



C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

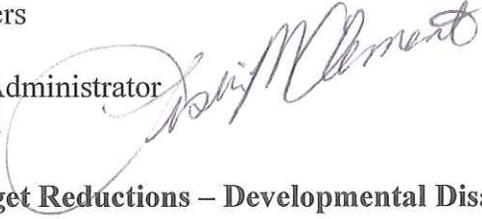
IDAHO DEPARTMENT OF HEALTH & WELFARE

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 1, 2010

MEDICAID INFORMATION RELEASE MA10-22

To: Medicaid Providers of DD Services, HCBS-DD Waiver Services, Adult DD Targeted Service Coordination Providers, and Children's Service Coordination Providers

From: Leslie M. Clement, Administrator
Division of Medicaid 

Subject: **House Bill 701 Budget Reductions – Developmental Disability Services**

Effective January 1, 2011, the Department will initiate temporary rules which will reflect changes in developmental disability benefits that are intended to align with legislative direction to maintain a viable, but reduced Medicaid program.

These changes in services and benefits are being implemented to comply with House Bill 701, Section 14 A and B that reflects legislative priorities for cost reductions. Medicaid was instructed to first review pricing to ensure that it did not pay any services higher than Medicare and did not overpay. The Department was also instructed to work with all providers to review and reduce current pricing through negotiations. The Department had previously worked with providers to adopt a reimbursement methodology that has been approved by the Centers for Medicare and Medicaid. No additional changes were made in pricing methodology this year and separate rules will be promulgated to reflect the existing rate methodology. The Department initiated statewide stakeholder participation regarding cost reduction ideas using teleconferencing, face to face meetings, and web surveys. The temporary rule changes identified below are intended to reflect the cost reduction suggestions received through these various channels and include eliminating non-effective, non-outcome based services; reducing and simplifying administrative requirements; and making other minor benefit changes. Other longer term efforts are in various stages of development to address legislative direction regarding selective contracting, waivers, and standardized statewide assessments.

The specific language of the temporary rule changes is being published on December 1, 2010, in the Idaho Administrative Bulletin at www.idaho.gov/adminrules. The temporary rule changes are:

Collateral Contact Will Not Be Available (Procedure Code 90887)

While the temporary rules are in effect, beginning with the claim date of service January 1, 2011, collateral contact will no longer be an allowed benefit, and will not be reimbursed by Medicaid. Addendums to individual support plans will not be required.

Supportive Counseling Will Not Be Available (Procedure Code H0004 HM)

While the temporary rules are in effect, beginning with the claim date of service of January 1, 2011, supportive counseling will no longer be an allowed benefit, and will not be reimbursed by Medicaid. Adult developmental disability (DD) participants who require emotional support can access psychotherapy mental health (MH) benefits in lieu of supportive counseling. Participants who need psychotherapy can contact a local mental health clinic to arrange for appropriate services, or request their service coordinator to assist them with this. Addendums to individual support plans will only be required if a participant adds a service when supportive counseling is eliminated.

Duplication of Treatment

The Department has identified that duplication of treatment occurs when a participant who meets eligibility criteria for both the DD program and the MH program receives a combination of skill building services from two programs simultaneously.

MH Program Skill Building Services	Psychosocial Rehabilitation	H2017, H2014HQ, H0036
	Partial Care/Mental Health Clinic	H2014
DD Program Skill Building Services	Developmental Therapy	H2021, H2021HQ, H2014, H2014HQ, 97537, 97537HQ, H2032, H2032HQ; or IBI H2019, IBI H2019 HM
	Residential Habilitation	H2015, H2016, H2022, S5140

While the temporary rules are in effect, beginning January 1, 2011, unless otherwise notified by the receipt of an addendum, adult participants receiving duplicate skill building services will continue to receive specific DD skill building service, and will not be eligible to continue to also receive their psychosocial rehabilitation or partial care. If the adult participant desires to instead select psychosocial rehabilitation or partial care, an addendum to the participant's individual service plan (ISP) must be submitted to the Department by December 31, 2010, and is required to delete the DD skill building service from the participant's ISP.

Likewise children will continue to receive their specific DD skill building service as of January 1, 2011 and will not be eligible to continue to receive psychosocial rehabilitation, unless the Department is notified by December 31, 2010 that psychosocial rehabilitation services are

desired instead. If the child participant or their guardian wants to select psychosocial rehabilitation services the guardian should contact the Office of Mental Health and Substance Abuse at (208) 364-1844.

Participants will continue to have mental health clinic services (psychotherapy and pharmacologic management) available to them, since these are not considered skill building services.

The Department requests that providers work together to assist participants, and comply with this benefit limitation.

Reduction of Adult DD Plan Development (Procedure Code G9007)

While the temporary rules are in effect, benefit modifications will be made to plan development from 12 to 6 hours per plan year. This reduction will align with existing plan development benefits for children and participants receiving MH service coordination which are already limited to six hours per plan year. It is important for adult DD plan developer providers to know that requirements have also been modified to correspond to the reduced benefit. The modifications are as follows:

The Department will no longer require plan developers to complete plan monitor summaries at either 6 or 12 months.

Plan developers are required to develop a plan using the person centered planning process that reflects the participant's interests and desires, their assessed needs, and that demonstrates services, supports, and goals that are appropriate.

Upon review by the Department, plan developers must be able to demonstrate that they have received, reviewed, and maintained the provider status reviews in the participant file, and that the information contained in the provider status reviews links to the participant's individual support plan. Plans should also reflect the participant and provider feedback in relation to ongoing programming and changes.

Plan Developers will no longer be required to submit copies of the provider status reviews with the Individual Support Plan (ISP) document.

Plan developers are not required to submit copies of provider status reviews to the Department. Plan developers should obtain these documents as a function of their plan monitoring requirements, and maintain copies of these documents in the participant files. Periodically, the Department may need to request copies of these documents for the care management process.

The Health and Well Being Checklist is being eliminated.

The health and wellbeing checklist has been eliminated. Several questions from the health and wellbeing checklist have been written into the personal summary section of the individual service plan instead. It is important for the plan developer to document any potential risks to the participant on the plan and then to identify how the risks will be resolved in the personal summary section of the ISP.

The requirements for addendums have been reduced.

Plan developers are not required to submit addendums to document changes in program goals being made by providers. These changes in goals should be reflected in the provider's documentation, and reported in the associated provider status reviews. Periodically, the Department may need to request copies of these documents for the care management process.

Addendums are required in the following circumstances:

- When there is an increase to plan cost
- When there is an addition of a service or an increase to a service
- When there is a new service provider

It is not necessary to send copies of provider program implementation plans (PIP) with the ISP document.

Plan developers are not required to submit copies of the provider program implementation plans to the Department with the ISP. Plan developers should obtain these documents as a function of their plan monitoring requirements, and maintain copies of these documents in the participant files. Periodically, the Department may need to request copies of these documents for the care management process.

It is not necessary to submit copies of the developmental assessment with the ISP document.

Plan developers are not required to submit copies of the developmental assessment to the Department with the ISP. Plan developers should obtain these documents as a function of their plan monitoring requirements, and maintain copies of these documents in the participant files. Periodically, the Department may need to request copies of these documents for the care management process.

A self calculating costing sheet template has been developed by the Department to replace the current costing sheet.

The Department has created a new costing sheet template which plan developers must use to replace the current costing sheet. The template is self calculating. This excel template has been designed to improve accuracy in calculations, and prevent the return of plans due to errors. You will find the costing sheet template on the Department of Health and Welfare's Web site at www.healthandwelfare.idaho.gov. (Click on Medical>Developmental Disabilities>Adult DD Care Management.)

Prior Authorizations for Adult DD Plan Development

While the temporary rules are in effect, beginning with date of service January 1, 2011, the plan development reimbursement for adult DD participants (procedure code G9007) will be limited to a total of six hours per participant plan year. You will continue to use your existing PA number. Your PA for plan development that was issued prior to December 31, 2010 will be automatically limited to a maximum of the unused portion up to 6 hours for the remainder of the plan year.

Please submit plan development billing for services provided on or before December 31, 2010, as soon as possible and no later than January 15, 2011, so that the system may correctly automate the adjustments needed to your PA. Providers are not required to submit addendums to the Department. You may verify plan development units remaining for each PA number through the Molina provider portal after January 15, 2011.

Reduction of Assessments by a DDA

While the temporary rules are in effect, beginning January 1, 2011, the reduction of assessment and diagnostic services for participants will be modified from 12 hours per year to 4 hours per year. The benefit for psychological assessment is not included in the 4 hour limitation and is separately limited to four hours per year for a psychologist or technician, and two additional hours for psychological testing, computer.

Requirements for assessments by DDA providers have been modified to reflect the reduction. Providers should comply with the following guidelines as related to assessment practices and in order to avoid duplication of unnecessary services:

Updating Assessments

The Department would like providers to know that new assessments are not mandated to occur each year. The Department expects providers to update assessments as indicated, and rules have been changed to reflect that updates be completed at least once every two years. To update an assessment and meet the requirements of the Department, the qualified professional in the respective discipline must document in the file that the given assessment continues to reflect the status of the participant.

When an assessment is documented as currently reflecting the participant's status at least once every two years, it is considered a current assessment and a new evaluation is not necessary. A new assessment may be completed if the qualified professional determines that the assessment does not reflect the participant's status.

Psychological Assessments

The requirement for a psychological assessment in the event of a DD participant's use of behavior modifying drugs has been eliminated by the Department. A psychological assessment must be current, as defined above, in the event of the following circumstances:

- Prior to use of restrictive interventions to modify inappropriate behavior
- When it is necessary to determine eligibility
- When a participant has been diagnosed with mental illness, or when a child has been identified to have a severe emotional disturbance
- A new psychological assessment should be completed when the participant's assessed needs or status is no longer accurately reflected by the assessment

Assessments for Adults

For adults, the Department or its contractor completes the annual level of care review including a SIB-R and a medical social developmental history, when necessary. Because the SIB-R and medical social developmental history is completed by the Department or its contractor, the provider is not required to duplicate a SIB-R or a medical social developmental history and should use those assessments as provided by the Department.

Assessments for Children

Providers of children’s DD services will comply with the guidance above related to updating assessments, current assessments, and psychological assessments. When a service is medically necessary, EPSDT services are available to children who have exhausted defined benefit limitations. Participants should refer to the IDHW Web site for more information about how to make an EPSDT request.

Assessments by a DDA	Procedure Code
Comprehensive Developmental Assessment	H2000
Occupational Therapy Assessment	97003
Physical Therapy Assessment	97001
Speech and Language Assessment	92506
Medical/Social History	T1028
Psychiatric Diagnostic Interview Examination	90801
Limitation for above Combined Assessments = 4 hrs	

Psychological Assessments by a DDA	Procedure Code
Psychological Testing-Psychologist	96101
Psychological Testing -Technician	96102 = 4 hrs
Psychological Testing- Computer	96103 = 2 hrs

Department's Standard Administrative Appeal Process

In an effort to streamline administrative activities, the Bureau of Developmental Disability Services will eliminate the step of reconsideration and any denial will be reconsidered as part of the Department's standard administrative appeal process found at IDAPA 16.05.03 "Rules Governing Contested Case Proceedings and Declaratory Rulings."

If you have additional questions about the changes in developmental disability benefits, please contact the policy subject matter expert for the Bureau of Developmental Disabilities in the Division of Medicaid at DDProviderQuestions@dhw.idaho.gov or via phone at (208) 334-0944.

LMC/rs