MEDICAID MENTAL HEALTH REFORM
FREQUENTLY ASKED QUESTIONS REGARDING 2009 RULES

Rules applicable to Medicaid-reimbursed mental health clinics and psychosocial rehabilitation agencies can be viewed on the Department of Administration's Web site.
This document will be updated as we receive additional questions. To submit questions, please contact: Carolyn Burt at (208) 364-1844 or send an email to: burtc@dhw.idaho.gov.

Question	Answer
Is a Healthy Connections referral considered documentation that a history and physical has occurred?	No. A Healthy Connections referral from the participant's primary care physician serves as documentation that the physician agrees that a referral to the service is medically necessary. History and physical (H&P) documentation is the document itself or some notation of the communication that has occurred between the H&P provider and the mental health services provider regarding the relevant information contained in the H&P. The H&P should include the participant's reason for the visit, results of the physical exam, and details about any pertinent medical, behavioral, and psycho-social aspects. Mental health provider agencies are not responsible for the quality of the H&P but are responsible to ensure they do not provide services until an H&P has been completed (unless it is a crisis situation).
How long can a provider agency deliver services to a participant before it receives the results of the participant's H&P?	Provider agencies **can not** deliver services to new participants or existing participants who are facing their annual renewal of mental health services before receiving the results of the participant's H&P to ensure they do not provide services that contradict with the H&P. The provider agency needs the results of the H&P in order to understand possible physical origins of mental health symptoms. Only a participant in crisis can obtain mental health services before obtaining an H&P. In response to crisis situations, provider agencies can deliver mental health services to participants until the initial crisis is resolved.

Question	Answer
UPDATED May 2009: **Will the department be adding a new data field to the Healthy Connections Referral Form to include the need for a H&P?**	No. Healthy Connections (HC) primary care providers (PCPs) typically do not make referrals to other healthcare providers to perform H&Ps. This is because it is the PCP's responsibility to provide all primary care services for their HC enrollees, including the history and physical. If a participant wants to receive an H&P from a healthcare provider who is not the HC PCP, the participant would first have to obtain a referral or Idaho Medicaid will not cover the services.
Of the three types of assessments described in rule, how do providers know which one to use and when?	Providers should consider the purpose of the assessments to answer this question. An Intake Assessment must be performed in all cases in which the participant is obtaining services on the Basic Plan; it is the document that establishes why the participant is seeking treatment, what the treatment is for, and the participant's current status. The Comprehensive Diagnostic Assessment ("Diagnostic" for short) is used to provide a clinical diagnostic work-up with treatment recommendations and can also include intake information, as necessary. The diagnostic **can** be used in Basic Plan services if the clinician deems it necessary but **must** be used in order to access Enhanced Plan services. For Basic and Enhanced Plan services, the provider should not complete both an intake and a Diagnostic if one of these assessments is sufficient for treatment purposes. When a participant's Diagnostic indicates the need for any sort of skill training, **only then** should a Functional Assessment be completed. A new provision that will benefit provider agencies and participants alike is the option of providing an Intake Assessment on any participants newly transferred as an information update to whatever assessments already exist in order to establish why the participant transferred and what the participant expects out of the new agency. For participants newly discharged from psychiatric hospitalizations, the provider agency must at least perform an Intake Assessment but if no current diagnostic information is available to serve as the Diagnostic, then the provider agency must complete a new Diagnostic.

Question	Answer
At the annual treatment date, if the participant's mental status does not appear to have changed, does the agency need to perform a completely new Diagnostic?	A Comprehensive Diagnostic Assessment **Update** can be completed in those instances in which a review of the existing Diagnostic reveals that the information is still representative of the participant's status in the targeted service areas. However, the update must include a new mental status examination to support an accurate diagnosis and a new treatment plan. The performance of the update and the billing requirements are the same as the full assessment.
UPDATED July 2009 **Will the department provide templates for the required assessments?**	No. Providers are welcome to use whatever format they like to document participant information as long as it is consistent with best practice and industry standards. The "Common Assessment" template is no longer posted on the department's Web site; however, agencies can continue to use this format as a model as long as it is used to capture all the required information for the type of assessment it is being used for. Please refer to the specific requirements of the assessments as described in rule at IDAPA 16.03.09.709.03 and IDAPA 16.03.10.113-115.
Are there requirements regarding which staff person can perform a mental status examination?	Yes. The requirement specifically indicates that the staff person who performs a mental status examination must be trained to perform such examinations and trained to solicit sensitive health information. In a clinic setting, this staff person can be a licensed social worker with a bachelor's degree or hold a higher credential. In a psychosocial rehabilitation (PSR) agency, this person can be a PSR specialist or hold a higher credential. In either case, it is the employing agency's responsibility to maintain documentation in the staff person's personnel file of this training.
UPDATED July 2009 **Does every staff person who conducts mental status examinations have to prove they have had Mental Status Examination training?**	This is a competency issue. Licensed master's level professionals are assumed to have obtained training in conducting mental status examinations as part of their licensure requirements. The department relies on the Idaho Bureau of Occupational Licensing (IBOL) to regulate and enforce licensure requirements for scope of competency. Non-licensed and bachelor's level staff who perform mental status examinations must have undergone specific training in order to provide this service. Agencies may want to establish their non-licensed and bachelor's level staff's proof of competency by having documentation of in-service-training, workshop attendance, or education records.

Question	Answer
UPDATED March 2009: **When a bachelor's level staff is used to complete some of the work of the Comprehensive Diagnostic Assessment, can that work be claimed as a 90801?**	No. A licensed diagnostician is responsible for completing the diagnostic. There is the possibility of overlap between the information required in the Intake Assessment and the information required in the Comprehensive Diagnostic. IDAPA 16.03.10.113 specifically addresses this redundancy and restricts it. While a bachelor's level staff person may complete the Intake Assessment, this same person is not qualified to complete the diagnostic even though a diagnostic can, but not necessarily will, contain some of the same information. It is very important that in cases in which an intake is performed at the initiation of treatment and later a diagnostic is clinically indicated and performed, that the diagnostic does not contain information that would be redundant to the Intake Assessment. Also, at the initiation of treatment if a diagnostic is clinically indicated then the diagnostic should be performed in lieu of the Intake.
Is it true that under the reform rules only master's level clinicians can complete the required assessments?	No. There are three different types of assessments identified in the Mental Health Reform rules and they each have a specific purpose. Please refer to Table 1 in the Additional Information section at the end of this document to help clarify which professional can complete each type of assessment.
UPDATED July 2009: At our agency, we rely on our medical professional to conduct part of the comprehensive diagnostic and other licensed masters level staff to provide additional information to fulfill all the requirements of this assessment. How do we bill this?	Your staff should be collaborating with each other to coordinate the various components of the comprehensive diagnostic assessment that they are each performing in order to produce a single assessment that results in diagnoses and recommendations for treatment. Your medical professional and clinical staff should each bill a 90801 for the portion of the work they completed. System limitations require the use of modifier "76" whenever such collaboration occurs and results in more than one claim for a 90801 in a 24-hour period.
Doesn't the Comprehensive Diagnostic Assessment already include the information of a Functional Assessment?	No. In arriving at diagnoses and treatment recommendations, a diagnostic must necessarily include some description of how well the participant is functioning. While the diagnostic gives a brief overview of the participant's functional deficits, the purpose of the Functional Assessment is to provide a detailed summary of how the psychiatric disorder impacts the participant's life and identify the areas in which skill training is needed. The Functional Assessment should include a detailed description of a participant's ability to complete tasks that support activities of daily living that typically occur in family and community life, and the participant's ability to function independently. Out of these assessments, the specific type of interventions and services that best match the participant's needs should be able to be identified.

Question	Answer
Does the need for partial care services have to be identified through a Functional Assessment?	The medical necessity of the participant needing some sort of skill training would first be revealed in the Diagnostic. Whether a participant's skill deficits can best be addressed in a partial care setting or in PSR should be revealed through a Functional Assessment. Due to the nature of their symptomology, some participants may have a need for skill development that calls for home or community settings while other participants' needs for skill training may best be served in the clinical group environment.
Once the CAFAS/PECFAS instrument is completed on a child, does this constitute a complete Functional Assessment?	No. The Functional Assessment document must include a description of the child's level and types of functional impairment.
UPDATED May 2009: **How do we bill for an Intake Assessment for a participant who is on Medicaid Basic Benefits and wants baseline clinic services since the Intake Assessment does not necessarily produce a diagnosis and a diagnosis must be identified on the claim?**	There is no change in regard to the requirement that the claim contain a diagnosis. Providers should continue to submit claims with legitimate diagnoses as they always have.
UPDATED May 2009: **When a participant transfers from one agency to another agency and assessments have already been completed by the former agency, can the new agency still bill for an Intake Assessment?**	Service limitations for assessments remain the same as before the new reform rules. The rules allow for the provision of an intake assessment following an agency transfer (IDAPA 16.03.10.113) as a benefit to the participant; however it is the provider's responsibility to determine whether a participant's assessment/diagnostic benefits have been exhausted before performing the service. Whenever a provider encounters the situation in which the participant needs additional assessment but the assessment benefits are exhausted, the provider is encouraged to refer that participant to the Medicaid Mental Health Utilization Management program so we may conduct an internal review of that participant's utilization. This would allow Medicaid to determine if the participant is obtaining the right services in the right amount.

Question	Answer
Does the supervising physician (or mid-level professional, if PSR) need to attend the interdisciplinary team meetings?	No. At the very least, the members who should be present at interdisciplinary team meetings to create or review a treatment plan are the staff member from the provider agency who is working directly with the participant, the participant (when able), and the participant's parent or legal guardian (if applicable). While input from all interdisciplinary team members should be obtained, their attendance is not required at the actual meetings. The intent of the interdisciplinary team concept is that a participant's needs are reviewed and addressed by a broad spectrum of professionals who can contribute the most to a comprehensive treatment plan for the individual.
Does the individual who is providing a service need to be identified by name on the treatment plan or just by role (such as counselor, PSR Worker, doctor, etc…)?	The reform rules require that the individual staff person's name must be on the treatment plan. This is an aspect of the informed consent requirement as specified in rule at IDAPA 16.03.09.716.02. Considering the potential for staffing variances within a provider agency, the provider agency management should make appropriate accommodations to meet the needs of participants who are affected by any unexpected staffing changes.
Does the treatment plan have to have objectives in at least two functional areas identified as deficient on the comprehensive assessment, as previously required by PSR service rules?	No. The reform rules require that at least one objective is included on the plan in the areas that are most likely to lead to a participant's greatest level of stabilization. Best practice supports addressing one or two problem areas at a time. The clinician, authorizing physician (or licensed practitioner of the healing arts professional if PSR), the participant, and the participant's legal guardian (if applicable) should determine what areas are addressed and in what order.

Question	Answer
In regard to treatment planning, what are the different roles of the agency staff versus the physician (or licensed practitioner of the healing arts)?	IDAPA 16.03.10.129.04 specifically requires the provider agency to *develop* the plan with input from the team (which would include the physician or licensed practitioner of the healing arts). IDAPA 16.03.10.129.05 specifically requires the physician or licensed practitioner of the healing arts to *sign* the plan indicating the medical necessity of the services. These roles are the same roles for the Basic Plan except that a licensed practitioner of the healing arts cannot substitute for a physician.
UPDATED July 2009 **How does an agency develop a treatment plan for a participant who is discharging from the hospital when the hospital documentation is incomplete?**	If an agency cannot get adequate discharge information from the hospital or the assessment documentation does not include all the necessary elements of a comprehensive diagnostic, the agency can do a comprehensive diagnostic assessment within 10 days of the initiation of treatment instead of an intake assessment in order to complete the participant's treatment plan.
UPDATED July 2009: **Can you provide some direction about existing prior authorizations, amendments, and baselines?**	Agencies should have already adjusted all treatment plans to the PSR service limitations that took effect January 1, 2009. In order to clarify the additional changes that may be required for treatment plans since the new rules took effect on May 8, 2009, please see Table 3 at the end of this document.
According to the reform rules, it appears that 120-day reviews are no longer required—are any reviews required?	Yes. There is no change in the requirement for periodic reviews of the treatment plan; however, the requirement has been clarified. The occurrence of the review does not have to align with 120 day intervals, though the review must still occur. This adjustment to rule was made to accommodate the review being completed sooner if it is medically necessary.

Question	Answer
UPDATED May 2009: **In regards to the treatment plan reviews for PSR, are agencies allowed to bill additional hours for completion of these reviews or will the time have to come out of their allotted 5 hrs/wk of ongoing?**	The plan review practice has not changed. Previously, there was no code and no new code is being created to bill for plan reviews.
Because the mental health rules in chapter 9 state that "assessment and treatment planning services may be provided up to 12 hours a year", can a provider delivering basic plan services claim more than two hours a year for treatment planning for a participant?	No. The treatment planning benefit is limited to two hours per year per participant per provider agency. This is not a new requirement—it was first announced in the Information Release published July 1, 2006, and appears in the Medicaid Provider Handbook.
Are plans that were completed before the implementation of the reform rules still valid until the plan's annual review?	Yes, assuming the participant continues to meet the criteria for the requested services, the provider meets the new standards of care for delivery of such services and the services do not exceed the new service limitations. Agency providers are encouraged to carefully review plans to ensure they meet the newly defined criteria for group activities. Additionally, the use of collateral contact may be affected for some agencies based on the clarified service definition and description in the new rules.

Question	Answer
UPDATED May 2009: **Can providers deliver all the services exactly in the quantity they are listed on treatment plans that were previously authorized?**	No. It is true that treatment plans that have already been authorized do not require a new prior authorization; however, agencies need to internally adjust their existing plans to comply with the new service limitations of 10 hours per week for the total of individual and group PSR services. Also, collateral contact services can no longer be used as purely a communication device. If that was the intent on existing treatment plans then agencies need to re-evaluate their delivery of this service and ensure that the delivery of this service complies with the intent as newly clarified in IDAPA.
How should agency providers address the change from PSR as a service on current treatment plans to the newly defined combinations of "Skill Training" and "Community Reintegration"?	The rules in effect before the reform describe PSR as skill building only. If an agency wants to offer Community Reintegration to a participant, the agency provider will need to amend the participant's treatment plan.
I don't understand the context in which collaterals can be used to "advise others on how to assist the participant" as the CPT manual defines it. We have billed collateral contacts when we taught parenting skills—can we continue to do that?	No. Collateral contact is not intended to be used as routine status reports to parents or significant others, or as a mechanism to provide ongoing parent education or training of any type. Collateral contact is intended to be used by medical professionals to inform and explain psychiatric or other medically-related information to a participant's interdisciplinary team members "or other responsible persons". This can be a one-to-one communication or offered to the treatment team as a whole. According to CMS, the communication should result in a direct service to the participant. In other words, based on the information that is shared during the collateral contact, the person(s) receiving the information will take action necessary to benefit the participant; this action could not have occurred without the collateral contact information.

Question	Answer
Now that the definition of collateral contact no longer includes billing for communicating with family members about the participant's response to treatment, how are we to include families?	It is a legitimate billing practice for a professional working with a participant to end the session with a few minutes remaining to relay follow-up information to the participant's family. Unless the service being delivered is individual psychotherapy in which the confidentiality of personal issues may need to be preserved, parents may greatly benefit from witnessing the services being delivered to their child (e.g. skill training or community reintegration)—this would also reduce the amount of time needed to talk to the parent following the delivery of the service. In cases in which a participant's family needs greater involvement the most appropriate treatment approach is family therapy.
Because the reform rules restrict any use of chemical restraints, can you clarify the difference between pharmacological management and chemical restraints?	Pharmacological management involves the tasks of prescribing medication, monitoring consistent use and potential side effects, aims to relieve negative symptoms for the participant, and allows for brief psychotherapy by a physician or other practitioner of the healing arts. When non-routine medications are used to restrict a participant's behavior or physical movement, then the medications are considered chemical restraints.
Why was the CAFAS/ PECFAS initial full scale score that is used to qualify children for partial care and PSR services changed from 80 to 40?	The rules were revised to more accurately reflect the score that indicates a child has a serious emotional disturbance (SED), as measured by the CAFAS/PECFAS. Dr. Kay Hodges, the author of this instrument, states that a score of 40 indicates the presence of SED. This revision actually increases the number of children who can access Enhanced mental health services.
How will service hours be initiated since the requirement for prior authorization from the department is removed from rule?	The expectation is that providers will complete assessments and develop treatment plans for each participant within the service limits identified in rule. (See specific limitations listed at IDAPA 16.03.10.124) The system has been adjusted so that a baseline of services can be delivered and claims reimbursed without the PA mechanism. If additional hours above the baselines described in rule are needed, they must be authorized through the existing PA process.

Question	Answer
UPDATED July 2009: **Language at IDAPA 112.05 suggests to me that we need to perform a CAFAS as a part of the comprehensive diagnostic assessment so that *"items endorsed on the CAFAS/PECFAS (are) supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment".* Isn't this contradictory to requirements that the functional assessment should only be performed if the CDA recommends it?**	Providers must ensure that items endorsed on the CAFAS are linked to behaviors that are **originally** described in the comprehensive diagnostic assessment. According to the functional assessment definition at IDAPA 16.03.10.111.07, "In rehabilitative mental health, this assessment is used to provide **supplemental** information to the comprehensive diagnostic assessment…".
With the inclusion of new requirements in the reform rules for staff-to-participant ratios, do parents always have to be present in the same room of the service delivery in order for the service to be billable?	No; however, the expectation for all services delivered to children is that their parent(s) be actively involved and available for consultation. Since it would be counter to the evidence and recommendations from the Surgeon General that parental involvement is therapeutic, if the child's interdisciplinary treatment team recommends that the parent not be involved, then the reasons for this decision must be documented. You can get more information on the Office of the Surgeon General's Web site.

Question	Answer
Why are there limits on the group sizes for children?	Limited group sizes for children are considered a best practice for therapy work with children. According to developmental theory, children under the age of four years typically do not interact with their peers in groups although they will play in a "parallel" fashion; therefore, they do not have the developmental skill to benefit from group therapies. The literature endorses larger group sizes as the ages of the children in the group go up. Even for adults, a group of more than 10 is considered too large to be therapeutic.
UPDATED May 2009: **If a participant turns 18 in the course of the treatment plan year, does a new adult assessment and treatment plan need to be completed?**	Yes. Agencies intending to provide services to participants who are 17 years old should write the treatment plan, including transitional elements, to cover the time up to the 18th birthday. Upon reaching age 18, unless a legal guardianship is obtained, the participant has the right to withdraw from services, request a change in services, or request a change in service providers. Agencies should anticipate the participant's 18th birthday and work with the participant regarding transitional issues. Should the 18 year old participant indicate a desire to continue in services with the agency, the agency must confirm the participant meets the adult program criteria and must give the participant the opportunity to sign a treatment plan (indicating the participant agrees with it). Naturally, the treatment plan should include appropriate modifications, as needed.
Since we have a fenced-in playground on our facility's premises and play is good for children, can we bill for time spent on the playground?	No. However, if a licensed master's clinician wants to use the playground to facilitate the effectiveness of psychotherapy with a child in terms of delivering "play therapy" according to an evidence-based model, then use of the playground would be considered appropriate. The need for this type of intervention should initially be identified in the assessment and the intervention must be described on the treatment plan with specific objectives related to a treatment goal.
With the addition of new rules addressing the use of seclusion, restraint, and aversive techniques, can a provider use "time-out" techniques?	Agency providers can only use "time-out" techniques in response to maladaptive behaviors if the technique does not violate the provisions of IDAPA 16.03.09.714.12 and 16.03.10.130.11. If "time-out" means isolating a participant alone in a location, then it violates the provisions of these rules as isolation is considered aversive. If a provider wants to use "time-out", it must employ it in a way that does not isolate the participant. All responses to maladaptive behaviors must be delivered by the professionals allowed to work in the setting as specified in rule - **support staff cannot be used**.

Question	Answer
UPDATED May 2009: **Have the new rules eliminated the requirement for a qualifying diagnosis to receive PSR services?**	No. The qualifying criteria for PSR services have not changed; however, the new arrangement of information is meant to reduce redundant text. Serious Mental Illness (SMI)and Serious and Persistent Mental Illness (SPMI)are two terms that now appear in the definition section whereas previously they were imbedded in the text of rule requirements. The definition of PSR (IDAPA 16.03.10.111.21) indicates the participant must meet the criteria for SPMI. The definition of SPMI (IDAPA 16.03.10.111.28) includes SMI (IDAPA 16.03.10.111.27)
What is the difference between the social and recreational activities that are prohibited by rule and the "social relationships and supports" that can be addressed as a skill training area?	When working with participants to teach them how to establish or maintain personal support systems or relationships, the primary focus of the activity is training, but an experiential component is appropriate. Such training should be associated with a specific goal and objective on the treatment plan. The provider should have a plan that clarifies the training steps and the participant needs to understand what step is being worked on. Merely bringing a participant to a social or recreational type activity does not constitute training. Please refer to IDAPA 16.03.10.115.04 and 16.03.10.125.02.
What are "Community Reintegration" and "Skill Training" services?	"Community Reintegration" and "Skill Training" are new names for a service that has been being delivered under the name of "Individual PSR".
How do we document the medical necessity of "Community Reintegration" and "Skill Training" services?	The Diagnostic must document the need for these services and the Functional Assessment must be completed in order to reveal the specific aspects of treatment, training, and support that are needed. The terms are defined at IDAPA 16.03.10.010; the goals of these services are listed at 16.03.10.116, the service descriptions with some examples are described at 16.03.10.123, and the service limitations are listed at 16.03.10.124.

Question	Answer
UPDATED April 2009: **Did the code for Group Skill Training change from what was previously used for Group PSR? Does this code require the group modifier?**	No. Group Skill Training should be billed with code H2014. An error was made on the initial chart that was published in this FAQ document. The code H2014 does not require the group modifier. See the *corrected* Table 2 at the end of this document.
How is the newly defined service of "Community Reintegration" that appears to allow PSR staff to help participants with their self-care needs different from the Medicaid benefit of personal care services (PCS)?	The newly defined service of "Community Reintegration" is a result of "unbundling" what used to be called PSR (the service, not the program). Based on information obtained from stakeholder input, audits, credentialing, and QA processes, we identified that PSR is actually more than one type of service---there is an instructive component and there is a supportive component. Whenever possible, Medicaid is supposed to unbundle services and identify the separate components of a service in a distinct way. For the service of PSR, "Community Reintegration" is the name for the supportive component and "Skill Training" is the name of the instructive component. Community Reintegration is intended to provide practical information and direct support on those occasions when it is necessary to help a participant accomplish tasks. Considering the clinical course of SED/SPMI, there are occasions when the participant's symptoms are exacerbated and the participant is not able to use existing skills to perform tasks and if these tasks are not performed, the participant is at risk of deteriorating (e.g., eating nutritionally, adhering to a medication regimen, paying rent on time, etc). In such instances, the PSR worker can provide information and support to the participant for the participant to perform the skills. In this way, deterioration in health status may be avoided. In comparison, PCS is a direct, hands-on service for a participant that needs help because of the participant's inability to function without physical assistance.
UPDATED July 2009: **What work is meant to be covered when billing H0032 for treatment planning?**	Code H0032, treatment planning, should encompass all the work needed to formulate the treatment plan which may include review of all existing assessments, review of medical records, school records, and any other information pertinent to working with the participant to develop treatment goals and objectives. The work includes collaborating with the treatment team (including the participant, and family when appropriate) to formulate the treatment goals and objectives, and producing this document. This code may also be used to bill for work done with participants in treatment plan reviews.

Question	Answer
UPDATED May 2009: **If an agency has an existing authorized treatment plan containing 2 hrs per week of H2017, can the plan just be adjusted up to the 5 hrs per week without a Department-approved amendment once the rules take effect?**	No. A participant's treatment plan must not be changed just because a prior authorization is no longer required for baseline services. Any changes to a participant's treatment plan must reflect the participant's true healthcare need as documented in the medical record. Except for the PA requirement, the process for amending treatment plans has not changed; therefore providers should continue to amend treatment plans based on medical necessity and should obtain all required signatures. Previously authorized treatment plans should continue to be followed as written if they remain appropriate and are accurately meeting the participant's needs.
UPDATED May 2009: **If a participant does not attend the scheduled amount of treatment sessions in a given week, can the participant make up that missed time in the following week?**	First and foremost, services may only be delivered if there is documented medical necessity. If a participant misses services one week and needs them in addition to everything else that is scheduled the following week *and* that missed service is already prior authorized, then those treatment hours can be "rolled over" to the following week. Services that appear on the treatment plan in an amount that do not require prior authorization can also be "rolled over" as long as the regularly scheduled amount of hours plus the "rolled over" hours do not exceed 5 hours, because any amount over 5 hours in one week requires prior authorization in order for the system to recognize the claim and pay.
If a staff person is accompanying a participant who has communication limitations to a healthcare appointment and training occurs in the vehicle, is all of that time in the vehicle reimbursable?	No. The duration of the billable time must match the medical necessity of such a training occurrence, not the mileage of the distance between the participant's home and the location of the appointment. IDAPA 16.03.10.24.09 allows for the possibility of treatment locations other than the participant's home or community if the location is identified on the treatment plan and it is medically necessary to maximize the impact of the service. For example, if the staff person needs to accompany the participant to an appointment for the purposes of providing "in vivo" skill training, then some of the time in the vehicle could be used to work with the participant on the skills necessary for the participant's appointment to be successful; or following the appointment, the staff person may want to review what transpired in the appointment to provide feedback and further training to the participant.

Question	Answer
Is the phone contact we have with participants to remind them of scheduled PSR appointments a billable service?	No. The list of payment limitations identifies that "reimbursement is not allowed for…scheduling appointments for any purpose." The PSR program of services is intended to assist a participant toward greater independence and recovery. Training the participant to manage their time and keep scheduled appointments would constitute a billable PSR service (skill training).
Can individuals with a bachelor's or master's in social work, or a master's in counseling, work under the designation of PSR specialist if they do not hold a license in the field in which they are educated?	No. To work as a PSR Specialist the individual must obtain the USPRA PSR specialist certification by 2012. A bachelor's or master's degree in social work or a master's in counseling are not substitutes for this certification. A person who meets the requirements for a license but has not obtained licensure should be cautious if working as a PSR specialist. It is a prosecutable violation of the licensing laws to perform work within the scope of that license if the person does not hold the license. A PSR specialist with a degree in social work or counseling must guard against working outside the scope of permissible services provided by a PSR specialist. Individuals are encouraged to contact their applicable licensing board to discuss working without a license.
UPDATED July 2009: **In regard to the PSR certification requirements, what are the requirements for the staff who have a masters degree, though have not yet become licensed or are waiting to become eligible for licensure? Can they continue to work as PSR specialists?**	IDAPA 16.03.10.131.03 pertains only to those individuals who have fulfilled all the Idaho Bureau of Occupational Licenses (IBOL) requirements for licensure but still have not pursued licensure or have been denied licensure. This **does not** pertain to a person educated as a counselor or other professional regulated by the IBOL that has not fulfilled such IBOL requirements OR a person that has fulfilled the requirements but has not had the opportunity to sit for the exam OR does not yet have exam results.
What IDAPA regulations are governing PSR specialists until the new standards go into effect on July 30, 2009?	According to the Office of the Attorney General, until July 30, 2009, persons working as PSR specialists must meet the current standard set forth in IDAPA 16.03.10.131.10. Beginning on July 30, 2009, persons working as PSR specialists will fall under the new rule requiring certification by January 1, 2012, in accordance with USPRA requirements.

Question	Answer
UPDATED May 2009: **If a person is certified with USPRA, do they automatically qualify to provide PSR services, or do they also have to have one of the degrees listed in the IDAPA?**	All existing staff who are working as PSR Specialists have one requirement ahead of them—they must obtain USPRA certification by 2012. Any staff who are currently certified by USPRA have already met this requirement and have no other requirements to fulfill except to maintain their certification. Beginning July 1, 2009, any person intending to obtain employment in a Medicaid-reimbursed PSR agency and obtain reimbursement for that agency delivering PSR services must meet the specific qualifications described in rule for PSR Specialists which includes specific education and USPRA certification.
UPDATED May 2009: **Are the 21 semester credit hours of human-service related course work still required for PSR specialists under the new rules?**	No. The new rule (IDAPA 16.03.10.131.03.) that addresses the qualifying criteria to become PSR Specialists now lists specific degrees that meet the criteria. Existing PSR Specialists are allowed to continue working as such until January 1, 2012. This group of people are considered PSR Specialists only if they have already been in compliance with the previous requirements for PSR Specialists (bachelor's degree in behavioral science, medicine, or education with at least 21 semester credit hours in human service fields). In order to meet the new criteria and continue providing PSR services after the 2012 date, these legitimate PSR Specialists must be certified by USPRA.
How are PSR specialists who work only with children going to meet the USPRA requirement that they have one year's experience working in the field with people age 18 or older in order to sit for the USPRA certification exam?	The department is currently working with USPRA to further identify certification expectations for PSR specialists who intend to work primarily with children. For instance, USPRA's policy regarding required work experience is actually broader: individuals who work for agencies that serve children age 15 or older actually meet this requirement as USPRA acknowledges that this is a "transitional age" and some of the principles of PSR for adults apply to this younger group. Certification applicants do not have to have worked directly with this age group. As long as applicants works for agencies that serve this age group, they meet the work experience requirement.

Question	Answer
Can you clarify the requirements for supervision in PSR agencies?	The intent of the rule at IDAPA 16.03.10.130.06 is that staff who are currently working as uncertified PSR specialists but who do not intend to achieve certification by 2012 must be supervised by one of the professionals (listed at IDAPA 16.03.09. 715.01) who possess a master's degree or higher credential. This is an assurance that those individuals who are not focused on a professional career in the field of mental health rehabilitation are sufficiently overseen by those professionals who have already established their professional standing in the field and have a wider scope of supervisory skills than those who do not have a master's degree. To acknowledge the value of the skill set of the certified PSR specialist and the expected scope of supervisory skills, the rules at IDAPA 16.03.10.131.03.c allows for staff who are currently working as PSR specialists and who are actively pursuing USPRA certification (by completing educational and experiential requirements) to be supervised by a certified PSR specialist.
Will the Medicaid Provider Handbook be updated to include the new billing codes and service descriptions contained in the reform rules?	Yes. The Medicaid Provider Handbook is updated twice a year. Please see Table 2 in the Additional Information section at the end of this document for updated procedure codes that will be used until the next handbook is published in July, 2009.
UPDATED July 2009: **Will the department be distributing another checklist to help providers know what documents need to be submitted for PAs?**	No. Providers should submit all pertinent clinical data when seeking prior authorizations; at a minimum this would include a participant's comprehensive diagnostic assessment, a functional assessment if one exists, (including CAFAS/PECFAS if for a child), and the participant's treatment plan. Additional documentation may be required in order to present an accurate and current status description and sufficient details that will allow the care management staff to make an authorization determination.

Additional Information

Tabe 1. Professional Mental Health Staff and Scope of Assessments

	Intake Assessment	Comprehensive Diagnostic Assessment	Functional Assessment
PSR Specialist working for a PSR Agency	•		•
LSW	•		•
LMSW, LPC, LAMFT or Psychologist Extender, with required licensing supervision	•	•	•
LCSW, LCPC, LMFT, Psychologist	•	•	•
Certified Nurse Practitioner, RN	•	•	•
Practitioner of the Healing Arts	•	•	•
Physician, Psychiatrist	•	•	•

Table 2. Codes, Service Descriptions, Billing Units, and Explanatory Comments

Code	Services	Billing	Comments
T1028	Intake Assessment (formerly Social History Evaluation)	1 unit = 15 minutes	No change in rate.
90801	Comprehensive Diagnostic Assessment (formerly Psychiatric Diagnostic Interview Exam)	1 unit = 15 minutes	No change in rate.
H0031	Functional Assessment (formerly Mental Health Assessment or Rehabilitative Evaluation)	1 unit = 15 minutes	Focus entirely on participant's functional skills; Exclusively for participants seeking skill training-type interventions in Partial Care or Rehab Services
H2017	Individual Skill Training (formerly Individual PSR)	1 unit = 15 minutes	No change in rate.
H0036	Community Reintegration (*NEW CODE*)	1 unit = 15 minutes	Pays same rate as H2017. Individual service only.
H2014 *HQ*	Group Skill Training (formerly Group PSR)	1 unit = 15 minutes	Modified required. No change in rate.

Table 3. Prior Authorization (PA) Alternatives for Same Services and Changing Services.

PA Alternatives	Same Services	Change Services
PA'd over 10 hrs/week	Ensure new service limits not exceeded; proceed with service delivery	Amend plan; ensure service limits not exceeded; submit for new authorization if adding H0036
PA'd greater than 5 but not greater than 10 hrs/week	Proceed with service delivery	Amend plan; ensure service limits not exceeded; submit for new authorization if adding H0036
PA'd for 5 or less hrs/week	Proceed with service delivery	Amend plan; proceed with service delivery
Transfers	Submit for authorization if services on plan exceed baselines described in rule	Submit for authorization if services on plan exceed baselines described in rule or if adding H0036
New and subsequent treatment plans with service(s) at or below baselines	All new and recurring treatment plans containing services at or below baselines described in rule do not need to be submitted for authorization; provider should create plan and proceed with service delivery.	
New and subsequent treatment plans with service(s) above baselines	All new and recurring treatment plans containing services in excess of baselines described in rule must be submitted for authorization.	