under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Certified Pediatric or Family Nurse Practitioners' Services. Certified pediatric or family nurse practitioners' services are those services provided by certified pediatric or family nurse practitioners as defined by state and federal law. This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a) (21) of the Act. Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code.

Physician Assistant Services. Physician assistant services include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.

Chiropractor Services. Chiropractic services are limited for payment to a total of six (6) office visits during any calendar year. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.

Podiatrist Services. Podiatrist Services are limited to treatment based on chronic care criteria and treatment of acute foot conditions that, if left untreated could cause an adverse outcome to the participant's health.

Optometrist Services. Optometrist services are limited to providing eye examination and eyeglasses covered under this State Plan unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services. Limitations for vision services are defined in section 3.P VISION SERVICES

Nurse-Midwife Services. Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

providers, outpatient rehabilitation facilities, and developmental disability agencies.

- Home health agency visits by home health aides, nursing services, physical therapists, occupational therapists, and speech-language pathologists in any combination are limited to a total of one-hundred (100) visits per participant per calendar year.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.N AUDIOLOGY SERVICES

The Basic Benchmark Benefit Package Audiology Services permitted under sections 1905(a)(6) and 2110(a)(24) of the Social Security Act. These services include services for individuals with hearing disorders provided by an audiologist who is licensed by the Idaho Speech and Hearing Services Licensure Board in accordance with {42 CFR 440.110(c)}.

Participants age 21 and Older:
Participants who are 21 years of age and older are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis.
Participants under the age of 21:
Services for participants who are under the age of 21 include audiometric services and supplies according to applicable Department rules. The Department will provide hearing screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens; the hearing screen is considered part of the medical screening service.

Hearing Aids. Hearing aids and related services for adults age 21 and over are not covered. Hearing aids for participants under the age of 21 will be covered by the Department.

Augmentative Communication Devices. Augmentative communication devices are covered as specified in applicable Department rules.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

- The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician. Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done.
- The Department will purchase medically necessary hearing aids for participants under the age of 21.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Follow up services are included in the purchase of the hearing aid for the two years. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist.

The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.

3.0 MEDICAL EQUIPMENT, SUPPLIES AND DEVICES

3.0.1 Medical Equipment and Supplies

The Basic Benchmark Benefit Package includes **Medical Equipment and Supplies** permitted under sections 1905(a)(12), 2110(a)(12) and 2110(a)(13) of the Social Security Act. These services include durable medical equipment and other medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home.

Medical equipment and medical supplies must be ordered in writing by a physician. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.

The Department requires recipients to obtain certain services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.P VISION SERVICES

The Basic Benchmark Benefit Package includes **Vision Services** permitted under sections 1905(a)(5), 1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

Vision Screening. The Department will provide vision-screening services for participants under the age of 21 according to the recommended guidelines of the American Academy of Pediatrics. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart).

The Department will pay for the following vision services and supplies.

Eye Examination.

- **Participants age 21 and older:** The Department will pay for vision exams if:
  - The Services are based on chronic care criteria and are necessary to monitor a chronic condition that could harm the person's vision.
  - The participant has an acute condition that, if left untreated, may cause permanent or chronic damage to the eye.
- **Participants under the age of 21:** The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month to determine the need for glasses to correct or treat refractive error. The participant may receive more frequent eye examinations if:
  - The participant experiences a significant vision change.
  - There is a medically necessary reason for the exam such as a foreign body in the eye, redness, etc.

Eyeglasses.

- Participants age 21 and older: The Department will pay for eyeglasses only when necessary to treat a medical condition and one pair following cataract surgery.
- Participants under the age of 21: Participants under the age of 21 who have been diagnosed with a visual defect and who need eyeglasses for correction of a refractive error, can receive one (1) pair of single vision or bifocal eyeglasses annually. Frames or lenses may be provided more frequently when:
  - There is a major visual change of plus or minus one-half (0.5) diopter of correction. There has been a major change in visual acuity documented by the physician and/or optometrist; and the necessary new lenses cannot be accommodated in the participant's existing frames

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

- Payment for tinted lenses for participants under the age of twenty-one (21) will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department.
- Contact lenses for participants age twenty-one (21) and older will only be covered if the lenses are necessary to treat a medical condition that can progressively impact the participant's health or vision such as keratoconus.
- Contact lenses for participants under the age of twenty-one will be covered only when there is documentation showing that the participant has an extreme condition precluding the use of conventional lenses including:
  - An extreme myopic condition requiring a correction equal to or greater than plus or minus ten (10) diopters,
  - Cataract surgery,
  - Keratoconus,
  - Anisometropia, or
  - Other extreme medical condition precluding the use of conventional lenses.
- Broken, lost, or missing glasses will not be repaired or replaced by the Department for individuals age twenty-one (21) and older.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Selective Contract. The Department requires recipients to obtain eyeglasses only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services

The State assures it will comply with 42CFR 431.54 as it relates to this fee-for-service selective contracting system.

3.Q DENTAL SERVICES

3.Q.1 Medical and Surgical Services

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

The Basic Benchmark Benefit Package includes Medical and Surgical Services furnished by a dentist permitted under sections 1905(a)(5)(B), and 2110(a)(17) of the Social Security Act (in accordance with section 1905(a)(5)(B) of the Act) are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the

Physician Assistant Services. Physician assistant services include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.

Chiropractor Services. Chiropractic services are limited for payment to a total of six (6) office visits during any calendar year. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.

Podiatrist Services. Podiatrist Services are limited to treatment based on chronic care criteria and for treatment of acute foot conditions that, if left untreated could cause an adverse outcome to the participant's health.

Optometrist Services. Optometrist services are limited to providing eye examination and eyeglasses covered under this State plan unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services. Limitations for vision services are defined in section 3.P VISION SERVICES

Nurse-Midwife Services. Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Certified nurse-midwife services are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.

3.F PRIMARY CARE CASE MANAGEMENT

The Enhanced Benchmark Benefit Package includes **Primary Care Case Management Services** permitted under in sections 1905(a)(25) and 2110(a)(21) of the Social Security Act. These services are provided by a primary care case manager consistent with a program authorized under section 1937 of the Social Security Act. All individuals opting into the Enhanced Benefit Package are required to enroll with a PCCM.

Respiratory care services may be furnished to Individuals less than twenty-one (21) years of age qualifying under EPSDT.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State Plan.

Physical therapy, occupational therapy, and speech-language pathology services are limited to:

- Twenty-five (25) physical therapy visits per calendar year; and
- Twenty-five (25) occupational therapy visits per calendar year; and
- Forty (40) speech-language pathologist visits per calendar year

Additional visits may be prior authorized when medically necessary. Included in this limitation are outpatient hospital facilities, independent therapy providers, and developmental disability agencies.

Home health agency visits by home health aides, nursing services, physical therapists, occupational therapists, and speech-language pathologists in any combination are limited to a total of one-hundred (100) visits per participant per calendar year. Included in the total visits are all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination. Audiology services are not provided for under home health services.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.N AUDIOLOGY SERVICES

The Enhanced Benchmark Benefit Package includes **Audiology Services** permitted under sections 1905(a)(6) and 2110(a)(24) of the Social Security Act. These services include services for individuals with hearing disorders provided by or under the supervision of an audiologist who is licensed by the Idaho Speech and Hearing Services Licensure Board in accordance with 42 CFR 440.110(c).

Participants Age 21 and Older: Participants who are 21 years of age and older are eligible to receive diagnostic screening services if they are necessary to obtain a differential diagnosis and have been ordered by a physician or midlevel practitioner. **Participants Under the Age of 21:** Services for participants under the age of 21 include audiometric services and supplies according to applicable Department rules. The Department will provide hearing screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens; the hearing screen is considered part of the medical screening service.

Hearing Aids. Hearing aids and related services for adults age 21 and over are not covered. Hearing aids for participants under the age of 21 will be covered by the Department.

Augmentative Communication Devices. Augmentative communication devices are covered as specified in applicable Department rules.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive additional audiology services services if determined to be medically necessary and prior authorized by the Department.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

- The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician. Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done.
- The Department will purchase medically necessary hearing aids for participants under the age of 21.
- Follow up services are included in the purchase of the hearing aid for the first two years. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis.

The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.0 MEDICAL EQUIPMENT, SUPPLIES AND DEVICES

3.0.1 Medical Equipment and Supplies

The Enhanced Benchmark Benefit Package includes **Medical Equipment and Supplies** permitted under sections 1905(a)(28), 2110(a)(12) and 2110(a)(13) of the Social Security Act. These services include durable medical equipment and other

Specialized Medical Equipment and Supplies are also covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.O.3 **Prosthetic Devices**

The Enhanced Benchmark Benefit Package includes **Prosthetic Devices** permitted under sections 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.P VISION SERVICES

The Enhanced Benchmark Benefit Package includes **Vision Services** permitted under sections 1905(a)(6), 1905(a)(5), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

Screening: The Department will provide vision-screening services for participants under the age of 21 according to the recommended guidelines of the American Academy of Pediatrics. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart).

ENHANCED PLAN
(For Individuals with Disabilities, Including Elders, or Special Health Needs)
BENCHMARK BENEFIT PACKAGE

The Department will pay for the following vision services and supplies:

Eye Examination:

- **Participants age 21 and older**: The Department will pay for vision exams if:
  - The Services are based on chronic care criteria and are necessary to monitor a chronic condition that could harm the person's vision.
  - The participant has an acute condition that, if left untreated, may cause permanent or chronic damage to the eye.
- **Participants under the age of 21:** The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period to determine the need for glasses to correct or treat refractive error. The participant may receive more frequent eye examinations if:
  - The participant experiences a significant vision change.
  - There is a medically necessary reason for the exam such as a foreign body in the eye, redness, etc.

Eyeglasses:

- **Participants age 21 and older**: The Department will pay for eyeglasses only when necessary to treat a medical condition or one pair following cataract surgery.
  - **Participants under the age of 21:** Participants under the age of 21 Eligible participants who have been diagnosed with a visual defect and who need eyeglasses to correct a refractive error, can receive one (1) pair of single vision or bifocal eyeglasses annually. Frames and lenses may be provided more frequently when:
  - There is a major visual change of plus or minus one-half (0.5).
  - There has been a major change in visual acuity documented by the physician and/or optometrist; and the medically necessary new lenses cannot be accommodated in the participant's existing frames.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under this State plan.

- Payment for tinted lenses will only be made for participants under the age of twenty-one (21) when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department. Contact lenses for participants age twenty-one (21) and older will only be covered if the lenses are necessary to treat a medical condition that can progressively impact the participant's health or vision (i.e. keratoconus). One pair of contacts or one set of frames and lenses is covered following cataract surgery.
- **Contact** lenses for participants under the age of twenty-one (21) will be covered only when there is documentation showing that the participant has an extreme condition precluding the use of conventional lenses including:
  - An extreme myopic condition requiring a correction equal to or greater than plus or minus ten (10) diopters,
  - Cataract surgery,
  - Keratoconus,
  - Anisometropia, or
  - Other extreme medical condition that precludes the use of conventional lenses.
- Broken, lost, or missing glasses will not be replaced by the Department, and are the responsibility of the participant age twenty-one (21) and older.

Selective Contract. The Department requires recipients to obtain eyeglasses only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42CFR 431.54 as it relates to this fee-for-service selective contracting system.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

5. a. Physicians — The Department's Medical Assistance Unit upper limit for reimbursement is the lower of: The physician's actual charge for a service; or

i. The maximum allowable charge as established by the Department's Medical Assistance Unit fee schedule

The fee schedule for these services and any annual/periodic adjustments to the fee schedule are published at the following web site:

http://www.healthandwelfare.idaho.gov

The fee schedule was last updated on 07/01/11 to be effective for services on or after 07/01/11.

If the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or

ii. The Medicare fee schedule for non patients for clinical diagnostic laboratory tests; or

iii. For the exceptions in Section 2303 (d) of the Deficit Reduction Act — providers will be reimbursed based on the Department's Medical Assistance Unit fee schedule as noted in section 5.a.i above.

5. b. Medical and surgical services furnished by a dentist – Payment will be determined in the same manner as physicians in Attachment 4.19-B.5.a.

6. Payment for the providers listed below in items a through d will be determined in the same manner as physicians in Attachment 4.19-B.5.a.

   a. Podiatrists - Care and treatment by podiatrists.

   b. Optometrists – Care and treatment by optometrists for vision services, and payment care by practitioners who are certified to treat and diagnose disease and injuries of the eye.

   c. Chiropractors – Treatment by chiropractors.

   d. Other Practitioner Services -

      i. Physician Assistants - Care and treatment by physician assistants.

      ii. Certified Registered Nurse Anesthetists (CRNA) – Services provided by CRNAs.