notify the child's case manager when any significant changes in the child's condition are noted during service delivery. Such notification will be documented in the service record.

2.10.3.3. Interdisciplinary Training

Service Description

Interdisciplinary training is professional instruction to the direct service provider. Interdisciplinary training must only be provided during the provision of a support or intervention service. Interdisciplinary training is provided to assist the direct provider to meet the needs of the child receiving waiver services.

Interdisciplinary training includes training on health and medication monitoring, positioning and transfer, intervention techniques, positive behavior support, and use of equipment.

The following limitations apply for interdisciplinary training:

- Must only be provided to the direct service provider when the child is present.
- Training between a habilitative interventionist and a therapeutic consultant, and training between employees of the same discipline is not a reimbursable service.
- Must maintain documentation of the training in the child's record documenting the provision of activities outlined in the plan of service.

Provider Qualifications

Interdisciplinary training must be delivered by one of the following professionals (Developmental Disability Agencies must bill for this service):

- Occupational Therapist, as defined in Section 734 under *IDAPA 16.03.09, Medicaid Basic Plan Benefits.*
- Physical Therapist, as defined in Section 734 under *IDAPA 16.03.09, Medicaid Basic Plan Benefits.*
- Speech-Language Pathologist, as defined in Section 734 under *IDAPA 16.03.09, Medicaid Basic Plan Benefits.*
- Practitioner of the healing arts.
- Habilitative intervention provider, as described in this handbook under *Section 2.10.3.1 Habilitative Intervention – Provider Qualifications.*
- Therapeutic consultation provider, as described in this handbook under *2.10.3.4 Therapeutic Consultation.*

Record Keeping

Providers delivering interdisciplinary training must maintain records for each child served as described in this handbook under *2.10.2.1 General Requirements for Program Documentation.*

In addition to the general requirements, identification of the type of interdisciplinary training and the objectives related to the training must be included on the program implementation plan, and the training must be a service identified on the plan of service.

2.10.3.4. Therapeutic Consultation

Service Description

Therapeutic consultation provides a higher level of expertise and experience to support children who exhibit severe aggression, self-injury, or other dangerous behaviors. Therapeutic consultation is provided when a child receiving habilitative intervention has been assessed as requiring a more advanced level of training and assistance based on the child's complex needs.

A child requires therapeutic consultation when interventions are not demonstrating outcomes and it is anticipated that a crisis event may occur without the consultation service. The therapeutic consultant assists the habilitative interventionist by:

- Performing advanced assessments as necessary
- Developing and overseeing the implementation of a positive behavior support plan
- Monitoring the progress and coordinating the implementation of the positive behavioral support plan across environments
- Providing consultation to other service providers and the child's family

The following limitations apply for therapeutic consultation:

- Therapeutic consultation cannot be provided as a direct intervention service.
- Children must be receiving habilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations.
- Therapeutic consultation must be prior authorized by the Department, and is limited to eighteen (18) hours per year per child.

Provider Qualifications

Therapeutic consultation may be provided by a certified DDA or by an independent Medicaid provider under agreement with the Department. Providers of therapeutic consultation must meet the following minimum qualifications:

- Doctoral or master's degree in psychology, education, applied behavioral analysis, or a related discipline, and/or one thousand five hundred (1500) hours of relevant coursework or training in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program).
- Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
- Therapeutic consultation providers must satisfactorily complete a criminal history and background check in accordance with *IDAPA 16.05.06, Criminal History and Background Checks.*
- When employed by a DDA, must be certified in CPR and first aid in accordance with the general training requirements for a DDA. When acting as an independent therapeutic consultation provider, must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.

Record Keeping

Providers delivering therapeutic consultation must maintain records for each child served as described in this handbook under *2.10.2.1 General Requirements for Program Documentation.*

In addition to the general requirements, when the child has a current positive behavior support plan, it must be incorporated into the program implementation plan.

2.10.3.5. Crisis Intervention

Service Description

Crisis intervention services provide direct consultation and clinical evaluation of children who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis.

Crisis is defined as being an unanticipated event, circumstance, or life situation that places a child at risk of at least one of the following: hospitalization; loss of housing; loss of employment; incarceration; or physical harm to self or others, including family altercation or psychiatric relapse.

This service may provide training and staff development related to the needs of a child, and also provides emergency back-up involving the direct support of the child in crisis. The following limitations apply for children's crisis intervention services:

- Must be provided in the home and community.
- Provided on a short-term basis typically not to exceed thirty (30) days.
- Cannot exceed fourteen (14) days of out-of-home placement.
- Must be prior authorized by the Department.
    - Authorization for crisis intervention may be requested retroactively as a result of a crisis, when no other means of support is available to the child. In retroactive authorizations, the crisis intervention provider must submit a request for crisis intervention to the Department within seventy-two (72) hours of providing the service.
    - If staying in the home endangers the health and safety of the child or family, the provider may request short-term out of home placement for the child. Out of home placement must be prior authorized by the Department.
- Must use positive behavior interventions prior to and in conjunction with the implementation of any restrictive intervention. Restrictive interventions must be identified on the plan of service.

Provider Qualifications

Crisis intervention may be provided by a certified DDA or by an independent Medicaid provider under agreement with the Department. Providers of crisis intervention must meet the following minimum qualifications:

- Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in this handbook under *2.10.3.4 Therapeutic Consultation – Provider Qualifications.*
- Emergency intervention technician providers must meet the minimum habilitative support provider qualifications as described in this handbook under *2.9.3.2 Habilitative Supports – Provider Qualifications.*
- Crisis intervention providers must satisfactorily complete a criminal history and background check in accordance with *IDAPA 16.05.06, Criminal History and Background Checks.*

Record Keeping

Providers delivering crisis intervention must maintain records for each child served as described in this handbook under *2.10.2.1 General Requirements for Program Documentation.*

2.10.4. Family-Directed Services Option – Children's DD Waiver

Families of children eligible for the children's DD waiver may choose to direct their individual budget rather than receive the traditional services. The requirements for the family-directed services option are outlined in *IDAPA 16.03.13, Consumer-Directed Services.*

For additional guidance, refer to the *Family Directed Services Workbook* at www.familydirected.dhw.idaho.gov.

The Act Early waiver does not have a family-directed services option. Families always have the choice to enroll their child in the children's DD waiver rather than the Act Early waiver if they wish to participate in the family-direction program.

2.10.5. Covered Service Limits

Children's waiver services are subject to the following limitations:

- Waiver services may be provided in the child's home, community, or DDA. The following living situations are specifically excluded as a place of service for waiver services:
  - Licensed skilled or intermediate care facilities, certified nursing facility (NF), or hospital.
  - Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ ID).
  - Residential care or assisted living facility.
- Traditional and family-directed waiver services are limited by the child's individual budget amount, excluding crisis intervention and therapeutic consultation services under the traditional option. The budget amounts are available at www.childrensDDservices.dhw.idaho.gov.
- Therapeutic consultation must be prior authorized by the Department, and is not limited by the child's budget. Therapeutic consultation is limited to eighteen (18) hours per year per child.
- Crisis intervention must be prior authorized by the Department, and is not limited by the child's budget.
  - Authorization for crisis intervention may be requested retroactively as a result of a crisis when no other means of support is available to the child.
  - In retroactive authorizations, the crisis intervention provider must submit a request for crisis intervention to the Department within seventy-two (72) hours of providing the service.
  - If staying in the home endangers the health and safety of the child or family, the provider may request short-term out-of-home placement for the child. Out-of-home placement must be prior authorized by the Department.

Non-Covered Services

The following services are excluded from Medicaid payment for children's waiver services, including habilitative intervention and evaluation, family training, interdisciplinary training, therapeutic consultation, and crisis intervention:

- Vocational services
- Educational services
- Recreational services
- Individual Education Plan (IEP) Services
    - According to 42 CFR 440.180, Medicaid Waiver services cannot be used to pay for special education and related services that are included in a child's IEP under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA), that are otherwise available through a local educational agency.

2.11. Waiver Services for Adults with Developmental Disabilities

2.11.1. 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/ID) 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/ID.

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/ID.

2.11.2. 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.

2.11.2.1. 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/ID).
- Residential care or assisted living facility.

2.11.3. 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.

2.11.3.1. 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.

2.11.3.2. 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.

2.11.4. Implementation Plans

The following DD providers 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 Care (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 a provider status review six months after the start date of the plan of service and annually to the plan monitor.

2.11.5. Important Billing Instructions

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 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 detail lines must be used.

In the example (Figure 2-2), the last week in August 2001, begins Sunday, August 26, 2001, and ends Saturday, September 1, 2001. Two separate detail lines must be entered on the claim form for this week. One detail line will have service dates of 08/26/2001 through 08/31/2001. The second detail line 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 detail line as long as the same quantity of services have been provided each day.

Figure 2-2: Example for August 2001 Billing

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			Aug. 1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	Sept. 1

2.11.6. 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.

2.11.7. 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.

2.11.7.1. 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.

2.11.8. Change of Provider Information

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

Send corrections to the following address:

Idaho Medicaid
Provider Enrollment
PO Box 70082
Boise, ID 83707
Fax: (877) 517-2041

2.12. Skilled Nursing Services – DD Waiver

2.12.1. 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.

2.12.2. 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.

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

2.13.1. 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.

2.13.2. Provider Qualifications

2.13.2.1. 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.

2.13.2.2. Emergency Back-up Providers

Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under *IDAPA 16.04.17, Rules Governing Residential Habilitation Agencies.*

2.14. Chore Services – DD Waiver

2.14.1. 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.

2.14.2. 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.

2.15. Residential Habilitation – DD Waiver

2.15.1. 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:
    - Self-direction
    - Money management
    - Daily living skills
    - Socialization
    - 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.

2.15.2. Residential Habilitation – Supported Living

2.15.2.1. 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*, *Rules Governing 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, two, or three 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 or three participants reside in the same home, services may be provided through individual or group staffing arrangements as approved by the Department.

2.15.2.2. 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.

2.15.3. Residential Habilitation – Certified Family Home

2.15.3.1. Service Description

An individual who provides direct residential habilitation services in his own home must be certified by the Department to operate a certified family home under *IDAPA 16.03.19, Rules Governing 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.

2.15.3.2. 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.

2.16. Respite Care DD Waiver

2.16.1. 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 Care (Health) Facility.

2.16.2. 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.

2.17. Supported Employment Services – DD Waiver

2.17.1. 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.

2.17.2. 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.

2.18. Non-Medical Transportation – DD Waiver

2.18.1. 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 1800 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.

2.18.2. 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.

2.19. Environmental Accessibility Adaptations – DD Waiver

2.19.1. 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

2.19.2. 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.

2.20. Specialized Medical Equipment and Supplies – DD Waiver

2.20.1. 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.

2.20.2. 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.

2.21. Personal Emergency Response System DD Waiver

2.21.1. 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

2.21.2. 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.

2.22. Home Delivered Meals – DD Waiver

2.22.1. 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

2.22.2. 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, Food Safety and Sanitation Standards for Food Establishments.*

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

2.23.Adult Day Care (Health) – DD Waiver

2.23.1. Service Description

Adult Day Care (Health) is a supervised, structured service generally furnished four or more hours per day on a regularly scheduled basis, for one 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 Care (Health) cannot exceed thirty (30) hours per week, either alone or in combination with developmental therapy and occupational therapy.

2.23.2. Provider Qualifications

Adult Day Care (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 years, and as needed based on service monitoring concerns.

Providers of Adult Day Care (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, Rules Governing Certified Family Home.*
    - 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.

2.24. Dental Services – DD Waiver

2.24.1. Service Description

Dental services include exams, radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in *IDAPA 16.03.10* are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants.

Coverage must include a provision for a second opinion from a qualified dental care professional within the network, or arrange for a second opinion outside the network at no cost to the participant. Participants may obtain a second opinion if they believe that they did not receive the appropriate service or diagnosis. The contractor reviews and may approve the request.

Waiver dental services are limited to participants who are past the month of their twenty-first (21) birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan.

2.24.2. Provider Qualifications

Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor.

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

2.25. 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.*

2.25.1. Community Supports Workers

2.25.1.1. 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

2.25.1.2. 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.

2.25.2. Support Broker

2.25.2.1. 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.

2.25.2.2. 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.

2.25.3. Fiscal Employer Agent

2.25.3.1. 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.

2.25.3.2. 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.

2.26.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 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.

2.27. Aged & Disabled Waiver Services

2.27.1. Overview

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 care (health).
- Adult residential care.
- 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.

2.27.1.1. 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.

The Division of Medicaid 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 develop an Individual Service Plan (ISP).

2.27.2. General Information

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

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

2.27.2.1. 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.*10.32*9, *Aged and Disabled Waiver Services – Provider Qualifications and Duties*. Medicaid 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 services providers must be enrolled as transportation vendors with the Idaho Medicaid program; see *Non-Emergent Non-Medical Transportation* for more information.

Specialized medical equipment and supplies services providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see *Suppliers* for more information.

Environmental accessibility adaptation providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see *Suppliers* for more information.

Personal emergency response system services providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see *Suppliers* for more information.

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

Providers of homemaker services, attendant care, chore services, consultation, and skilled nursing must be enrolled or affiliated with a Personal Care Services Agency with an *Aged and Disabled Waiver - Personal Care Services* additional terms provider agreement.

Supported employment providers 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.

2.27.2.2. 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 records necessary to fully document the extent of services submitted for Medicaid reimbursement. Providers must also retain all medical records to document services submitted for Medicaid reimbursement for at least five years after the date of final payment for the service. 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.

2.27.2.3. 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.

2.27.2.4. Prior Authorization (PA)

Medicaid or its contractor must authorize all services reimbursed by Medicaid under the A&D Waiver program before services are rendered.

2.27.2.5. 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. Providers 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:

3 units	≥ 38 minutes to	< 53 minutes
4 units	≥ 53 minutes to	< 68 minutes
5 units	≥ 68 minutes to	< 83 minutes
6 units	≥ 83 minutes to	< 98 minutes
7 units	≥ 98 minutes to	< 113 minutes
8 units	≥ 113 minutes to	< 128 minutes

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.

Date(s) of Service	Procedure Code	Charges
12/11/2008 – 12/11/2008	XXXXX	$XXX.XX
12/13/2008 – 12/13/2008	XXXXX	$XXX.XX

2.27.2.6. Healthy Connections (HC)

HC referrals are not required for services under the A&D Waiver.

2.27.2.7. 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.
- Day care.
- Residential Care and 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/ID).

2.27.2.8. Individual Service Plan (ISP)

All services must be prior authorized by Medicaid in the region where the participant resides. The services must be based on a written Individual Service Plan (ISP).

Medicaid or its contractor 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 Medicaid 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 – Provider Qualifications and Duties,* for supervision requirements for each participant service.

2.27.2.9. 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, agency supervisory registered nurse (RN), service providers, and others identified by the participant, and in the participant's home.

The agency must use the Medicaid 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.

2.28. Adult Day Care (Health) – A&D Waiver

2.28.1. Overview

Adult Day Care (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 Care (Health) services provided under this waiver will not include room and board payments.

2.28.2. Facilities

Facilities that provide Adult Day Care (Health) must be maintained in a safe and sanitary manner and meet the requirements of the Adult Day Care (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.

2.28.2.1. 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 Care (Health) provider agreement and home certification identified in *IDAPA 16.03.19, Rules Governing Certified Family Homes*. The provider must provide supervision as necessary to assure the comfort and safety of the participants served.

2.28.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.28.4. Place of Service (POS) Codes

Adult Day Care (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.

2.29. Non-Medical Transportation – A&D Waiver

2.29.1. Overview

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 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.

2.29.2. Provider Qualifications

Providers of non-medical transportation services must possess a valid driver's license, valid vehicle insurance, and comply with all applicable state laws and be enrolled as a Medicaid transportation provider.

2.29.3. Payment

Payment for non-medical waiver transportation 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.

2.29.4. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM 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.

- ICD-9-CM: *799.9 – Other Unknown*
- ICD-10-CM: *R69 – Illness, unspecified*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.29.5. Place of Service (POS) Code

Non-medical transportation 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.

2.30. Specialized Medical Equipment and Supplies – A&D Waiver

2.30.1. Overview

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* guidelines.

2.30.2. 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.

2.30.3. Place of Service (POS) Codes

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

11 Office
12 Home

2.30.4. Procedure Codes

Specialized medical equipment and supplies for A&D waivered services (Figure 2-3) are covered for Medicaid Enhanced Plan participants.

Figure 2-3: Specialized Medical Equipment Procedure Code

Service	HCPCS	Description
Specialized Medical Equipment	E1399	Durable Medical Equipment

2.31. Attendant Care – A&D Waiver

2.31.1. Overview

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.

2.31.2. 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*.

2.31.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.31.4. 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.

2.31.5. Procedure Code

Figure 2-4: Procedure Code for Attendant Care

Service	HCPCS	Description
Attendant Care	S5125	Attendant Care Services Unit = 15 minutes

2.32. Dental Services – A&D Waiver

2.32.1. Overview

Dental services include exams, radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in these rules are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants. Waiver dental services are limited to participants who are past the month of their 21st birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan.

2.32.2. Provider Qualifications

Providers are credentialed by the contractor to ensure they meet the licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor.

2.33.Chore Services – A&D Waiver

2.33.1. Overview

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.

2.33.2. 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*.

2.33.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.33.4. 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.

2.33.5. Procedure Code

Figure 2-5: Procedure Codes for Chore Services

Provider Specialty	Service	Description
TBI	S5120	Chore Services, 1 unit = 15 minutes
PCS Agency	S5120	Chore Services, 1 unit = 1 Hour
Chore Services Agency	S5120	Chore Services, 1 unit = 15 minutes

2.34.Companion Services – A&D Waiver

2.34.1. Overview

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 cuing 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.

2.34.2. 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.*

2.34.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.34.4. 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.

2.34.5. Procedure Code

Figure 2-6: Procedure Code for Companion Services

Service	HCPCS	Description
Companion	S5135	Adult Companion Care Unit = 15 minutes

2.35. Consultation Services – A&D Waiver

2.35.1. Overview

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.

2.35.2. 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.

2.35.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.35.4. Place of Service (POS) Codes

Consultation services can only be provided face-to-face with the participant or family in the following POS:

03 School
12 Home
33 Custodial Care Facility (certified family home, assisted living facility, residential care facility, or other facility where care is provided commercially)
99 Other (Community, Adult Day Care, participant's work location)

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

2.35.5. Procedure Code

Figure 2-7: Procedure Code for Consultation Services

Service	HCPCS	Description
Consultation	S5115	Home Care Training – non family Unit = 15 minutes

2.36. Homemaker Services – A&D Waiver

2.36.1. Overview

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.

2.36.2. 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*.

2.36.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.36.4. 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.

2.36.5. Procedure Code

Figure 2-8: Procedure Code for Homemaker Services

Service	HCPCS	Description
Homemaker Services	S5130	Homemaker Service, NOS Unit = 15 minutes

2.37. Home Delivered Meals – A&D Waiver

2.37.1. Overview

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

2.37.2. 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, Food Safety and Sanitation Standards for Food Establishments*
- 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 Subsection 329.03 of this rule have been met.

2.37.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.37.4. 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.

2.37.5. Procedure Code

Figure 2-9: Procedure Code for Home Delivered Meals

Service	HCPCS	Description
Home Delivered Meals	S5170	Home Delivered Meals, including preparation Unit = 1 meal

2.38. Environmental Accessibility Adaptations – A&D Waiver

2.38.1. Overview

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.

2.38.2. 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.

2.38.3. Payment

Payment for environmental accessibility adaptations will be made as prior-authorized by Medicaid. 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.

2.38.4. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.38.5. 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.

2.38.6. Procedure Code

Figure 2-10: Procedure Code for Environmental Accessibility Adaptations

Service	HCPCS	Description
Environmental Accessibility Adaptations	S5165	Home Modification; per service Environmental Accessibility Adaptations Services, per item and dollar amount as authorized by Medicaid.

2.39. Respite Care – A&D Waiver

2.39.1. Overview

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 Care (Health) facility.

2.39.2. 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.*

2.39.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.39.4. 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.

2.39.5. Procedure Code

Figure 2-11: Procedure Code for In-Home Respite

Service	HCPCS	Description
In-Home Respite	T1005	Respite Care Services Unit = 15 minutes

2.40. Skilled Nursing Services – A&D Waiver

2.40.1. Overview

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.

2.40.2. Provider Qualifications

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.*

2.40.3. 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.

2.40.4. 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.

2.40.5. 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.

2.40.6. 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.

2.40.7. Place of Service (POS) Codes

Nursing Services can only be provided in the following POS:

03 School
12 Home
33 Custodial Care Facility, if such services are not included in the negotiated service agreement with the facility
99 Other (Adult Day Care (Health))

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

2.40.8. Procedure Codes

Figure 2-12: Procedure Codes for Nursing Services

Service	HCPCS	Description
Nursing Services – R.N.	T1002	RN Services, 1 Unit = 15 minutes
Aged and Disabled Nursing Service	T1001	Nursing Assessment/Evaluation RN service, 1 Unit = 1 visit
Nursing Services – L.P.N.	T1003	LPN/LVN Services, Unit = 15 minutes

2.41. Personal Emergency Response System (PERS) – A&D Waiver

2.41.1. Overview

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

2.41.2. 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* guidelines.

2.41.3. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.41.4. 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.

2.41.5. Procedure Codes

Figure 2-13: Procedure Codes for PERS

Service	HCPCS	Description
System Installation	S5160	Emergency Response System; installation and testing and first month service rental.
Monthly Rent	S5161	Emergency Response System; service fee, per month (excludes installation and testing).

2.42. Day Habilitation Services – A&D Waiver

2.42.1. Overview

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.

2.42.2. 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.*

2.42.3. 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 Medicaid 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.

2.42.4. 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.

2.42.5. 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.

2.42.6. Procedure Codes

Figure 2-14: Procedure Codes for Day Habilitation

Service	HCPCS	Description
Day Habilitation (Individual)	**T2021**	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
Day Habilitation (Group) limited to not more than six participants	**T2021**	Day Habilitation, waiver; per 15 minutes Unit = 15 minutes

2.43. Residential Habilitation Services – A&D Waiver

2.43.1. Overview

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.

2.43.2. 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, Rules Governing 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. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007.
  - 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
  - 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
  - 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, Rules Governing Residential Habilitation Agencies*. Residential habilitation agencies must be capable of supervising the direct services provided.

2.43.3. Provider Responsibilities

2.43.3.1. 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.

2.43.3.2. 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.
  11/24/2005; 10:30 A.M. – 3:15 P.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 Medicaid as a result of changes in the participant's condition or skill level.
- The participant's signature on the service record, unless Medicaid determines the participant is unable to sign.

2.43.3.3. 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.

2.43.3.4. 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.

2.43.3.5. 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.

2.43.4. Payment

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

2.43.5. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.43.6. 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.

2.43.7. Procedure Codes

Figure 2-15: TBI Supported Living Codes

Service	HCPCS	Description
Supported Living - Agency Two Participants	**H2015** Modifiers Required **HQ**	Comprehensive Community Support Services, per 15 minutes Supported living for two participants who live in their own home/apartment or with a non-paid caregiver. 1 Unit = 15 minutes

Service	HCPCS	Description
Supported Living - Agency One Participant	**H2015** Modifier Required	Comprehensive Community Support Services; per 15 minutes Supported living for one participant who lives in his/her own home/apartment or with a non-paid caregiver. 1 Unit = 15 minutes
Independent Residential Rehabilitation Program Coordinator	**0930T**	Independent Residential Habilitation Program Coordinator 1 Unit = 15 minutes Limited to 27 units per month **Note:** May only be billed if there is not an agency available in the participant's geographic location.
TBI Daily Rate (Bundled) One Provider, One or Two Participants; or Two Providers with Two Participants	**H2016**	Comprehensive Community Support Services, *per diem* 1 Unit = 1 day (Bundled Care)

2.43.7.1. Billing Restrictions

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

2.44. Supported Employment – A&D Waiver

2.44.1. Overview

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.

2.44.2. 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.

2.44.3. Provider Responsibilities

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

2.44.4. Payment

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

2.44.5. Diagnosis Codes

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.44.6. 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.

2.44.7. Procedure Code

Figure 2-16: Procedure Code for Supported Employment

Service	HCPCS	Description
Supported Employment	**H2023**	Supported Employment, per 15 minutes Maximum allowable – 160 units per week. 1 Unit = 15 minutes

2.45. Personal Care Services (PCS)

2.45.1. Overview

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 16.03.09.536*, 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.

2.45.2. General Information

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

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

2.45.2.1. 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 - 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.

2.45.2.2. 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 records necessary to fully document the extent of services submitted for Medicaid reimbursement. Retain all medical records to document services submitted for Medicaid reimbursement for at least five years after the date of service.

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.

2.45.2.3. 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.

2.45.2.4. Healthy Connections (HC)

HC referrals are not required for services under the PCS program.

2.45.2.5. 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 result in claims being denied. In addition, one detail line on a claim form cannot span more than one calendar month. If the end of the month falls in the middle of a week, two separate detail lines 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 details or lines must be entered on the claim form for this week. One line will have service dates of 4/25/2010 through 4/30/2010. The second line 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 detail line as long as the same quantity of services has been provided each day.

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
April 2010				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	May 1

2.45.2.6. 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 23.01.01, Rules of the Idaho Board of Nursing,* Subsection 490.05.
- 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.

2.45.3. 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.

2.45.4. 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.

2.45.4.1. Transportation

Non-medical transportation (such as to the grocery store) is not reimbursable to the personal assistant.

2.45.5. Diagnosis Code

Based on dates of service, enter the appropriate ICD-9-CM or ICD-10-CM code for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- ICD-9-CM: *V60.4 - No Other Household Member Able to Render Care*
- ICD-10-CM: *Z74.2 – Need for assistance at home and no other household member able to render care*

For more information on which ICD version to use, refer to *ICD-9 and ICD-10 Diagnosis Billing Requirements*.

2.45.6. 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/ID).
- Intensive treatment facility for children as described in *IDAPA 16.06.01.620, Rules Governing Family and Children's Services*.
- A home receiving payment for specialized foster care, professional foster care, or group foster care for children.

See *2.45.9.1 Qualified Intellectual Disabilities Professional (QIDP)* for more on the QIDP and special requirements for individuals with DD.

2.45.7. 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 Medicaid'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 the participant or guardian, agency supervisory RN, and agency supervisory personnel as applicable for adult POC.

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 the agency nurse who is responsible for updating the POC. 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.

2.45.8. 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:

- Develop a POC for the participant.
- 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.

2.45.9. 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 442.401*.

Note: PCS QMRP services are covered for Medicaid Enhanced Plan participants.

2.45.9.1. 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.

2.45.9.2. 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.

2.45.10. 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 Medicaid 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.

2.45.11.Procedure Codes

See *CMS 1500 Instructions* for covered services.

Figure 2-17: Procedure Codes for PCS

Service	HCPCS	Description
Supervisory RN Codes		
PCS Assessment - Participant Evaluation & Care Plan Development - Agency	**G9002**	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.
RN Supervising Visit - Agency	**T1001**	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

Service	HCPCS	Description
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 RMS 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		
Agency PCS Provider	**T1019**	PCS, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/ID 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

2.45.12. Record Keeping

A personal care service record (progress notes) must be filled out and maintained for each participant receiving services. 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.
The personal assistant must keep the original for the personal assistant's records.

Note: Do not attach progress notes to claims submitted to Idaho Medicaid.

After every visit, the personal assistant will enter, at a minimum, the following information:

- The date of the visit in the format: 02/10/2005.
- The time in and time out for the visit in the format:
  8:00 a.m. - 11:15 a.m.
- The length of the visit (total hours). Example: 3.25 hours.
- The services provided during the visit. If *other* is marked, a narrative must be provided.
- A statement of the participant's response to the services, including any changes noted in the participant's condition.
- Any changes in the plan of care authorized by the referring physician or supervising RN as the result of changes in the participant's condition.
- The participant's signature on the PCS record, unless Medicaid determines that the individual is unable to sign.