

# Negotiated Rulemaking Meeting and Comment Summary

June 17, 2015 10:00 AM (MDT) to 12:00 PM (MDT)

Negotiated Rulemaking DOCKET NO. 16-0309-1501

Video meeting with location in Boise as published in the Administrative Bulletin  
Boise

**Facilitator:** Matt Wimmer, Deputy Administrator, Administration Policy and Innovations

**Facilitator:** Art Evans, Bureau Chief, Bureau of Developmental Disability Services

**Facilitator:** Tiffany Kinzler, Bureau Chief, Bureau of Medical Care

**Bureau of Developmental Disability Services:** Frede Trenkle-MacAllister, Alternative Care Coordinator

**Bureau of Medical Care:** Jeanne Siroky, Alternative Care Coordinator

## Call to Order and Outline Meeting Format

### I. Purpose of Meeting

Therapy Services: IDAPA 16.03.09.730 - 739

School-Based Services: IDAPA 16.03.09.850 – 859

Rule changes are being proposed to clarify gaps that have been identified in these rules and adjust to changes in current Medicaid practice regarding school-based services and therapy services. Further, rule changes are being proposed to adjust requirements currently resulting in unnecessary regulatory burdens on providers in their efforts to remain in compliance with the rules. The negotiated rulemaking meetings listed above will allow stakeholders to provide their input concerning the proposed changes to school-based services and therapy services.

### II. Discussion Points

#### a. Therapy Services

- i. Define and clarify the language for maintenance therapy to align with Medicare.
- ii. Clarify the language about therapy assistants and aides to align with licensing board rules.
- iii. Clarify which providers are included in the therapy cap.
- iv. Redefine the requirements for physician orders/referral based on comments from the therapy organizations and schools to prevent delays in services.
- v. Define the elements of an acceptable plan of care as recommended by the professional organizations.
- vi. Redefine the criteria for feeding therapy.
- vii. Address supervision requirements.

#### b. School-Based Services

- i. Clarify the definition for “Educational Services”
- ii. Clarify the requirement to obtain the authorization to bill Medicaid
- iii. Clarify timeframe for the Physician’s recommendation
- iv. Individualized Education Program
  1. Removal of age limit to comply with federal regulations
- v. Service Detail Reports
  1. Clarify requirements for documentation

- vi. Notification to Primary Care Physician
  - 1. Review and clarify requirement
- vii. Psychosocial Rehabilitation (PSR)
  - 1. Remove burdensome requirements for student eligibility for service
  - 2. Review and clarify staff qualifications
- viii. Behavioral Intervention (BI)
  - 1. Review and clarify student eligibility requirements
  - 2. Clarify BI definition
  - 3. Review and clarify group service requirements
  - 4. Removal of BI paraprofessional qualification that states staff must meet the “standards for paraprofessional supporting students with special needs” to align with the Idaho Special Education Manual
- ix. Personal Care Services
  - 1. Clarify requirements for the service
  - 2. Review and clarify personal assistant qualifications to align with highly qualified paraprofessional in the school setting.
- x. Transportation Services
  - 1. Clarify requirements for the service
- xi. Interpretive Services
  - 1. Clarify documentation requirements
- xii. Therapy Paraprofessionals
  - 1. Identify supervision requirements
- xiii. Quality Assurance
  - 1. Increase quality assurance and quality control activities

### **III. Follow Up**

- a. Written comments for Docket No. 16-0309-1501 are to be submitted on or before July 19, 2015 to:

Frede' Trenkle-MacAllister  
Idaho Department of Health and Welfare  
Attn: Medicaid Central Office  
PO Box 83720  
Boise, ID 83720-0036  
Phone: (208) 287-1169; Fax: (208) 332-7286  
E-mail: [TrenkleF@dhw.idaho.gov](mailto:TrenkleF@dhw.idaho.gov)

# Negotiated Rulemaking - Comment Summary

## DOCKET NO. 16-0309-1501

### Comments from June 17, 2015 10:00 AM (MDT) to 12:00 PM (MDT) Written Comments Submitted Post-Meeting and Responses

Verbal and written comments were submitted by the following individuals/organizations:  
{List who comments are from }

Comments		Responses		
W-Written V-Verbal	Therapy Services – Referral, Order and Prescription		Policy Change	
<p>W Tom Howell IPTA</p>	<p>#1 and #2: We use these terms synonymously but prefer “referral”.</p> <p>#3: The main problem as discussed has been the timeliness of the start of PT which we feel should not be limited by waiting for an order (referral) that has to meet the current restrictive regulation and included frequency and duration. The establishment of the frequency and duration is often left to the therapist including by Medicare and should always include input from the initial PT evaluation. This delay especially affects our pediatric clients.</p> <p>Therefore, we recommend a process similar in some ways to Medicare which allows for a patient to be seen for a PT evaluation, after which the evaluating physical therapist must submit a plan of care to the referring provider (physician, PA or NP) for approval and signature. The referring provider may ask for a change in that plan. The elements of the plan of care will be discussed in section # 2. Physical therapists are trained in all the elements of evaluation which includes setting frequency and duration based on current evidence; however we also feel that the combination of therapist – referring provider can give an even more accurate and appropriate frequency and duration.</p> <p>The Medicare regulations on certification and re-certification (See Section 220.1.3, Paragraphs A -E, pages 164 – 169) also specify that therapy can start based on the plan of care pending physician signature and for how long it can continued pending the return of the signed plan of care which, once signed, becomes a “certification” which is 30 days unsigned and 90 days for the initial signed certification unless the referring provider specifies a different initial period. The certification is THE important document, similar to the Healthy Connections referral and orders now in the Medicaid handbook BUT the certification includes the information gathered by the PT as well during evaluation. This info with the medical expertise of the referring provider who is required by these regulations to review and sign off on (or set) the frequency and duration, allows often for a more realistic (and often shorter) frequency and duration to</p>		<p>Response:</p> <p>#1: We understand the confusion between the words order and referral. However, because of the referral requirements for the Idaho Medicaid Healthy Connections Program, we will need to continue to use the words “physician order”.</p> <p>#2: We will consider removing the added requirement for a healthy connections referral since a physician order is required.</p> <p>#3: We too are also concerned about the timeliness of care and will consider changing this requirement. We will consider the comments here and review the Medicare requirements when writing the proposed rules.</p>	<p>#1: Not planned</p> <p>#2: Yes</p> <p>#3: Yes</p>

	<p>be set. Most therapists now have the experience (with other insurances) that most referring providers leave it up to the PT to set the frequency and duration allowing them to sign off on it. The certification process still gives referring providers full control to modify the frequency and duration. The therapist is charged to get the plan of care to the referring provider as soon as possible but the regs are specific that delayed certification should not hold up therapy (see page 167 under Paragraph D: “ It is not intended that needed therapy be stopped or denied when certification is delayed.”). The regs also specify what happens if there is a delay as well. This is the process that most therapists are now well-versed in and it would be good to have something close to it for Medicaid orders.</p> <p>So to summarize: for the orders (referral), we recommend language that would allow PT to start therapy in a timely manner (immediately would be best, if possible) and continue it even if it is just a few allowed treatments until the plan of care/certification is reviewed and approved by the referring physician. There are numerous studies which show that getting therapy started immediately in many conditions reduces the number of overall treatments. The Medicare regulations have worked well and allow therapy to begin immediately and provide a structured way in which information has to be communicated between the PT and the referring provider. There are other ways to handle this as well. Some insurances give an evaluation and 1-2 treatments and some give an evaluation and a number of treatments based on benchmarks for diagnostic groups. Unfortunately, what happens with this method is therapy starts in a timely way, but then has to stop for a period to wait for additional visits to be authorized. Anything learned or gained in the initial visits is usually lost. We would prefer something similar to the Medicare regs; however, ultimately the goal is new Medicaid regulation that will eliminate any delay for therapy to get started AND not cause any further delays or time gaps in the therapy process.</p> <p>Please also note that after the initial certification, Medicare also includes specific conditions and time frames for recertification (see pages 166-167) which differs from the “progress report” required on or before every 10<sup>th</sup> visit (see Section 220.3, Paragraph D, pages 184 – 189 for info on the Progress Report). They do allow that a “progress report” can function as a recertification only if it has all the required elements needed to recertify. Any change in the initial order process would also need consideration for the follow-up process of progress reports and recertification including how to handle those that get readmitted to a facility and/ or then go back into OP PT.</p>		
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**Therapy Services – Plan of Care**

<p>W Tom Howell IPTA</p>	<p>As referenced above, the Medicare regs ( Section 220.1.2, Paragraphs A through C, pages 160 – 164; Paragraph B specifically refers to the elements of the plan of care; see also documentation elements required in PT evaluation/plan of care in Section 220.3, Paragraph C, pages 179-184 ) are very specific as to what information has to be in the plan of</p>	<p>The Department appreciates the recommendations from the IPTA, and will consider adding plan-of-care information to ensure and promote quality care.</p>	<p>Yes</p>
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	care. Most therapists are used to these elements now. The “plan of care” now in most clinics is essentially the same as a PT evaluation with clinics making sure that there evaluations, at minimum, cover all the areas designated for the plan of care. This gets sent to the referring provider asap after evaluation for their approval and signature. We recommend that Medicaid consider using the same or similar definitions of what needs to be in the plan of care. Even if the Medicare regs for “certification” are not used, we recommend that the rules should recommend that a PT send a plan of care, with the required elements in it, to the referring provider to communicate any updates or changes requested in the initial order.		
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**Therapy Services – Use of Aides and Assistants**

W Tom Howell IPTA	We appreciate that Medicaid has been willing to add to your regs the concept of proper Supervision, in our case especially with the non-licensed aides. We are committed to the proper use of these personnel as per our practice act but also committed and open to expanding their use, for instance, in schools, as long as supervision regs are followed. Though not part of this discussion, please note that we also support that the Supervision of licensed Physical Therapist Assistants (PTA’s) should be GENERAL across all settings (which differs from current Medicare regs in the outpatient private practice only)	We concur and will consider revising language to reflect the comprehensive, well thought out rules in both the PT and the OT regulations.	Yes
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**Therapy Services - Telehealth**

W Tom Howell IPTA	To summarize from the meeting today. The IPTA has surveyed licensed PT’s and PTA’s and has found near unanimous support to amend our practice act to include the ability to practice using telehealth in limited situations. The survey also showed support for starting out limiting the practice to PT’s that are licensed AND reside in Idaho. This second point will be the only sticky point when it comes to moving legislation. We have model language to follow to draft a practice act amendment. It is just up to the IPTA to move to the next step and there are no concrete plans yet on when that will happen. I am not participating in this part of the legislative process so you would need to contact the IPTA president, Cory Lewis at <a href="mailto:lewicory@yahoo.com">lewicory@yahoo.com</a> for any plan on moving that legislation.	We recognize the need to improve access by allowing telehealth for therapy services and will consider adding language to that effect	Yes
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**Therapy Services – Maintenance Care**

W Tom Howell IPTA	We support the Medicare regulations on maintenance as updated earlier this year (See Section 220.2, Paragraph D., pages 173 - 176) which removed the unwritten but heavily used requirement for “progress” but maintained the need to show medical necessity of any additional visits. These regs also defined what limited maintenance care was. To limit confusion, we suggest that the same or similar language be used by Medicaid. Our chronically ill patients that would decline without continued PT intervention are what this change is aimed at. Research shows that continued periodic care to prevent decline can save overall medical costs down the line.	We recognize the need to change the current language for maintenance therapy.	Yes
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**Therapy Services – Therapy Cap**

W Tom Howell IPTA	All Part B providers currently are covered by the therapy cap. For less confusion, the IPTA would recommend that Medicaid adopt this for their own cap. One side note is that we would also like	We will review the current language and the necessary system changes that this would require to see if it is feasible.	No
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	<p>Medicaid to consider and increase in that cap soon. The Medicare cap is increased yearly tied to inflation and the Medicaid cap is not. A periodic increase would be appreciated.</p> <p>Though not on the docket, we still are in favor of changing the documentation requirements for each procedure used and would prefer to use the Medicare language which only requires documentation of total treatment time and total time code time. Time for each procedure is recommended but not mandatory (see page 190).</p>		
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**Therapy Services – Physician Orders**

<p>Verbal Kelly Hall Boise School District</p>	<p>I would like to throw our voice in to support extending the physician orders from six months to annual. That would be exceptionally helpful for us.</p>	<p>We appreciate comments from Ms. Hall. Policy changes have been made for OT/PT/SLP physician orders.</p>	<p>Yes</p>
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**School Based Services – Criteria for Severely Emotionally Disturbed Children**

<p>Verbal Kelly Hall Boise School District</p>	<p>We are going to lose kids then. If I were to pull a lot of our eligibilities right now, I would wager to say that upwards of 50% of them, we are going to lose. By removing that diagnosis of ED. Not all of them are meeting the diagnose list DSM 5. There are other disorders that we are qualifying kids under that are not on this list.</p>	<p>The SED is looking at all environments which follows the medical model. The ED disability is looking at educational environment only.</p> <p>Most kids on an IEP are going to qualify with the SED criteria. It's looking at that assessment that captures all environments instead of just the educational environment. So when we look at department approved assessments, we are going to look at assessments that capture all environments and that is what that SED criteria is going to be based off of. That is what you will need to look at for those under 18.</p>	<p>No</p>
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**School Based Services – PSR / CBRs Supervision Requirements**

<p>Verbal Kelly Hall Boise School District</p>	<p>We have a ton of kids that would qualify for this but it is the certifications and supervision that eliminate us as a district to implement that. A couple of years ago we had a couple of social workers that we put our highest needs kids through but we were unable to fund the social workers. So we don't have social workers now.</p>	<p>Supervision requirements are specifically identified in our state plan. Supervision will be provided by a licensed certified behavioral health professional staff, physician or a nurse. Optum's recommended policy regarding this is monthly one-on-one supervision. PSR has always required the supervision. This service is a clinical service therefore it must be clinically supervised.</p>	<p>No</p>
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**School Based Services – PSR / CBRs Supervision Requirements**

<p>Verbal Kelly Hall Boise School District</p>	<p>I don't see anything in the PSR section that refers to supervision.</p> <p>In our district personally, I don't see it being that major of an impact because we do have social workers and every one of our social workers does go in and actually does groups in our classrooms. So for us, at least that piece of it, isn't going to change much. But again, the largest district in the state doesn't have those individuals on board and it would be a big burden to go out there and try to find; recruit; and pay those people to come in.</p> <p>All the rest of the small districts in the state, this could potentially cripple them from doing PSR at all. A number of years ago there was funding available for social workers. Schools utilized that funding and then when the funding went away, some districts weren't able to keep the social workers in their budget. And then there was a period of time recently where there was another way for us to fund, which for our district, we were able to fund social workers.</p> <p>When you are talking about supervision from a</p>	<p>(Matt) You are right. It is not clear right now and that is what we are trying to do is make it clear. If this is delivered in the school it has got to be under the supervision of someone licensed just like it is on the outpatient Behavioral Health side.</p> <p>It would depend upon how you define "supervision". If you are defining supervision as one on one you would have to be there watching them. That's one thing. If you</p>	<p>No</p>
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	TeleHealth perspective, how am I going to supervise what is going on in that child's general education classroom and in these other settings when I can't be there.	are defining supervision as supervising at least once monthly, you meet with them, you review their notes, talk about what they are trying to accomplish with the child and you give them some clinical input and direction on how they do that. That's a different thing and that might be something that is supported under our TeleHealth model.	
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**School Based Services – Psychosocial Rehabilitation Services**

Verbal Tom Dayley House	Aren't these services required of schools to provide to students? I guess my question is, how do you provide the services if you don't have the developed staff to do it?  (Kelly Hall) Yes, we do have to be providing these services but then it is our choice whether to turn around and bill Medicaid for them or not. But we currently we are not required to provide an LCSW supervising them.	(Art) It's different under IDEA than Medicaid.  *During an IEP meeting the team determines the services that meet the needs of the student. Once that is determined the school will assess to see if the service provided meets the Medicaid requirements. Schools provide many services to students in their educational setting, all services are not billable to Medicaid.	No
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**School Based Services – Personal Care Services**

Verbal Kelly Hall Boise School District	Right now we can bill for QIDP services but that was for billing task analysis because they had an IAP goal for that service. So for taking away the requirement for an IAP goal.....For us to be able to bill QIDP that QIDP had to be doing something and that doing something was completing a task analysis assessment for an IAP goal.  The service itself is Personal Care Services but the QIDP part of that (doing that task analysis and doing the quarterly visits) is a separate billing code and a separate rate for the QIDP.  All of the children we have on PCS are in self-contained classrooms and have severe developmental disabilities. They are functioning 2 to 4 grade levels below their peers. Significant functional limitations.  There are times when we have children that are performing at the level of a typical student but then come to the classroom for personal care services.	We are looking at removing the QIDP piece of PCS in the school setting and allowing everyone to put all of their PCS under this activity so there won't be any requirements for IEP goals or a specific developmental disability. Currently we are duplicating the service with additional requirements for the QIDP.  (Art) What we are trying to do is remove the extra burden of needing a QIDP to get those PCS services. You still get the services but you don't need the task analysis.  (Matt) We do need to revisit this one and get specific on what we need to change and discuss the impacts of the proposed changes.  *It has been determined that by keeping the QIDP option in the rules there is duplication of the same service. The QIDP adds more requirements and has caused children who are not DD to have IEP's that do not meet the individual needs. Therefore, it is recommended to remove the QIDP requirements to allow more flexibility for all students.	Yes
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