STATE OF IDAHO
ICF/ID SPECIAL RATE REQUEST FORM

In accordance with the Medicaid Enhanced Plan Benefits, IDAPA 16.03.10.632, special rates **may** be approved for care given to participants who have medical or behavioral long-term needs beyond the normal scope of facility services. If after reviewing your situation, it is determined special rates are needed, please complete the application form and submit all additional documentation as follows:

- All Special Rate requests must be FAXED to1-877-483-0279 on the **current** State of Idaho ICF/ID Special Rate Request Form (effective July 2011)

- An appropriate reason for the request must be indicated and all documentation must be submitted, as specified for the requested item as specified below. Documentation from this section is used to determine necessity.

- Requests for Increased Unlicensed/Licensed Staff Time must show the number of hours requested, type of staff requested, and whether or not agency staff was used

- Incomplete requests will be denied. Approved special rate requests are effective on the date received by the Bureau of Developmental Disability Services.

Important Notes:

- For participants with an on-going special rate, a **new** Special Rate Request Form must be submitted **each** time they are moved between facilities with different Medicaid provider numbers. This requirement applies to all facilities including those under a single-ownership.

- When a participant expires, is discharged, or a special rate is no longer needed, please notify the Bureau of Developmental Disability Services Care Manager at 1-208-239-6277 as soon as possible. Include the participant name, Medicaid ID number, facility name, facility provider number, and date of occurrence so that the special rate can be discontinued.

- Requests related to time spent in Day Treatment. If a portion of this request relates to Day Treatment time, does the current Day Treatment portion of the rate currently in effect for the facility that this resident resides at already provide for individual one-on-one reimbursement for this resident? If yes, then the Day Treatment portion of this request will not be allowed.

- Requests for this resident already covered in your current reimbursement for the entire facility this resident will reside in. Current reimbursement is defined as your current combined special rates and normal daily rates for this facility for all Idaho Medicaid residents at the facility. Note: If an approval of this special rate results in an overpayment of funds to the entire facility, based on incorrect claims made by the provider on this form, including a claim that no overpayment will result from this request, when in fact, an overpayment does occur, then a retrospective settlement of the entire facility is possible, per IDAPA 16.03.10.626. This retrospective settlement will recoup any overpayments related to this special rate request, and any other payments in excess of cost for all Idaho Medicaid residents in this facility.

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Per IDAPA 16.03.10.632, ICF/ID: SPECIAL RATES. Section 56-117, Idaho Code, provides that the Department may pay facilities a special rate for care given to consumers who have medical or behavior long-term care needs beyond the normal scope of facility services. These individuals must have one (1) or more of the following behavior needs; additional personnel for supervision, additional behavior management, or additional psychiatric or pharmacology services. A special rate may also be given to consumers having medical needs that may include but are not limited to individuals needing ventilator assistance, certain medical pediatric needs, or individuals requiring nasogastric or intravenous feeding devices. These medical and behavior needs are not adequately reflected in the rates calculated pursuant to the principles set in Section 56-113, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter and will be based on a per diem rate applicable to the incremental additional costs incurred by the facility. Payment for special rates will start with approval by the Department and be and reviewed at least yearly for continued need. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of Section 632 of these rules, will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."

To: Bureau of Developmental Disability Services Date of request: _____

Participant Name: _____ MID#:_____

Facility: _____ Provider #: _____ Phone #: _____

Printed name and Title of Authorized Official: _____

I certify the information herein submitted is true, complete, and correct to the best of my knowledge and belief.

_____ _____
Authorized Official's Signature Date

For all requests please submit the following:

1. A Narrative Report describing how the needs of the individual(s) have exceeded the normal scope of the facility's services, which includes:
    1. The names of the individual and Medicaid Identification Number for whom special payment is being requested
    2. The projected time period the special rate will be needed, start date and end date
    3. The specific need(s) which warrant special rates
    4. What training plans, interventions, etc. are in place to decrease the need for special rates

2. Please submit all supporting documentation as indicated based on the nature of your request as specified below. Please Fax completed form to: Molina at 1-877-483-0279.

Reason for Application	*Specific services being requested*	*Required information which must be submitted*
Personnel for supervision Supervision Need _____ _____ _____	Number of Hours _____ Start and stop dates _____	Individual Program Plan Care plans/protocols specifically related to the condition(s) for which the supervision is being requested. Ensure the type and hours of additional staff required to implement the interventions are specified. If applicable, Behavioral Assessments and/or Behavior Management Plans. Additional documentation supporting the need and demonstrate care provided.
Behavior Management Behavior Management Need	Number of Hours _____ Start and stop dates	Individual Program Plan Current Physician Orders (include orders for all behavior modifying medications which are being used) Behavioral Assessments including the type, severity, frequency and duration of the behavior Behavior Management Plans including all intervention

_____ _____ _____	_____	strategies and the number of staff required to implement the interventions (e.g. prone restraint requiring 3 staff, mechanical restraints requiring 2 staff to apply, etc.) Replacement behavior plans (if not included in the behavior management plan) Behavioral and restraint summary data for past 3 months (please include both actual incidents and attempted incidents which staff prevented). Other (additional documentation supporting the need and care provided i.e., community safety plans, probationary guidelines, offender risk assessments, psychiatric evaluations, psychological evaluations, treatment plans related to counseling, etc.)
Psychiatric or pharmacology services Psychiatric or pharmacology services need _____ _____ _____	Specify type of staff _____ Number of Hours _____ Start and stop dates _____	Documentation to support psychiatric or pharmacology services (i.e., psychiatric evaluations, psychological evaluations, treatment plans related to counseling, etc.) Additional documentation supporting the need and demonstrate care provided
Medical Needs Ventilator assistance Certain medical pediatric needs Individuals requiring nasogastric or intravenous feeding devices	Specify type of staff _____ Number of Hours _____ Start and stop dates _____	Individual Program Plan Current Physician Orders Documentation to support request and care provided

Participant Name: _____ MID#: _____