Table of Contents

Table of Figures

1. Section Modifications

Version	Section	Update	Publish Date	SME
26.0	All	Published version	1/29/15	TQD
25.1	2.1.5 National Correct Coding Initiative, and subsections 2.1.5.1 – 2.1.5.4	Section added	1/29/15	J Siroky C Taylor D Baker
25.0	All	Published version	12/18/14	TQD
24.2	2.1.6 Timely Filing Limit; 2.1.6.6 Medicare Processing; 2.1.6.12 Timely Filing Documentation	Changed “six months” to “365 days”	12/18/14	C Van Zile D Baker
24.1	2.7 Interpretation Services	Updated for clarity	12/18/14	F Trenkle-MacAllister C Taylor D Baker
24.0	All	Published version	9/25/14	TQD
23.2	2.8.1.2 Trading Partner Agreement	Updated TPA User Guide link	9/25/14	H McCain C Taylor
23.1	2.1.6.1 Documentation to Support Timely Filing	Added bullet for County Indigent Fund Notification	9/25/14	C Taylor
23.0	All	Published version	08/08/14	TQD
22.2	2.10.2 Exclusions	Changed “Prenatal Care” to “Normal pregnancy diagnoses”	08/08/14	C Taylor
22.1	2.9.1 Overview	Added PA requirement for claim	08/08/14	C Taylor
22.0	All	Published version	08/01/14	TQD
21.1	2.1.6 Timely Filing Limit; 2.1.6.2 Participant Eligibility; Figure 2-4: Timely Filing Chart	Changed “AS OF” date to “notice date”; removed figure 2-4: Retroactive Eligibility Letter/Notice of Action	08/01/14	C Taylor
21.0	All	Published version	7/7/14	TQD
20.2	Figure 2-5: Timely Filing Chart	Denials: deleted “a remittance advice or a letter from EDS saying that they are no longer processing claims.”	7/7/14	C Taylor D Baker
20.1	2.1.6.1. Documentation to Support Timely Filing	Updated to reflect current requirements	7/7/14	C Taylor D Baker
20.0	All	Published version	7/2/14	TQD
19.4	2.11.2.1 Part A Dually Eligible Claims – Hospital	Removed duplicate information	7/2/14	F Clarke T Kinzler
19.3	2.11.2 Billing Medicare	Updated for clarity	7/2/14	F Clarke T Kinzler
19.2	2.11.1 Overview	Updated for clarity and MMCP	7/2/14	F Clarke T Kinzler
19.1	2.3 Co-payments	Removed sentence that amount would be adjusted annually and Hospital bullet	7/2/14	A Coppinger C Taylor
19.0	All	Published version	5/23/14	TQD
18.1	2.1.2.1 Procedure Codes Without a Price on the Fee Schedule	Added section		A Coppinger C Taylor D Baker
18.0	All	Published version	4/18/14	TQD
17.2	2.10.7 Litigation Cases	Updated for clarity	4/18/14	J Kennedy-Gooch C Taylor
17.1	2.1.2 Procedure Codes	Added ICD-10 information	4/18/14	C Taylor
17.0	All	Published version	1/24/14	TQD

Version	Section	Update	Publish Date	SME
16.4	2.6 Hyperbaric Oxygen Treatment	Section added	1/24/14	C Taylor D Baker
16.3	2.11.1.1 Electronic Adjustments	Updated TPA User Guide name and link	1/24/14	C Taylor
16.2	2.7.4 Claim Status	Updated TPA User Guide name and link	1/24/14	C Taylor
16.1	2.4 Share of Cost	Updated TPA User Guide name and link	1/24/14	C Taylor
16.0	All	Published version	12/13/13	TQD
15.6	2.11.3	Changed “claim adjustment request form” to “Claim Review Request form”	12/13/13	C Taylor
15.5	2.11.1.1	Clarified that attachments can be submitted via EDI	12/13/13	C Taylor
15.4	2.8.2.1	Updated link for QIO provider manual	12/13/13	A Coppinger
15.3	2.8.3	Added statement about expedited appeals meeting definition of urgent care case	12/13/13	A Coppinger
15.2	2.8.1	Removed reference to the Traumatic Brain Injuries Waiver, which no longer exists.	12/13/13	M. Wasserman
15.0	All	Published version	8/30/13	TQD
14.2	2.9.2 Exclusions	Removed Mental health from bulleted list	8/30/13	C Burt / C Taylor
14.1	2.8.1 Overview	Removed Office of MH and Substance Abuse from first bulleted list. For Service Coordination services, removed (except for adults with mental illness) and added for children with special health needs.	8/30/13	C Burt / C Taylor
14.0	All	Published version	6/11/13	D Baker
13.1	2.5 Hospice Participants	Added paragraph on how to check if participant is on Hospice Medicaid Benefit	6/11/13	J Ehrhart
13.0	All	Published version	2/21/13	TQD
12.1	2.11.4 Claim Review Request	Added information	2/21/13	C Taylor
12.0	All	Published version	2/20/13	TQD
11.11	2.10.2.3 Split Claims	Updated information	2/20/13	C Taylor
11.10	2.10.2 Billing Medicare	Updated information	2/20/13	K McNeal
11.9	2.9.5 Split Claims	Updated information	2/20/13	J Kennedy-Gooch
11.8	2.9.4.3 Unacceptable Denial Codes	Updated information	2/20/13	J Kennedy-Gooch
11.7	2.9.4.2 TPR Fields on Paper Claim Forms	Updated table	2/20/13	J Kennedy-Gooch
11.6	2.9.4 Processing TPR Claims	Updated information	2/20/13	J Kennedy-Gooch
11.5	2.9.3.2 TPR Carrier Codes	Removed from document and put into the Reference section of the Provider Handbook.	2/20/13	J Kennedy-Gooch
11.4	2.9.3.1 TPR Coverage Codes	Updated list	2/20/13	J Kennedy-Gooch
11.3	2.9.2 Exclusions	Updated information	2/20/13	J Kennedy-Gooch
11.2	2.8.1 PA Overview	Updated list who can issue PA/ list of services that require PA	2/20/13	C Burt
11.1	2.2 COB	Added examples and additional verbiage for clarity	2/20/13	M Wood
11.0	All	Published version	10/12/12	TQD
10.3	2.3 Co-payments	Added list of providers that can have applicable co-payment	10/12/12	R Sosin
10.2	2.1.6.1 Timely Filing Documentation	Added to chart – Adjustments to Denied Claim	10/12/12	C Taylor
10.1	2.1.6 Timely Filing Limit; Adjustments of Paid or Denied Claims	Added Denied and updated paragraph.	10/12/12	C Taylor
10.0	All	Published version	9/21/12	TQD

Version	Section	Update	Publish Date	SME
9.7	2.10.6 Medicare/Medicaid Crossover Inquiries	Updated Noridian contact information	9/21/12	L Neal
9.6	2.9.4 Processing TPR Claims	Changed **Medicaid** to **Medicare** Remittance Notice	9/21/12	J Kennedy-Gooch
9.5	2.7.3.1 Examples of Documentation Necessary for Billing	Updated table	9/21/12	C Taylor
9.4	2.5 Hospice Participants	Updated for clarity	9/21/12	J Ehrhart
9.3	2.4 Share of Cost	Added section with more detailed information	9/21/12	N Peterson
9.2	2.3. Co-payments	Updated information	9/21/12	C Taylor
9.1	2.2 COB	Removed SOC information and moved to section 2.4	9/21/12	N Peterson
9.0	All	Published version	7/19/12	TQD
8.4	2.10 Oxygen Services	Removed section and added to Suppliers Guidelines	7/19/12	J Siroky
8.3	2.10 Oxygen Services	Added section	7/19/12	J Kennedy-Gooch
8.2	2.11.5 Medicaid Review of Claim Determination	Updated for clarity	7/19/12	J Kennedy-Gooch
8.1	2.11.4 Claim Review Request	Updated for clarity	7/19/12	J Kennedy-Gooch
8.0	All	Published version	5/23/12	TQD
7.5	2.7.3 Attachments	Added request that all attachments be legible. Added complete name of CMN.	5/23/12	D Decrevel
7.4	2.7.2.2 Mailing the Claim Form	Updated PO boxes	5/23/12	D Decrevel
7.3	2.2 Coordination of Benefits (COB)	Added information on SOC	5/23/12	C Taylor
7.2	2.1.6 Timely Filing Limit	Clarified EOB requirements	5/23/12	D Decrevel
7.1	2.10 Oxygen Services	Added section	5/23/12	C Taylor
7.0	All	Published Version	1/18/12	TQD
6.1	2.1.2 Procedure Codes	Added section	1/18/12	C Taylor
6.0	All	Published Version	11/23/11	TQD
5.13	2.3 Co-payments	Added section	11/23/11	R Sosin
5.12	2.2 Coordination of Benefits (COB)	Added section	11/23/11	M Wood
5.11	2.11 Adjustments	Updated section	11/23/11	D Bell
5.10	2.9.4 Processing Third Party Recovery (TPR) Claims	Updated section	11/23/11	K Mcneal
5.9	2.4 Hospice Participants	Updated section	11/23/11	K Mcneal
5.8	2.1.4 Determining How to Bill Units for 15-Minute Timed Codes	Updated section	11/23/11	K Mcneal
5.7	2.1.2 Procedure Codes	Updated section	11/23/11	K Mcneal
5.6	2.8.3 Claim Refund Payments	Updated section about making refunds to Medicaid	11/23/11	J Stroo
5.5	2.9.4 Processing Third Party Recovery (TPR) Claims	Updated for clarity	11/23/11	Molina
5.4	2.2 Coordination of Benefits (COB)	Updated paragraph	11/23/11	Molina
5.3	2.1.4 Determining How to Bill Units for 15-Minute Timed Codes	Added section for clarity	11/23/11	Molina
5.2	2.1.2 Procedure Codes	Added section for clarity	11/23/11	Molina
5.1	2.5 Interpretation Services	Moved up a level	11/23/11	J Siroky

Version	Section	Update	Publish Date	SME
5.0	All	Published version	8/4/11	TQD
4.1	2.10.4 Claim Review Request	Added back to document	8/4/11	J Stroo
4.0	All	Published version	7/29/11	TQD
3.7	2 General Billing Information	Added paragraph for dental coverage through Idaho Smiles	7/29/11	R Sosin
3.6	2.1.6 Timely Filing Limit	Revised to match June MedicAide article	7/29/11	J Stroo
3.5	2.9.4.1 Electronic Third Party Claims	Revised to discuss the Remittance Advice Remark Codes (RARC)	7/29/11	J Stroo
3.4	2.10 Claims for Dually Eligible Participants	Revised to clarify dually eligible/crossover	7/29/11	J Stroo
3.3	2.11.1.1, Electronic Adjustments	Revised for clarity	7/29/11	J Stroo
3.2	2.11.2 Denied Claims	Updated second paragraph	7/29/11	A Ramirez
3.1	2.9.4.4 Medicaid Participation	Updated Medicaid Participation for clarity. Medicaid will pay the lesser amount of the primary coinsurance/deductible or the Medicaid allowed amount.	7/29/11	C Stone
3.0	All	Published version	8/27/10	TQD
2.2	2.7.2.1 Vendor Software and Clearinghouses	Updated Completing the Claim Form	8/27/10	W Ingalls
2.1	2.1.6.1 Timely Filing Documentation	**Late Billing Documentation** Updated for clarity	8/27/10	M Wood
2.0	All	**Published version**	06/14/10	TQD
1.18	All	Sections were renumbered to accommodate additional information	06/14/10	C Stickney
1.17	2.1.1.3	**Hospice Participants** Updated for clarity	06/14/10	A Farmer
1.16	2.5	**Interpretation Services** Codes listed incorrectly. Updated section.	06/14/10	T Smith
1.15	2.5.1	**Diagnosis Codes** Added section for clarity	06/14/10	C Taylor
1.14	2.5.2.1	**Medicaid Identification Number** Updated section for clarity	06/14/10	T Kinzler
1.13	2.5.3.1.	**Signature on File** Updated section for clarity	06/14/10	T Kinzler
1.12	2.5.3.2	**Idaho Medicaid Provider Number** Updated section for clarity	06/14/10	T Kinzler
1.11	2.6	**Claims Submission** Updated section for clarity	06/14/10	T Kinzler
1.10	2.6.1.	**Electronic Claims Submission** Updated section for clarity	06/14/10	T Kinzler
1.9	2.6.1.1.	**Vendor Software and Clearinghouses** Updated section for clarity	06/14/10	T Kinzler
1.8	2.6.2.1.	**Completing the Claim Form** Updated section for clarity	06/14/10	T Kinzler
1.7	2.6.4	**Claim Status** Updated for clarity	06/14/10	T Kinzler
1.6	2.6.5	**Which Claim Form to Use** Updated section for clarity	06/14/10	T Kinzler
1.5	2.7	Previous section 1.3 **PA** Removed the following: *All claims for all services that require PA must include the PA number on the claim, whether the claim is electronic or paper.*	06/14/10	M Meints C Taylor

Version	Section	Update	Publish Date	SME
1.4	2.7.2	Previous Section 1.3.2. **Medicaid PA** Removed all information regarding PAs on claims.	06/14/10	M Meints C Taylor
1.3	2.9.2.2	Changed Part B Crossover Claims to Professional	06/14/10	M Meints
1.2	2.10.1.2	Paper Adjustments Updated for clarity	06/14/10	M Wood
1.1	2.10.4	Updated with information for pre-appeals	06/14/10	M Wood
1.0	All	Initial document – Published version	5/7/10	Molina/ TQD

2. General Billing Information

All Medicaid dental coverage is administered through Idaho Smiles as of July 1 2011, with the exception of those participants receiving dental benefits through a Medicare Advantage plan. Dentists may continue to enroll with Molina only for purposes of billing for interpretation services. No other claims are payable through Molina. All reimbursement for dental claims and services is handled through Idaho Smiles or Medicare Advantage plan carriers. Please call 1 (800) 936-0978 or visit the Idaho Smiles website for more information on this program.

2.1. Introduction

This section covers the basic billing information providers need to submit claims and adjustments to Idaho Medicaid. It describes Medicaid billing policies; how to submit Medicaid claims electronically, on paper, and online directly into Health PAS; how to check claim status; and where to get help with submitting claims. In addition, it describes the prior authorization (PA) process, third party liability (TPL), and claim review requests/pre-appeals/adjustments (both online and paper).

Note: The **Provider Handbooks** and **Companion Guides** are intended to provide basic program guidelines, however, in any case where the guidelines appear to contradict relevant provisions of the Idaho Code or rules, the code, or rules prevail.

Note: Information in this document relating to dental services applies only to dates of service up to and including June 30, 2011.

2.1.1. Online Portal Access

The Molina Medicaid website offers several options for providers such as:

- Check the status of a claim
- Check participant eligibility
- Check participant's co-pay
- Check participant's share of cost
- Check payment information
- Manually enter and submit a claim

The Molina Medicaid website also has documentation available such as:

- Companion Guides – (vendor specifications)
- Frequently Asked Questions (FAQs)
- User Guides
- Provider Guides
- New Provider Enrollment Application

Other information available at the Molina Medicaid website includes:

- MedicAide Newsletters
- Links to other websites that contain provider information
- Information Releases

The minimum system requirements for the Molina Medicaid website are shown on the next page.

Figure 2-1: Minimum System Requirements

Minimum	Recommended
Pentium II with CD-ROM	Pentium II with CD-ROM
Windows 2000/XP	Windows 2000, NT, ME, XP
MS Internet Explorer 5.5 or greater	MS Internet Explorer 5.5 or greater
64 Megabytes RAM	128 Megabytes RAM
800 X 600 Resolution	1024 X 768 Resolution
28.8 Baud rate modem or faster is preferred	33.6 Baud rate modem or faster
100 MB Free Hard Drive Space	100 MB Free Hard Drive Space
CD-ROM	CD-ROM
Printer with 8 pt MS Sans Serif is preferred	Printer with 8 pt MS Sans Serif

2.1.2. Procedure Codes

Idaho Medicaid follows national procedure codes as listed in the most current version of:

- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM through dates of service September 30, 2015)
- International Classification of Diseases Clinical Modification (ICD-10-PCS for dates of service October 1, 2015 and later)

2.1.2.1. Procedure Codes without a Price on the Fee Schedule

Procedure codes which appear on the Medicaid Fee Schedule without a price must have the following attachments for the code to be priced correctly. Claims without the required attachment will be priced at zero.

- For codes which do not require a prior authorization attach either:
  - Invoice showing provider cost. The code will be priced at cost plus 10%
  - Manufacturer's Suggested Retail Price (MSRP). The code will be priced at 75% of the MSRP.
- For codes which require a prior authorization:
  - Request the appropriate authorization with required medical justification before providing the service or item **and**
  - Attach the invoice or MSRP information.

2.1.3. Billing Procedure for Date Spanning

For CMS 1500 Claims, **non-consecutive** dates should not be spanned on a single claim detail. Providers risk claim denials due to duplicate logic, overlapping dates, and/or mutually exclusive edits.

When date spanning, services must have been provided for every day within that span. For example, it would be incorrect to date span the entire week or month when services were only performed on Thursday and Saturday within the same week or January 1 and January 10 within the same month.

Example:
For services provided to the participant on the following days:
Thursday, December 11, 2008
Saturday, December 13, 2008
…enter each date on a separate detail line.

Figure 2-2: Example of Date Spanning

Date(s) of Service	Procedure Code	Charges
12/11/2008 – 12/11/2008	XXXXX	$ XXX.XX
12/13/2008 – 12/13/2008	XXXXX	$ XXX.XX

2.1.4. Determining How to Bill Units for 15-Minute Timed Codes

Several CPT and HCPC codes used for evaluations, therapy modalities, procedures, and collateral contacts specify that one (1) unit equals 15 minutes. Providers must bill procedure codes for the services they delivered using CPT codes and the appropriate number of units of service. For any single CPT code, providers may bill a single 15-minute unit for treatment that is greater than or equal to eight (8) minutes. Two units should be billed when the interaction with the participant or collateral contact is greater than or equal to 23 minutes but is less than 38 minutes. Time intervals for larger numbers of units are as follows.

Figure 2-3: Units for 15-Minute Timed Codes

Number of Units	Time Interval
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for less than eight (8) minutes. The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

The above schedule of units is intended to provide assistance in rounding time into 15-minute increments for billing purposes. It does not imply that any minute until the eighth should be excluded from the total count because the time that is counted for active treatment includes all time. The beginning and ending time of the treatment must be recorded in the participant's medical record with a note describing the treatment.

(For additional guidance please consult *CMS Program Memorandum Transmittal AB-00-14*.)

2.1.5. National Correct Coding Initiative

2.1.5.1. Medicaid NCCI Methodologies

The National Correct Coding Initiative (NCCI) is a program developed by CMS that uses correct coding methodologies to reduce overpayments to providers due to incorrect coding

on claims. Section 6507 of the Affordable Care Act directed all State Medicaid programs to implement use of NCCI methodologies that are "compatible" with claims filed with Medicaid. This is to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid.

Federal law mandates that the NCCI edits be implemented. These edits supersede the Medicaid State Plan, all Idaho Medicaid policies, MedicAide articles, and other guidance provided.

There are two types of edits, including:

1. NCCI edits, or procedure-to-procedure (PTP) edits, that define pairs of HCPCS/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The Medicaid NCCI edits apply to claims that contain the following:
    - Same Provider
    - Same Participant
    - Same Date of Service

2. Medically Unlikely Edits (MUEs), or units-of-service edits, that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g., claims for excision of more than one gallbladder or more than one pancreas).

2.1.5.2. Modifiers

A number of NCCI edits allow providers to use modifiers to indicate medical necessity for procedures or services that are distinct or separate. Effective January 1, 2015, CMS established four new modifiers to define subsets of Modifier 59, Distinct Procedural Services, to be used by all State Medicaid Programs.

Modifier 59 is the most widely-used HCPCS modifier. Modifier 59 is for use in a wide variety of circumstances, and is often incorrectly applied to bypass National Correct Coding Initiative (NCCI) edits.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The introduction of subset modifiers is designed to reduce improper use of modifier 59 and help to improve claims processing for providers. The four new modifiers are:

- XE Separate Encounter: A service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.
- XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
- XP Separate Practitioner: A service that is distinct because it was performed by a different practitioner.
- XU Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

Idaho Medicaid will continue to recognize modifier 59; however, the 59 modifier should not be used when a more descriptive modifier is available.
Idaho, through the NCCI edits, may selectively require a more specific modifier –X{E, P, S, or U} for billing certain codes at high risk for incorrect billing. For example, a particular

NCCI PTP code pair may be identified as payable only with the XE separate encounter modifier, but not the 59 or other X{E, P, S, or U} modifiers. The X{E, P, S, or U} modifiers are more selective versions of the 59 modifier, so it would be incorrect to include both modifiers on the same line.

More extensive information about use of one of these modifiers can be found at the CMS Medicaid NCCI website.

2.1.5.3. Zero Medically Unlikely Edits (MUE)

To ensure patient safety, Medicare, in October 2012, implemented an outpatient hospital medically unlikely edit (MUE) of zero to any services that should be limited to an inpatient hospital setting. Due to Medicare and Medicaid's shared safety concerns, Centers for Medicare and Medicaid Services (CMS) implemented these edits without facilitating comment from the medical community. This place of service edit is effective for claims submitted for dates of service on or after April 1, 2013. A list of Medicaid MUE of Zero procedures on the Inpatient only list settings is available on www.medicaid.gov; see the links under **Medicaid NCCI Edit Files**. Modifiers cannot be used to override the zero MUE.

2.1.5.4. State Flexibility

Idaho may not override an edit through the prior authorization process. The state may seek an exemption from CMS for an individual code only when the MUE is contrary to state policy, such as the case where Idaho instructs a provider to bill in 15 minute increments and the national code description does not designate a time frame for the code.

NCCI edits are updated on a quarterly basis, with new edits added each quarter. For additional information and instruction as well as lists of current edits, providers should access the Medicaid NCCI page referenced above.

2.1.6. Medicaid Billing Policies

Once enrolled, providers may begin billing for services rendered to Idaho Medicaid participants. Providers are not obligated to accept all Medicaid participants on an ongoing, day-to-day basis. Provider enrollment signifies only that a provider may bill Medicaid. Providers should charge their usual and customary fee for services and submit those charges to Medicaid for payment consideration.

Providers must accept payment from Medicaid as payment in full for services rendered if they bill Medicaid for covered services. Non-covered Medicaid services can be billed to the participant. Medicaid requires that the provider inform the participant, preferably in writing, prior to rendering the service if the service is not covered or if a particular covered service will not be billed to Medicaid. If the participant agrees to pay for the service prior to the delivery of the service, then the provider may bill the participant for the entire amount of the fee.

If the participant has other insurance and the service is submitted for Medicaid payment, the provider must bill the third party insurance and complete all the billing requirements for that carrier first, and then bill Medicaid. In this case, the participant cannot be billed for the difference between the Medicaid allowed amount and the usual and customary charge or the difference between the Medicaid allowed amount and the provider's standard charge for the service.

2.1.6.1. Service Limitations

Medicaid policy restricts certain services. These restrictions are referred to as service limitations. Each procedure and revenue code may be reviewed for a variety of limitation criteria. Examples of these criteria are:

- Same provider or regardless of provider
- Time frame (yearly, calendar time period, or specific number of days)
- Number of dollars, per time frame
- Units
- Required justification (such as reports, test results, time of treatment)
- Pregnancy
- Age of participant
- Lifetime procedures

Some services with exceeded limitations may be covered with specific required justification or a PA. Refer to your specific *Provider Guidelines* carefully for any service limitations.

2.1.7. Timely Filing Limit

Timely filing refers to the requirement that a complete claim must be submitted to any carrier within a time period specified by the carrier.

For an Idaho Medicaid claim to be considered as filed on a timely basis, the complete claim must be submitted within 12 months (365 days) of the date of service or in the case of a date range from the start date of service. There are two exceptions to this requirement:

1) Services for dually eligible participants (those who have both Medicare and Medicaid) must be billed to Idaho Medicaid within 365 days of the date of payment/date of the explanation of benefits (EOB) or Medicare Remittance Notice (MRN). (See the *Medicare Processing* section below for more information on processing paid or denied Medicare claims.)
2) If the participant is approved for Medicaid coverage after the date of service, there will be a special letter issued by IDHW called a Notice of Action explaining the retroactive eligibility. To be considered within the timely filing limits, the claim for this participant must be submitted within 12 months (365 days) of the *notice* date on the letter. (See the *Participant Eligibility* section below for more information.)

Claims which are submitted within the timely filing period do not need to be paid to be considered for timely filing. They can be paid, pended, or denied as long as they are in the processing system within 365 days of the start date of service.

2.1.7.1. Documentation to Support Timely Filing

When billing Medicaid, it is important to keep the documentation that confirms that you billed initially within the timely filing period in case you must resubmit the claim after the end of the timely filing period. That support information is required in order to process your resubmission. Documentation that supports timely filing includes:

- EDI rejection report
- Return to Provider letter from any Medicaid fiscal agent
- Paper claims require an EOB from Medicare which displays the paid date
- Retro Eligibility document/Notice of Action for the participant
- County Indigent Fund Notification

When you send an EOB from any payer for any reason, it is required that you include the other payer's processing information to support the claim you are submitting. Additional

required documentation from the other payer is the page which explains the applicable remark codes so the payment/denial information can be correctly interpreted.

The documentation can be mailed with a paper claim or scanned and attached to your Health PAS-OnLine entry.

To identify the date of a previous submission, look at the Julian date in the claim number on a Molina MMIS claim or in the ICN on an HP/EDS claim.

- For a Molina claim look at the 3rd, 4th, and 5th digits of the claim number
- For an HP/EDS claim look at the 5th, 6th, and 7th digits of the ICN

There is additional information under the ICN entry found in the Glossary of the Provider Handbook.

2.1.7.2. Participant Eligibility

Claims for Idaho Medicaid participants who receive retroactive eligibility must be submitted within 365 days from the notice date on the retroactive eligibility approval letter which was issued to the participant. The retroactive eligibility approval letter, also called the *Notice of Action*, should be attached to the claim for timely filing documentation.

Figure 2-4: Retroactive Eligibility Letter / Notice of Action

If the initial claim is submitted electronically in a timely manner without a participant Medicaid identification number (MID) or with an invalid MID, the claim transaction will be rejected and an EDI transaction rejection report will be generated. This must be retained as documentation of timely filing. If the claim is submitted on paper, the provider will be mailed a Return to Provider (RTP) letter, which must be kept for documentation to support timely filing.

Once a provider has acquired the participant's MID, the claim must be submitted within 365 days of the notice date on the retroactive eligibility letter with supporting documentation, including a copy of the participant's retroactive eligibility letter/Notice of Action and either the EDI transaction rejection notice or the RTP letter.

2.1.7.3. Additional Services on a Resubmitted Claim

If a claim is resubmitted more than 365 days after the date of service with proof of timely filing attached, but the claim includes services that did not appear on the original claim, those additional services will be denied. Additional services that need processing and payment should be submitted on a separate claim form with required documentation if that submission is more than 365 days from the date of service.

2.1.7.4. Resubmissions of Denied Claims

An original claim must be submitted within 365 days of the date of service. If more than 365 days have elapsed since the date of service, and the claim was not submitted originally within 365 days of the start date, the system will pend the claim for review. If the appropriate documentation is not attached (a copy of the remittance advice (RA) with the denial, a copy of retro eligibility notice, etc.), the claim will be denied. Denied claims or claim details must be resubmitted as a new claim. If any portion of the original claim was paid, the claim must be adjusted rather than resubmitted. See *Adjustments of Paid or Denied Claims*.

Denied claims may be resubmitted on paper or through your Trading Partner Account online at www.idmedicaid.com, but must be for the same services submitted on the original claim. If new services need to be billed, they must be submitted on a separate claim form with appropriate documentation to avoid having those additional services denied for timely filing.

2.1.7.5. Adjustments of Paid or Denied Claims

Adjustments to paid or denied claims must be made within two years after the payment was issued on the original claim or within two years from the date of denial.

Adjusted claims may be resubmitted on paper or online, but must be for the same services submitted on the original claim. If new services need to be billed, they must be submitted in a separate claim with appropriate documentation to avoid having those services denied for timely filing. If requesting an adjustment on ***paper***, include the original claim number/ICN and the claim frequency code in Field 22 on the CMS 1500 and Field 64 on the UB-04.

We recommend using your online Trading Partner Account to process the paid claim so the link between the original timely submission and the adjusted claim are retained. It will still be necessary to attach the RA from the denied submission. The online claim will retain the same claim number or internal claim control number (ICN) as the original claim with a two-character extension that begins with an “A.” For example, if this is the first resubmission, it would be “A1.”

2.1.7.6. Medicare Processing

A participant who has both Medicare coverage and Medicaid coverage is considered dually eligible. See *Section 2.11* for more information about participants with dual eligibility.

Be sure to bill Medicare first for any services and follow their billing requirements. If Medicare denies a claim for timely filing, Medicaid will also deny it for timely filing. Most of the time claims processed by Medicare are sent electronically to Medicaid for processing by Medicaid; these electronically forwarded claims are called crossover claims.

If the Medicare claim is not included in the electronic crossover or for those situations where it is necessary to bill Medicaid after Medicare has paid, it is necessary to submit a paper claim or an electronic claim within 365 days of the of the date of the Medicare payment. That date will be the date of the explanation of benefits (EOB)/Medicare Remittance Notice (MRN). The applicable EOB/MRN should be attached to the claim; be sure to include the page with the processing information about the claim you are submitting and the page that explains the applicable remark codes.

2.1.7.7. Medicare Advantage

To insure the claim is processed correctly, claim forms must be filled out completely. If the EOB does not designate Medicare Advantage, specify which plan is indicated in box 9D or 11C on the CMS-1500. On the UB-04, indicate the plan in box 50.

2.1.7.8. Medicare Claims with Valid Denials

Medicare claims with valid denials are processed as straight Medicaid claims (not Medicare primary claims). Also, they are subject to the Medicaid timely filing requirement that the claim must be submitted within 365 days of the start date of service. The Medicare Remittance Notice (MRN) should be included with the claim whether submitted on paper or online.

2.1.7.9. Third Party Insurance

If the participant has third party insurance other than Medicare, the claim must be submitted to Idaho Medicaid within 365 days of the date of service *regardless* of whether the other insurance has processed the claim or has paid or denied the claim. Claims denied by third party carriers for timely filing will also be denied by Idaho Medicaid. Be sure to include with your submission the third party insurance explanation of benefits (EOB), including both the page with the information about the claim, and the explanations of any remark codes.

2.1.7.10. Prior Authorization

Claims requiring Prior Authorization (PA) must be submitted within 365 days of the date of service *regardless* of the date the PA was issued.

2.1.7.11. Provider Retroactive Eligibility

If the provider was not enrolled on the participant's date of service, the claim must still be submitted within 365 days of the date of service regardless of the provider's enrollment date.

2.1.7.12. Timely Filing Documentation

The following table is a quick reference guide for timely filing.

Figure 2-5: Timely Filing Chart

Claim Type Description	Submission Rule
Original Claim	Claim must be submitted within 12 months (365 days) of the date of service. There are two exceptions: • Claims paid by Medicare must be billed to Medicaid within 365 days of the Medicare payment date. • Claims for members with retroactive eligibility must be billed within 12 months/365 days of notice date in the retroactive eligibility letter/Notice of Action.
Submitting EOBs as Proof of Timely Filing	When sending an EOB to support timely filing, be sure to send the page which applies to the resubmitted claims AND the page that explains all associated remark codes.
Participant Retroactive Eligibility	Claim must be submitted within 12 months (365 days) of the notice date on the retroactive eligibility letter/Notice of Action.

Claim Type Description	Submission Rule
Additional Services on Resubmitted Claim	Additional services on the resubmitted claim which do not appear on the original claim will be denied; resubmit them on a separate claim with supporting documentation to show that the additional services were billed with the timely filing requirements.
Denials	Claims should be submitted within 12 months (365 days) of the date of service. If more than a year has elapsed since the date of service, proof of timely filing must be attached to a resubmitted claim. Idaho Medicaid will consider EDS claims for payment if proof of timely submission is documented; examples include an RTP letter or an electronic rejection report.
Adjustments to Denied Claim	Adjustment/adjustment request must be submitted within two (2) years from the date of denial as shown on the Medicaid RA.
Adjustments to Paid Claim	Adjustment/adjustment request must be submitted within two (2) years after the payment from ID Medicaid was made as shown on the Medicaid RA.
Medicare Crossover and Dually Eligible Claim	Claim must be submitted within 365 days of the date of payment or date of the EOB of the Medicare claim; attach the MRN. Medicare claims with valid denials are processed as straight Medicaid claims and are subject to the Medicaid requirement to submit within 365 days of the date of service.
Other Insurance	Claim must be submitted initially within 12 months (365 days) of the date of service regardless of the date of payment or date of denial by the other insurance; attach the EOB.
Claim Requiring PA	Claim must be submitted within 12 months (365 days) of the date of service regardless of the date of issue of the PA.
Provider Retroactive Eligibility	Claim must be submitted within 12 months (365 days) of the date of service regardless of the PROVIDER'S enrollment date.

2.2. Coordination of Benefits (COB)

The Coordination of Benefits (COB) calculation is performed at the HEADER level of all claims. COB calculation is not performed line by line. COB amounts entered at the claim detail level are summed up for the claim and then the COB calculation is performed. The payment is then distributed to the claim detail lines.
Note: It is necessary to report the Medicare / Other Insurance allowed amount, coinsurance amount, deductible amount and paid amount accurately for correct payment consideration.

Participant Claims with Commercial/Comprehensive Insurance as the Primary Carrier

The system will apply COB Method 10 to the Claims processing.

- Calculation for Method 10 based on lesser of 2 calculations:
  - Difference between primary insurance allowed and paid amounts.
  - Difference of Medicaid allowed and primary insurance payment amount.

1. Provider Billed Amount $100.00
   Medicaid Allowed Amount 80.00
   Insurance Payment 80.00
   Medicaid Payment **0.00**

2. Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	50.00
Medicaid Payment	**30.00**

3. Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	90.00
Medicaid Payment	**0.00**

NOTE: Medicare Excluded Services do not require a Medicare Remittance Notice (MRN) to be considered by Medicaid for a Medicare participant. If the Member's coverage is handled through a private insurance carrier that is ***not*** Medicare, then the provider must submit an Explanation of Benefits (EOB) from the primary insurance. In the past, Medicare Excluded Services did not require and EOB or MRN regardless of coverage, now only Medicare coverage will be considered when determining if an EOB or MRN is required.

Participants Enrolled as 'QMB Only' Will Have Medicare as the Primary Carrier

- The system will apply COB Method 12 to the claims processing.
    - Calculation will pay the Medicare coinsurance and Medicare deductible only for Professional and Institutional Claims.

Provider Billed Amount: $100.00
Medicare Allowed Amount: $80.00
Medicare Paid Amount: $64.00
Medicare Deductible: $0.00
Medicare Co-Insurance: $16.00
Medicaid Allowed Amount: $70.00
Medicaid Payment: $16.00

Provider Billed Amount: $100.00
Medicare Allowed Amount: $60.00
Medicare Paid Amount: $24.00
Medicare Deductible: $20.00
Medicare Co-Insurance: $16.00
Medicaid Allowed Amount: $80.00
Medicaid Payment: $36.00

*****Medicare Non-Covered Services (No payment received from Medicare):

Provider Billed Amount: $100.00
Medicare Allowed Amount: $0.00
Medicare Paid Amount: $0.00
Medicare Deductible: $0.00
Medicare Co-Insurance: $0.00
Medicaid Allowed Amount: $0.00
Medicaid Payment: $0.00

***Note**: No payments are made for Medicare non-covered services.

Members with Medicare A and/or Medicare B Who Are Not QMB Only

The system will apply COB Method 9 to the claims processing (with some exceptions based on provider and/or claim type.

Calculation for **Method 9 (Professional Claims)** is to pay the lesser of:

A. the Medicare co-insurance and deductible, or
B. the Medicaid allowed amount minus the Medicare payment.

Professional Claims:

Calculation A	Calculation B	Lesser of
Provider Billed Amount: $100.00 Medicare Allowed Amount: $80.00 Medicare Paid Amount: $64.00 **Medicare Deductible: $0.00** **Medicare Co-Insurance: $16.00** Medicaid Allowed Amount: $70.00 **Calculated Medicaid Payment: $16.00**	Provider Billed Amount: $100.00 Medicare Allowed Amount: $80.00 **Medicare Paid Amount: $64.00** Medicare Deductible: $0.00 Medicare Co-Insurance: $16.00 **Medicaid Allowed Amount: $70.00** **Calculated Medicaid Payment: $6.00**	A = $16 B = $6 **Medicaid will pay $6**
Provider Billed Amount: $100.00 Medicare Allowed Amount: $80.00 Medicare Paid Amount: $64.00 **Medicare Deductible: $0.00** **Medicare Co-Insurance: $16.00** Medicaid Allowed Amount: $60.00 **Calculated Medicaid Payment: $16.00**	Provider Billed Amount: $100.00 Medicare Allowed Amount: $80.00 **Medicare Paid Amount: $64.00** Medicare Deductible: $0.00 Medicare Co-Insurance: $16.00 **Medicaid Allowed Amount: $60.00** **Calculated Medicaid Payment: $0.00**	A = $16 B = $0 **Medicaid will pay $0**
Provider Billed Amount: $100.00 Medicare Allowed Amount: $80.00 Medicare Paid Amount: $64.00 **Medicare Deductible: $8.00** **Medicare Co-Insurance: $8.00** Medicaid Allowed Amount: $90.00 **Calculated Medicaid Payment: $16.00**	Provider Billed Amount: $100.00 Medicare Allowed Amount: $80.00 **Medicare Paid Amount: $64.00** Medicare Deductible: $8.00 Medicare Co-Insurance: $8.00 **Medicaid Allowed Amount: $90.00** **Calculated Medicaid Payment: $26.00**	A = $16 B = $26 **Medicaid will pay $16**

Calculation for **Method 9 (Institutional Claims)** is to pay the Medicare Coinsurance and Deductible.

Institutional/Facility Claims:

- Provider Billed Amount: $1000.00
- Medicare Allowed Amount: $800.00
- Medicare Paid Amount: $640.00
- Medicare Co-Insurance: $160.00
- Medicaid Allowed Amount: $70.00
- Medicaid Payment: $160.00

Institutional/Facility Claims:

- Provider Billed Amount: $1000.00
- Medicare Allowed Amount: $800.00
- Medicare Paid Amount: $640.00
- Medicare Co-Insurance: $160.00
- Medicaid Allowed Amount: $200.00
- Medicaid Payment: $160.00

Exceptions:

Professional Claims for Medicare Non-covered Service
Calculation for Method 9 is to pay the lesser of:

A. the Medicare co-insurance and deductible,
B. the Medicaid allowed amount minus the Medicare payment unless Medicare reports zero (0) for non-covered services, then claims DHW are processed the claim as Primary and pays the Medicaid allowed amount.

Provider Billed Amount: $100.00
Medicare Allowed Amount: $0.00 (Medicare non-covered)
Medicare Paid Amount: $0
Medicare Co-Insurance: $0
Medicaid Allowed Amount: $60.00
Medicaid Payment: $60.00

Long Term Care Facility claims are processed based on a custom calculation:

- Medicaid contracted amount minus the primary carrier payment(s) – a primary carrier payment is any payment from a commercial and/or Medicare carrier.
- Then minus any unpaid Share of Cost (SOC) amount.

Provider Billed Amount: $1,000.00
Insurance Allowed Amount: $800.00
Insurance Payment: $640.00
Insurance Co-Insurance: $160.00
Medicaid Contract Amount: $700.00
Share of Cost (SOC): $0.00
Medicaid Payment: $60.00

Provider Billed Amount: $1,000.00
Insurance Allowed Amount: $800.00
Insurance Payment: $640.00
Insurance Co-Insurance: $160.00
Medicaid Contract Amount: $600.00
Share of Cost (SOC): $0.00
Medicaid Payment: $0.00

Provider Billed Amount: $1,000.00
Insurance Allowed Amount: $800.00
Insurance Payment: $640.00
Insurance Co-Insurance: $160.00
Medicaid Contract Amount: $750.00
Share of Cost (SOC): $100.00
Medicaid Payment: $10.00

FQHC/RHC/IHC claims are processed based on a custom calculation:

- The Medicaid contracted amount minus the primary carrier payment(s)

Provider Billed Amount: $100.00
Insurance Allowed Amount: $80.00
Insurance Payment: $64.00
Insurance Co-Insurance: $16.00
Medicaid Contract Amount: $70.00
Medicaid Payment: $6.00

Provider Billed Amount: $100.00
Insurance Allowed Amount: $80.00
Insurance Payment: $64.00
Insurance Co-Insurance: $16.00
Medicaid Contract Amount: $60.00
Medicaid Payment: $0.00

Claims for members enrolled in **Medicare Advantage Programs** are processed using **Method 9**.

Medicare Covered/Medicare Non-covered

Claims submitted with both Medicare covered and Medicare non-covered services on the same claim will be denied. The provider must split bill covered and non-covered services.

The exception to this rule is when the provider reports modifiers GY or GZ on a Medicare non-covered service for which they expect no payment from Idaho Medicaid. This is the only time covered and non-covered services will be allowed together on same claim.

Authorization Requirements

When Medicare is the primary carrier for payment, the authorization requirement for DHW does not apply. Medicare guidelines are followed. If Medicare denies the claim, Idaho Medicaid becomes the primary payer and Idaho Medicaid's prior authorization, processing, and payment rules apply.

Documentation Requirements
When Medicare is the primary carrier for payment and payment has been made, the requirement for documentation from DHW does not apply. Medicare guidelines are followed. If Medicare denies the claim, Idaho Medicaid becomes the primary payer and Idaho Medicaid's documentation, processing, and payment rules apply.

Crossover Claims
Crossover claims may require rebilling to Medicaid with appropriate Medicaid approved coding for consideration, for example, FQHC/RHC/IHC, LTC.

2.3. Co-payments

The provider of services is responsible for collection of the copayment from the participant. The co-pay starts at $3.65.

Visits to the following providers can have an applicable co-payment:

- Chiropractor
- Podiatrist
- Optometrist
- Physical, Occupational &Speech Therapies
- Physicians & mid-levels (NP or PA)
- FQHCs & RHCS

When checking a participant's eligibility using any of the various available methods, the response will contain information regarding whether or not the participant is subject to co-pay requirements. The response will return a co-pay indicator of "Exempt" or $3.65. If the dollar amount is indicated and co-pay ratio to the Medicaid reimbursement for the visit (according to the Medicaid Fee Schedule) is more than 10%, you may charge the participant the co-pay.

If the participant is unable to make the co-pay you have three options, you may:

- Bill the participant for the co-pay
- Refuse to provide services that day or
- Waive the co-pay

The provider may choose to waive payment of any co-pay. The provider must have a written policy describing the criteria for enforcing collection of co-payments and when the co-pay may be waived. When the co-pay is applicable, the provider's reimbursement will be reduced by the amount of the co-pay regardless of whether or not the co-pay was charged or collected by the provider. Please refer to the Co-pay Guide on the Molina Medicaid website for more information.

2.4. Share of Cost (SOC)

Share of Cost (SOC) is a financial arrangement for a participant to pay a specific portion of the monthly costs associated with a service. Share of Cost is associated to participants with a Developmental Disability Waiver, Aged and Disabled Waiver, or Skilled Nursing Facilities or ICF/ID Facilities (i.e. Long Term Care).

There are three eligibility categories (referred to as Rate Codes):

- Rate Code 14: Developmental Disability Waiver
- Rate Code 15: Aged and Disabled Waiver
- Rate Code 17: Skilled Nursing Facilities (Long Term Care) or ICF/ID Facilities

It is the provider's responsibility to verify the participant's SOC each month and collect this from the participant. The provider's allowable reimbursement will be reduced by the amount of the applicable SOC on a first claim in basis until the full amount of the SOC has been offset. Refer to *General Provider and Participant Information*, section on *Verifying Participant Eligibility,* and the *Eligibility Verification* section of the *Trading Partner Account (TPA) User Guide*.

Claims submitted that have applicable SOC must not span over multiple months. They must be billed within a single month on a claim.

2.4.1. Discrepancy Contact Information

If the participant or provider believes that the SOC amount is based on outdated or incomplete information, the participant or participant's personal representative should contact Self Reliance at 1 (877) 456-1233 to review the information used in the SOC calculation.

If there is a variance between the SOC identified in the participant's notification letter and what was reported on the participants SOC eligibility verification, an e-mail may be sent to SOCdiscrepancies@dhw.idaho.gov, or a fax may be sent to 1 (208) 334-5571 using the Fax Cover Sheet found on the Molina Medicaid website, under **Forms**, Provider Documents.

2.4.2. Paid Claim Discrepancies

If there is a variance between the amount of SOC offset on a claim and the amount reported during the SOC participant eligibility verification, the provider can complete the Nursing Home and Waiver Share of Cost (SOC) Review Request form e-mailed to idnursinghomes@molinahealthcare.com. This form is available online under Forms. The instructions to fill out the form are in the same location. All fields in the forms are ***required***.

2.5. Hospice Participants

When a participant is on hospice care, the hospice agency is responsible for all services related to the hospice diagnosis. If a provider bills for services that are not related to the participant's hospice diagnosis, in order to expedite payment, the provider may

- Submit a paper claim and add a comment in field 19 of the CMS 1500 claim form or field 80 of the paper UB04 claim form saying "services not related to hospice diagnosis" or if services are pre-existing to "Hospice enrollment".
- Submit a claim via the direct data entry (DDE) option, using the Molina Medicaid Provider secure website and attach supporting documentation that the services are not related to the Hospice diagnosis. Supporting documentation can include a physician visit note or a letter with a narrative explaining why the care/service given was not related to hospice. The letter can be from a doctor, nurse, therapist, or the billing office.

Any issues or questions concerning services for hospice participants regarding related or non-related charges should be referred to the hospice provider.

Medical Care Management
P.O. Box 83720
Boise, ID 83720-0009
Phone 1 (208) 364-1839
FAX 1 (877) 314-8779

In order to check if a participant is on the Hospice Medicaid Benefit, call Molina Medicaid at 1 (866) 686-4272. Ask the customer service representative to check the member record to see if a hospice alert is present for the claim date of service.

2.6. Hyperbaric Oxygen Treatment

Idaho Medicaid follows Medicare criteria for coverage of most services including Hyperbaric Oxygen (HBO) Therapy. HBO therapy is a technique of delivering higher pressures of oxygen to the tissues. Two methods of administration are available including topical and systemic HBO therapy.

Topical HBO therapy is a technique of delivering 100% oxygen directly to an open, moist wound at a pressure slightly higher than atmospheric pressure. Topical HBO therapy (i.e., exposure of isolated parts of the body to 100% oxygen) is considered investigational, and is not covered by Idaho Medicaid.

In systemic hyperbaric oxygen therapy, the patient is entirely enclosed in a pressurized chamber and breathes oxygen at a pressure greater than one atmosphere (the pressure of oxygen at sea level).

This technique relies on the systemic circulation to deliver highly oxygenated blood to the target site, typically a wound. In addition, systemic hyperbaric oxygen therapy can be used to treat systemic illness such as air or gas embolism, carbon monoxide poisoning, and Clostridial gas gangrene. Treatment may be carried out either in a monoplace (one person) chamber pressurized with oxygen or in a larger, multiplace (two or more persons) chamber pressurized with compressed air, in which case the patient receives pure oxygen by mask, head tent, or endotracheal tube.

Systemic HBO pressurization in a monoplace or multiplace chamber may be considered medically necessary in the treatment of the following conditions:

- Acute carbon monoxide intoxication.
- Decompression illness.
- Gas embolism.
- Gas gangrene.
- Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with
- Accepted standard therapeutic measures when loss of function, limb, or life is threatened.
- Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive
- Treatment when loss of function, limb, or life is threatened.
- Progressive necrotizing infections (necrotizing fasciitis).
- Acute peripheral arterial insufficiency.
- Preparation and preservation of compromised skin grafts (not for primary management of wounds).
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management.
- Osteoradionecrosis as an adjunct to conventional treatment.
- Soft tissue radionecrosis as an adjunct to conventional treatment.
- Cyanide poisoning, acute.
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and
- Surgical treatment.

- Diabetic wounds of the lower extremities in patients who meet the following three criteria:
    - Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;
    - Patient has a wound classified as Wagner grade III or higher; and
    - Patient has failed an adequate course of standard wound therapy.

Continued treatment is not covered if there is no measurable improvement after a 30-day period of treatment.

All other indications not specified are considered to be investigational and are not covered under the Medicaid Program.

2.7. Interpretive Services

Medicaid reimburses for interpretive services to assist participants receiving health-related Medicaid services who are deaf or who do not speak or understand English. Medicaid payment will be made to the provider when it is necessary for the provider to hire an interpreter. Interpretive services may be provided in order for the provider and participant to effectively communicate only when a Medicaid reimbursable service is being provided. To locate an interpreter in your area contact the Idaho CareLine at 211 or 1 (800) 926-2588.

Payment for interpretive services is subject to the following limitations:

- Payment will not be made for interpretive services when the provider of the service is able to communicate in the participant's language or sign language.
- Payment will not be made for interpretive services to assist the participant to understand information or services that are not reimbursed by Medicaid.
- Payment for interpretation services will not be made to providers who cost audit settle with DHW. These services are considered to be included in the provider's cost of doing business. This includes providers such as hospitals, home health agencies, rural health clinics (RHCs), federally qualified health centers (FQHCs), Indian Health Centers (IHCs), and long-term care facilities.

Providers must generate documentation at the time of service sufficient to support claim for reimbursement of interpretive services. Sufficient documentation must include the following elements:

- Name of the participant
- Name and title of the interpreter
- Date and time of the service
- Type of interpretive service provided

Bill for interpretive services with the following procedure codes:

- **T1013** – Language Interpretive – Oral Services, per 15 minutes
- **T1013** – **CG** – Sign Language Interpretive Services, per 15 minutes

2.7.1. Diagnosis Codes

MMIS requires that all diagnosis codes be entered with the decimal point on claims. This applies to paper, electronic or online/direct data entry claims.

2.7.2. Participant Billing Information

The participant's name is used in conjunction with the Medicaid identification number (MID) for identification when submitting claims. To avoid errors, verify participant eligibility every time services are rendered and watch for any name changes that may have occurred.

2.7.2.1. Medicaid Identification Number (MID)

Upon implementation of MMIS, every Idaho Medicaid participant (including children) received a unique 10-digit identification number. The MID is the only number accepted for processing claims. When entering the number on the claim form, do not use:

- Participant's Social Security number
- Another family member's MID
- Any letters, symbols, or hyphens

2.7.2.2. Participant Name

It is important to enter the participant's name accurately. The Health Insurance Portability and Accountability Act (HIPAA) compliant Molina Medicaid secure website allows you to search for the participant's name as it is on file with Medicaid. You will be required to enter only the first five letters of the participant's last name and the first three letters of the participant's first name.

Common errors that are made when entering the name on the claim form include:

- Spelling mistakes and typing errors.
- Name not entered in correct order, or the participant may use a hyphenated last name.
- When entering a two word last name, not starting with the lead name (Example Van S. Glen Garry, Glen is the beginning of the last name not Garry).
- Using a nickname or a participant's preferred spelling from the provider's records instead of the proper name on file with Medicaid.
- Participant name has been changed and the participant has not updated their records with Medicaid or the provider.
- Parent's name used for minor child with a different last name.

2.7.3. Provider Signature and Number

All paper claims must have a valid provider signature and their 10-digit NPI or their 8-digit Idaho Medicaid Provider Number. Claims that are not signed or do not have a signature on file form with Idaho Medicaid and/or do not have a provider number are returned.

2.7.3.1. Signature on File

Providers must sign every claim form or complete a Signature on File form. This form is used to submit paper claims without a handwritten signature and to submit electronic claims. It replaces a computer-generated signature, a signature stamp, or a typewritten signature. For a copy of the Signature on File form, go to the Molina Medicaid website, **Forms**, Provider Enrollment Maintenance or request a paper copy of the form from Provider Services.

2.7.3.2. Idaho Medicaid Provider Number

Healthcare Providers

Providers who meet the HIPAA definition of a healthcare provider should have a National Provider Identifier (NPI). During your enrollment/provider record update, you provided us

with this NPI and it became your Idaho Medicaid provider number. Your NPI is your primary numeric identification on all claims, documents, and communications with Medicaid. Claims cannot be processed without a valid National Provider Identification number.

Healthcare providers who want to send or receive electronic HIPAA transactions must have an NPI. If you do not have an NPI you can apply for an NPI online at the following Internet site: https://nppes.cms.hhs.gov/NPPES/Welcome.do or you can call 1 (800) 465-3203 for a paper application.

Atypical Providers

Providers who do not meet the HIPAA definition of a healthcare provider are called atypical providers. They generally are not eligible to receive an NPI number. If you are an atypical provider, your primary numeric identifier is the unique 8-digit Idaho Medicaid Provider Number assigned to you when you enrolled/completed your provider record update. The types of providers Idaho Medicaid recognizes as atypical are listed below:

- Non-emergency commercial transportation
- Transportation broker
- Individual transportation provider
- Agency transportation provider
- Personal emergency response systems
- Home modifications
- 24 hour personal care service (PCS) home for children – (foster care)
- PCS/aged and disabled (A&D) agency
- Adult day care
- Residential Assisted Living Facility (RALF)
- Behavior consultation/crisis management
- Chore services
- Home delivered meals
- Self-determination fiscal employer agent
- Residential habilitation agency
- Certified family homes
- Respite care
- Supported employment service

2.8. Claims Submission

Providers may submit claims by:

- Electronic Data Interchange (EDI)
- Direct data entry (DDE) into Health PAS-Online, Trading Partner Account
- By mail on original, preprinted paper claim forms (hardcopy, see *Section 2.8.2 Paper Claim Forms*)

Electronic claim submission has many benefits, including a reduced number of errors, quicker payments, and easier claim tracking.

2.8.1. Electronic Claims Submission

Molina offers two methods for electronic claims submission:

1. EDI is a HIPAA compliant X12 claim transaction referred to as an 837 which is submitted using online File Exchange upload. For EDI claim submission and billing instructions, please refer to the appropriate HIPAA X12 *Vendor Specifications Companion Guides* located at Health PAS-OnLine at www.idmedicaid.com. Electronic claims that are not in the correct HIPAA compliant format will be rejected.

2. DDE is the Web-based entry of claims into the Health PAS-OnLine secure provider portal.

2.8.1.1. Vendor Software and Clearinghouses

Providers can use electronic claims submission software from any vendor after it is tested and noted as in compliance with the MMIS EDI system. Software vendors will not be allowed to test their product with Molina Medicaid Solutions. Molina will not endorse any specific software application. Any testing of third party software must be performed by a registered provider. Contact the Molina Technical Help Desk if you have any questions regarding this process.

Providers who wish to bill electronically and who bill more than one insurance carrier should consider using a clearinghouse. Clearinghouses are private companies that handle insurance claims for multiple carriers. The advantage for the provider is that claims are entered only once for the clearinghouse. The clearinghouse then forwards the claim to the appropriate insurance carriers (including Idaho Medicaid). A list of all currently registered Clearinghouses and Billing Agencies is available on Health PAS-OnLine by selecting the link titled 'Registered Clearinghouses and Billing Agencies'. Molina will furnish the specifications, free of charge, to any vendor upon request. Once the clearinghouse has successfully transmitted enough test data to become production certified with the MMIS, providers using their services may begin using the clearinghouse to submit claims.

See the next section for details about registering as a trading partner to begin testing. Since providers use a variety of different billing software brands, it is not possible to give exact information on how to complete any specific electronic eligibility or claim form. Providers can review the EDI Companion Guides, available on the Molina Medicaid website, for a general example of HIPAA-compliant electronic transaction formats.

2.8.1.2. Trading Partner Agreement

All providers should register as trading partners with Molina via the Molina Medicaid website. Registration includes electronically signing a trading partner agreement for HIPAA compliance in order to receive a trading partner ID, which is used on the X12 transactions as an identifier of the submitting provider.

Registering as a trading partner will also allow you access to the secure portion of the website for all real time claim entries, inquiries, and status requests. The secure website allows for ease of access to reports including the remittance advice.

Please see the *Trading Partner Account (TPA) User Guide* in the User Guides online.

2.8.1.3. Health Insurance Portability and Accountability Act (HIPAA) Required Data Elements

When billing electronically, providers must complete all HIPAA required data elements; however, not all of the information is used by Idaho Medicaid in claims processing. The following HIPAA required data elements for an electronic HIPAA 837 claim submission are not used by Idaho Medicaid.

- Release of medical data
- Benefit assignment
- Patient signature
- Social Security number
- Tax ID number and qualifier
- Entity type qualifiers
- Provider and participant address
- Participant ID qualifier
- Participant date of birth
- Participant gender

2.8.2. Paper Claim Forms

Several different types of claim forms are used to bill services to Medicaid. The following forms are the only paper forms accepted by Idaho Medicaid:

- CMS 1500 (Red drop out form)
- UB-04 (Red drop out form)
- 2006 ADA (Black form)

All paper claims are electronically scanned for processing. The printed versions of the claim forms are machine readable which means they are printed using special paper, special color inks, and within precise specifications. For this reason only original color forms can be used for scanning. Forms that cannot be scanned are returned to the provider.

2.8.2.1. Completing the Claim Form

To ensure that paper claims are scanned correctly, follow these guidelines:

- Use the specified original claim form referenced above. Photocopies cannot be scanned and will be returned to the provider.
- Check the Claim Form Instructions; *CMS-1500 Instructions*, *UB04 Instructions*, *or the ADA Dental Instructions* (applicable until 6/30/2011), for your specific provider type for the required fields.
- Do not enter any data or documentation on the claim form that is not listed as required. When billing Medicaid there is no need to enter data into fields that are not required.
- Use black ink or a typewriter with a good ribbon or a printer with a good ink cartridge. Change the ribbon or ink source if the print is too light.
- When using a typewriter or printer, make sure the form is lined up correctly so it prints evenly. Claims cannot be processed when the information is not in the correct field or not within the box. If completing the form by hand, print neatly.
- Be sure to stay within the box for each field.
- When entering an X in a check-off box, be sure that the mark is centered in the box.
- White correction fluid is acceptable, but no other alterations should be made on the form.
- Do not use bold font.

2.8.2.2. Mailing the Claim Form

Do not staple or paper clip any attachments to the claim form. Check the Provider Guidelines for your specific provider type in this handbook to see if an attachment is required. Providers have the option to upload claim attachments through the Molina Medicaid website when entering claims through a Trading Partner Account. Attachments should be scanned completed forms, word processing, or spreadsheet documents.

If an attachment is required, providers can continue to send claims via US mail. Do not fold the form. Mail it flat in a 9 x 12 envelope (minimum size).

Mail to the appropriate address found in one of the following tables.

Figure 2-6: CMS 1500 Mailing Addresses

Address	Claim Type
Molina PO Box 70084 Boise, ID 83707	CMS 1500 Physician CMS 1500 Other
Molina PO Box 70084 Boise, ID 83707	CMS 1500 Medicare Primary Third Party Recovery (TPR)

Figure 2-7: UB-04 Mailing Addresses

Address	Claim Type
Molina PO Box 70084 Boise, ID 83707	UB-04 Inpatient UB-04 Hospice UB-04 LTC UB-04 Home Health
Molina PO Box 70084 Boise, ID 83707	UB-04 Medicare Primary Third Party Recovery (TPR)
Molina PO Box 70087 Boise, ID 83707	UB-04 Outpatient Financial (Adjustments, refunds, etc)

Figure 2-8: 2006 ADA Dental Mailing Addresses (For DOS until 6/30/2011)

Address	Claim Type
Molina PO Box 70087 Boise, ID 83707	Third Party Recovery (TPR)
Molina PO Box 70087 Boise, ID 83707	ADA Dental (DOS prior to 7/1/2011)

Send correspondence in a separate envelope or mark the outside of the claim envelope *Correspondence Enclosed*.

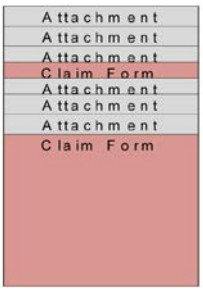
2.8.3. Attachments

Attachments are additional documentation required to support the processing and payment of a claim. *Please be sure all attachments are legible.*

Attachments may include:

- Third Party Explanation of Benefits (EOB)
- Medicare Remittance Notice (MRN)/Explanation of Medicare Benefits (EOMB)
- Certificate of Medical Necessity CMS-484—Oxygen (CMN)
- Pharmacy prescription
- Consent forms
- Manufacturer's invoice

Figure 2-9: Claim with Attachments



If a claim has an attachment, do not staple or clip it to the claim. Place it behind the claim form, as illustrated in the figure to the left.

If multiple claims refer to the same attachment, then make separate copies of the attachment for each claim.

If multiple claims are sent together, then stack the claims with each claim followed by its own attachment(s). See the diagram at left.

If an attachment has information on both sides of the page, then make a copy of the backside and include it with the claim.

If an attachment such as a sales receipt is on a small slip of paper, then copy or tape it onto an 8 ½" by 11" inch piece of paper.

If the submission is related to timely filing, it is required that you attach the Medicaid RA. If the submission is a claim review request or the like, attaching the RA will help explain the history of the claim and previous processing.

If no attachments are required, then consider submitting the claim electronically.

2.8.3.1. Examples of Documentation Necessary for Billing

Figure 2-10: Examples of Documentation Required for Billing

Example	Required Documentation	Solution
Three claims submitted for the same participant with one MRN/EOMB which covers the three claims	One copy of the MRN/EOMB for each claim	Submit services for all three claims on one claim form and include one EOMB **or** Submit three claims and include one copy of the MRN/EOMB with each claim
Corrected claims submitted which were previously denied	Include the RA explaining the previous denial	It is required to include the RA with claim. When the date on the claim exceeds the timely filing limit (one year from date of service) enter the claim number/ICN from the RA in the comment field of the claim and attach the applicable RA.
Two claims submitted, the first is marked *continued*, and one attachment is included to explain the use of a *dump* code for a lab test	None	Total each claim separately and enter the name of the lab test in **Field/Box 19**
Two claims submitted with one invoice attached	One copy of the invoice for each claim	Include one invoice copy with each claim form

2.8.4. Claim Status

Providers can determine the status of their claims four ways:

- Through the weekly Remittance Advice (RA). See *Remittance Advice Analysis* for information on RAs.
- Calling Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272.
- The electronic claim status request and response transaction (HIPAA 276/277).
- Online through the Molina Medicaid website.

MACS Inquiry: Providers can check the status of electronic and paper claims sent to Molina for processing by calling MACS and selecting the claims information option. For more information on how to access MACS and check claim status, refer to the MACS User Guide in the User Guides on the Molina Medicaid website.

Electronic Inquiry: Idaho Medicaid supports the HIPAA transaction known as the 276/277, Electronic Claim Status Inquiry and Response. This transaction allows providers to inquire on the status of claims and health plans to return the requested information. Providers should contact their software vendor or clearinghouse to determine if their vendor supports the claim status inquiry and response transactions.

Online Inquiry: This option is available to providers who have a trading partner account. More information about verifying eligibility online can be found in the *Eligibility Verification* section of the *Trading Partner Account (TPA) User Guide*.

2.8.5. Which Claim Form to Use

Claims that do not require attachments may be billed electronically (EDI) using the HIPAA compliant 837 transaction and MMIS compliant vendor software that has been tested and certified for use.

For claims that require attachments use the following options:

- To submit claims via the direct data entry (DDE) option, use the secure Molina Medicaid website.
- To submit claims on paper, use an original preprinted claim form.

Note: All claims must be received within 12 months (365 days) of the date of service. For additional information please see Section *2.1.6, Timely Filing Limit* in this document.

2.9. Prior Authorization (PA)

2.9.1. Overview

Federal regulations permit Medicaid to require a PA for any service where it is anticipated or known that the service could be abused by providers or participants, or easily result in excessive and uncontrollable Medicaid costs. The PA is required before certain services are delivered to a participant. Medicaid and private contractors maintain the PA process. The *Provider Handbook Directory* contains PA addresses and telephone numbers.

Depending on the service, a PA may be received from the:

- Division of Medicaid Central Office
- Regional Developmental Disabilities Program
- Medicaid Non-Emergent Transportation
- Regional Medicaid Services (RMS)
- Qualis Health (a private contractor)

It is the provider's responsibility to verify the participant's eligibility on the date of service and to request any required PA. Read this section of the handbook for more detailed information on specific services that require PA.

All claims submitted or adjusted on or after May 1, 2014 for services that require a prior authorization, will be denied if the PA number is not on the appropriate claim line. The PA number is found on the paper NOD letter or online through your Trading Partner Account (TPA) under Authorization Status.

Note: Requesting a PA for services does not guarantee payment. The participant must also be eligible on the date authorized services are rendered.

Idaho Medicaid requires a PA for the following general areas of service:

- Service Coordination services for children with special health needs
- Community-based Crisis Services
- Home and community based waiver services for the following waivers
    - Developmental Disabilities Waiver
    - Aged and Disabled Waiver
- Personal care services
- Preventative Health Assistance (PHA) services
- Some durable medical equipment (DME) purchases and rentals
- Cosmetic and reconstructive surgery
- Miscellaneous DME supplies totaling over $100.00 per month
- Some prosthetics and orthotics
- Some hospital inpatient/outpatient procedures
- Some optometric services
- Some prescription drugs
- Some physical therapy services
- Some surgical procedures
- Services/procedures identified as necessary in an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) that are outside the scope of Idaho Medicaid coverage, such as private duty nursing
- Some dental surgery and items (applicable until 6/30/2011)
- Surgery related to obesity
- Transplants
- Transportation by an ambulance or individual/commercial transportation provider for non-emergency Medicaid covered services from an Idaho Medicaid medical provider
- Any urgent/emergency inpatient or outpatient treatment where the procedure or diagnosis code appears on the select pre-authorization list must be reviewed by Qualis Health within one working day of admission. Those surgical procedures on the select pre-authorization list must be authorized regardless of the place of service. The diagnoses on the select pre-authorization list are for inpatient only.

2.9.2. Medicaid Prior Authorization (PA)

To render a service that requires Medicaid PA, download and complete the appropriate form. Fax the form and documentation justifying the medical necessity of the procedure to the fax number on the form.

Direct all requests for PAs to the appropriate contractor or Department unit as listed in the *Directory*. The requests should include:

- Participant name and MID number
- Signed physician's order
- A list of all items and a price quote for each
- Prescriber's statement of diagnosis and medical necessity for applicable drugs
- Requesting provider
- If the participant is enrolled under Healthy Connections, include the Healthy Connections (HC) referral number

A Note Regarding PA Requirements
Medicaid issues a written notification of authorization or denial for all written requests for PA. A PA number is assigned to all approved PAs.

The PA letter indicates the length of time the authorization is valid. The dates of service being billed must occur on or after the start date and on or before the expiration date indicated on the PA letter. If the PA expiration date occurs before services are provided, a new PA must be requested. To prevent a disruption or break in service to the participant, request PA as soon as the need for additional services is identified.

PA forms can be found online by clicking on **Forms** in the left navigation pane of the Molina Medicaid website. Specific prior authorization instructions can be found in the *Provider Guidelines* document for each provider type and specialty.

If transportation services are requested for an out-of-state admission, a PA must be issued by Medicaid Transportation.

Pharmacy
Please see the Idaho Medicaid Pharmacy Claims Submission Manual at https://idaho.fhsc.com/providers/manuals.asp.

2.9.2.1. Quality Improvement Organization (QIO) Prior Authorization (PA)

The Division of Medicaid contracts with Qualis Health, a quality improvement organization, to conduct medical necessity reviews on a pre-admission basis for selected diagnoses and procedures. Qualis Health also conducts concurrent review of all inpatient admissions that exceed a specified number of days and retrospective reviews when necessary. For specific instructions on how to request these reviews, see the QIO Provider Manual at http://www.qualishealth.org/healthcare-professionals/idaho-medicaid or contact the QIO directly using the following contact information.

Qualis Health
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-0400

Phone 1 (800) 783-9207
FAX 1 (800) 826-3836

2.9.3. Requests for Reconsideration and Appeals

Providers and participants may appeal a PA decision made by Medicaid or its designee, by following these steps.

Step 1

Carefully examine the Notice of Decision for Medical Benefits to ensure that the service(s) and requested procedure code were actually denied (see *Status*). Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice. If the provider or participant feels that an inappropriate denial of service has occurred, the next step is to submit a written Request for Reconsideration.

Step 2

Request for Reconsideration

Prepare a written Request for Reconsideration, which includes any additional extenuating circumstances and specific information that will assist the authorizing agent in the reconsideration review. Resubmit to the authorizing agent within 28 days from the mailing date of the Notice of Decision for Medical Benefits.

Upon completion of the reconsideration review, Medicaid will issue a second Notice of Decision for Medical Benefits. If the provider or participant disagrees with the PA reconsideration decision made by Medicaid or its designee, they may file a Request for Appeal. The provider or participant has 28 days from the mailing date of the second Notice of Decision for Medical Benefits to submit a formal appeal.

Step 3

Request for Appeal

To submit a written request for an appeal of the decision, complete the following. Documentation may be faxed but the fax must be followed with copies of original documents in the mail.

- Prepare a written request for an appeal that includes:
  - A copy of the first Notice of Decision for Medical Benefits from the authorizing agent.
  - A copy of the Request for Reconsideration from the provider/participant.
  - A copy of the second Notice of Decision for Medical Benefits from the authorizing agent showing that the request for reconsideration was performed.
  - An explanation of why the reconsideration remains contested by the provider/participant.
  - Copies of all supporting documentation.
- Mail the request and additional information to:
  Hearings Coordinator
  Idaho Department of Health and Welfare Administrative Procedures Section
  P.O. Box 83720
  Boise, ID 83720-0036
  FAX (208) 334-6558

QIO Appeals

The advisory letter sent from the QIO, Qualis Health, to physicians and hospitals gives two types of appeal options, expedited and standard. Appeals for non-certification or partial certification decisions must be completed with Qualis Health review before submitting an appeal to the Department's Hearings Coordinator.

- **Expedited Appeal -** An expedited appeal must meet the definition of an urgent care case shown in the Qualis Health provider manual, *Appendix B, Glossary* (http://www.qualishealth.org/healthcare-professionals/idaho-medicaid) and be requested by telephone, fax, or in writing within two business days after notification. Qualis

Health will complete the appeal within two business days from the receipt of the request. If you disagree with the results of the expedited appeal determination or have not submitted one, you have the option of requesting a standard appeal.

- **Standard Appeal -** The standard appeal request must be submitted within 180 days of receipt of the advisory letter from Qualis Health. Another peer physician will review the medical records and any new information you submit. You will be notified of the determination within 30 days. If you disagree with the final decision, you may then request a DWH appeal, also referred to as a contested case hearing appeal.
- **Department Appeal -** A contested case hearing may be requested from IDHW after the appeal process is exhausted with Qualis Health. The appeal must be received in writing by the Department's Hearings Coordinator, Administrative Procedures Section (see address above), within 28 days from the mailing date of the advisory letter. A copy of the final determination letter from Qualis Health attached to your appeal will help expedite your request. You will be notified in writing by a Hearing Officer to set up a date, time, and location of for the hearing.

2.10. Third Party Recovery (TPR)

2.10.1. Overview

This section covers the TPR situations that may apply to providers working with Idaho Medicaid participants. It briefly describes how Molina processes TPR claims. In accordance with Federal regulations 42 CFR-433.135-139, the Division of Medicaid or its designee must take all reasonable measures to determine the legal liability of third parties to pay for medical services under the plan.

A third party is any insurance company, private individual, corporation, or business that can be held legally responsible for the payment of all or part of the medical or dental costs of a participant. Third parties could include:

- Group health insurance
- Workers' compensation
- Homeowners' insurance
- Automobile liability insurance
- Non-custodial parents or their insurance carriers
- An individual responsible for a Medicaid participant's injury (a person who committed an assault on a participant, for instance)

Federal regulations require providers to bill all known insurance companies before submitting a claim to Medicaid. See *Section 2.10.2 Exclusions*, for the exceptions to this requirement.

To verify other insurance information, call Medicaid Automated Customer Service (MACS) at 1 (208) 373-1424, or 1 (888) 686-4272. MACS is available 24 hours a day including weekends and holidays, except during scheduled system maintenance. MACS will inform the caller if the system is unavailable.

2.10.1.1. Participant Responsibility

The provider must accept the Medicaid allowed amount as payment in full. The provider cannot bill the participant for any balance remaining after the primary insurance and Medicaid have both paid.

2.10.2. Exclusions

At this time services federally excluded from TPR requirements are:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services
- Normal pregnancy diagnoses
- Non-emergency medical transportation
- Personal care services
- Developmental disability
- Health related services provided by Idaho Public School Districts

Providers who bill for these services are not required to bill the third party before billing Medicaid.

Retrospective claim reviews completed by DHW contractors will seek reimbursement from responsible Third Parties. Your claim maybe reversed and adjusted to reflect this activity.

Please Note: Providers of certain services that are not covered by the primary insurance may be granted an exclusion from TPL requirements.

2.10.3. Determining Other Insurance Coverage

Use MACS, the Molina Medicaid website, or other successfully tested vendor software to determine if a participant has other insurance coverage before billing Idaho Medicaid.

The name of the insurance company and the type of coverage is given. If there is other insurance coverage, note the information on the other insurance carrier and bill the other insurance before billing Medicaid.

Refer to Section *2.10.3.1 Third Party Recovery (TPR) Coverage Codes*, in this document, for a complete listing of the TPR coverage codes and their descriptions.

Refer to Section *2.10.3.2 Third Party Recovery (TPR) Carrier Codes*, in this document, for a listing of the top insurance companies identified by Idaho Medicaid.

2.10.3.1. Third Party Recovery (TPR) Coverage Codes

Figure 2-11: Third Party Recovery (TPR) Coverage Codes

Code	Description
0001	Full coverage
0002	Full coverage, no dental
0003	Full coverage, no dental, no drugs
0004	Full coverage, no vision
0005	Full coverage, no dental, no vision
0006	Accident only policy
0007	Hospital only policy
0008	Surgical policy
0009	Accident & hospital only
0010	Cancer only policy
0011	Dental only
0012	Drug only
0013	Vision
0014	Medicare Part A
0015	Medicare Part B

Code	Description
0017	Full coverage with dental, no drug
0018	Medicare supplement with drug
0025	Full coverage, no dental, no vision, no drug
0027	Medicare HMO
0029	Unknown
0038	Air ambulance coverage
0039	LTC/nursing home coverage
0040	Full coverage, no vision, no drug
0041	Medicare HMO
0042	Medicare Advantage, Part A & B only
0043	Medicare Advantage, Part A & B with drug
0044	Medicare Advantage, Part A & B with dental
0045	Medicare Advantage, Part A & B with dental and drug
0046	Medicare Advantage, Part A & B with vision
0047	Medicare Advantage, Part A & B with drug and vision
0048	Medicare Advantage, Part A & B with dental and vision
0049	Medicare Advantage, Part A & B with dental, vision, and drug
0050	Medicaid/Medicaid Coordinated Plan

2.10.3.2. Third Party Recovery (TPR) Carrier Codes

Refer to the COB Carriers document found in the Provider Handbook Reference section. If you do not find the carrier on the list, please call HMS 1(800) 873-5875 for the appropriate carrier code.

2.10.4. Processing Third Party Recovery (TPR) Claims

After receiving either a partial payment or a denial from an insurance company, submit the claim to Medicaid for payment consideration along with a copy of the explanation of benefits (EOB) including the information for the claim and the explanation of the remark codes. If the insurance is Medicare, a Medicare Remittance Notice (MRN) is always required.

When submitting the claim to Medicaid, verify that the dates of service, units, detail charges, and total charges are the same on the primary insurance EOB and on the claim to Medicaid. If the other insurance carrier denied the claim, submit the claim to Molina for processing. A copy of the other insurance company's EOB (both detail about the claim and an explanation of the remark codes) must be attached to the claim to document the other insurance company's denial. The denial must be validated before the claim can be processed by Molina.

A paper EOB from the other insurer is included with paper claims, including the EOB claim resolution message from the other insurance and the explanation of any remark codes. Since there are hundreds of insurers, each with their own remark coding system, Idaho Medicaid cannot process a claim unless the EOB number and message is included with the paper claim.

Fill in the other insurance paid amount in the appropriate field of the claim. If the insurance pays at zero, **0.00** must be recorded in the appropriate field or the claim will be denied. These claims must be submitted to Medicaid with the EOB attached.

2.10.4.1. Electronic Third Party Claims

HIPAA Remittance Advice Remark Codes (RARC) replace the third party EOB codes that were formerly used on both paper and electronic third party claims. They explain how the claim was processed and give additional information about the payment of benefits or denial of the claim by the third party payer.

For electronic/EDI claims, the current RARC(s) are required on all TPR transactions. For paper claims and online entry claims, attach the required EOB(s) from the other insurance(s); these EOB(s) would also use the same RARC.

The RARC are updated three times a year by CMS. For a current list of the RARC codes, go to the Washington Publishing Company link http://www.wpc-edi.com/content/view/739/1.

Further information can also be obtained online at www.healthandwelfare.idaho.gov, the Molina Medicaid website, or by contacting Provider Services at 1 (866) 686-4272.

2.10.4.2. Third Party Recovery (TPR) Fields on Paper Claim Forms

The following table lists all the paper claim forms used by Idaho Medicaid and the fields used for TPR by number.

Figure 2-12: Third Party Recovery (TPR) Fields on Paper Claim Forms

Form	Service Line Charge	Total Charges	Other Insurance Payment	Balance Due	Comments
CMS-1500 claim form	24F	28	29	30	19
	$ Charges	Total Charge	Amount Paid	Balance Due	Reserved for local use
UB-04 claim form	(not used)	23	54	55	80
		Enter the total all claim charges	Prior Payments	Estimated Amount Due	Remarks

2.10.4.3. Unacceptable Denial Codes

A billing or timeliness error is not considered a valid denial for the purposes of satisfying the requirement to bill all other insurances. The following are examples of denials that will not be accepted for paper, online, or electronic claims:

- Claim lacks information that is needed for adjudication
- Patient cannot be identified as our insured
- Claim filed past filing time limit
- Duplicate of a previously submitted claim

2.10.4.4. Medicaid Participation

If the insurance company made a payment toward the services, enter the amount of the payment in the appropriate field on the claim form. Medicaid will pay the lesser amount of the primary coinsurance/deductible or the Medicaid allowed amount.

The following are examples of an insurance company (including Medicare) payment on Medicaid covered services.

Explanation and claim examples of Method 9, 10, 12, (as well as exceptions for LTC and FQHC/RHC/IHC claims) can be found in Section *2.2 Coordination of Benefits (COB)*.

1. Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	80.00
Medicaid Payment	**0.00**
2. Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	50.00
Medicaid Payment	**30.00**
3. Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	90.00
Medicaid Payment	**0.00**

For more information see Section *2.11 Claims for Dually Eligible Participants.*

2.10.5. Split Claims

Sometimes claims are billed to other insurance companies with more lines than will fit on the Medicaid paper claim form. To create a matching claim, the claim must be split.

If the other insurance's EOB has more detail lines than will fit on the claim form, divide the claim into two or more separate claims. Submit the first lines on one claim form and the remaining lines on additional claim forms. Write *Split Claim* in **Field/Box 19** of the CMS-1500 claim form, **Field/Box 80** of the UB-04 claim form, or **Field/Box 35** of the ADA 2006 claim forms. Total each claim. Pro-rate the third party payments to match the lines billed Attach a separate copy of the EOB to each split claim.

When billing electronically, it is not necessary to split a claim unless the provider is submitting more than the maximum number of detail lines allowed on the claim.

- Professional claims: Up to 50 details
- Institutional claims: Up to 999 details

Note: ICD-9-CM codes **800** to **999** are injury diagnoses. For more on using diagnosis codes in this range see Section *2.10.6.2 Injury Diagnosis,* before submitting your claim. This helps prevent an unnecessary claim denial.

2.10.6. Injury Liability

All claims submitted with a diagnosis indicating injury will be reviewed for possible liability recoveries. **Reminder**: all claims should be submitted to Medicaid within 365 days of the date of service or the start date if there is a range of dates of service.

2.10.6.1. Confirming the Facts of an Injury

To prevent a claim from being denied for additional information on injuries, providers should submit letters of denials; maximums met, no liability, or other documentation, with the claim and include the following information with the claim:

- How the injury occurred
- Where the injury occurred (home, someone else's home, work, commercial property, auto, etc.)
- When the injury occurred
- Name and phone number of the attorney, if applicable

Indicate the information in **Field/Box 19** of the CMS-1500 claim form, **Field/Box 80** of the UB-04 claim form, or **Field/Box 35** of the ADA 2006 claim forms. If the injury is not accident related, make note of this on the claim.

2.10.6.2. Injury Diagnosis

If a claim has been denied because of an injury diagnosis, investigate all possible third party involvement. Contact the participant and request additional information about the circumstances of the injury.

To process injury diagnosis claims, include the following information.

- Date of injury
- How injury occurred
- Indicate No TPL if investigation reveals that there is no third party liability

Include all documentation regarding the injury with the claim or on the electronic claim record, even if there are several claims for the same injury. Claims are reviewed separately and each stands on its own merit.

If investigation reveals no third party liability or shows the claim is not accident related, resubmit the claim to Medicaid for reconsideration. Include information regarding attempts made to identify a third party or obtain accident information. The information must include that at least three attempts were made. Document the person(s) to whom the provider spoke and the date and time of the contacts. Indicate this information in **Field/Box 19** of the CMS-1500 claim form, **Field/Box 80** of the UB-04 claim form, or **Field 35/Box** of the ADA 2006 claim forms. This information may also be listed in the first comment field of an electronic claim.

2.10.7. Litigation Cases

When an injury claim is in litigation or it is suspected that it will enter litigation the provider must chose only one of the following two options:

Option One:

Submit the claim to Medicaid, provide all the accident details, and include the name of the attorney, if available. Medicaid will pay up to the allowed amount for the services billed. By accepting Medicaid payment the provider agrees to accept what Medicaid paid as payment in full.

The provider is prohibited from submitting those same charges for reimbursement in the litigation and cannot refund Medicaid and keep a payment they receive from the litigation action.

Option Two:

Pursue payment from the litigation action. If the provider elects to do so they also elect at that time to not pursue payment from Medicaid. Regardless of whether a settlement occurs

or the settlement amount, the provider may not bill Medicaid or the Medicaid member for those services.

2.10.8. Third Party Recovery (TPR) Inquiries

Send direct inquiries regarding TPR and insurance information to HMS.

HMS
P.O. Box 2894
Boise, ID 83701
1 (208) 375-1132 or 1 (800) 873-5875

Provider representatives are available Monday through Friday from 8 A.M. – 5:30 P.M., MT, Monday – Friday excluding State holidays.

2.11. Claims for Dually Eligible Participants

2.11.1. Overview

When a participant is enrolled in (or eligible for) Medicare Part A and Part B and is eligible for full Medicaid, the participant is considered to be a full dual eligible participant.

Dual eligible participants meeting the criteria above that are 21 years of age or older, are eligible to voluntarily enroll in the Medicare-Medicaid Coordinated Plan (MMCP) with Blue Cross of Idaho (BCI) under its True Blue Special Needs Plan (SNP).

MMCP is only offered through BCI. Dual eligible participants that choose to purchase a Medicare Advantage Plan through any other insurance company/carrier other than BCI will not be able to enroll in MMCP.

- For participants enrolled in the MMCP see *General Provider and Participant Information* for billing information related to MMCP.
- A participant's Medicare Part A and Part B information is available by calling MACS and choosing the *other insurance* menu option.

2.11.2. Billing Medicare

Providers must enroll with the Idaho Medicaid Program separately from Medicare. If the participant is dually eligible for Medicare and Medicaid, Medicare must be billed first. Claims submitted to Medicare are electronically crossed over to Medicaid.

- Claims that do not automatically cross over from Medicare must be submitted to Medicaid with a Medicare Remittance Notice (MRN) attached. The MRN must include the Medicare payment or non-payment reason code.
- If the MRN does not clearly identify that it is a MRN, write on the top right margin of the claim or the MRN, "Medicare MRN" or "Medicare HMO", if applicable to help sort the claim.

2.11.2.1. Part A Dually Eligible Claims—Hospital

Providers must bill Medicare Part A fiscal intermediaries before billing Idaho Medicaid.

2.11.2.2. Part B Dually Eligible Claims—Professional

Providers submitting claims for Part B only participants must first bill the Medicare carrier for any Part B services before billing Idaho Medicaid.

Part B services include:

- Office visits with a provider
- Outpatient care
- Home health services
- Interpretation of laboratory tests
- Interpretation of radiology procedures
- Interpretation of nuclear medicine tests
- Interpretation of EKGs
- Speech therapy
- Physical therapy
- Prosthetic devices
- Interpretation of Pulmonary function tests
- Surgical supplies
- Catheters

2.11.2.3. Split Claims

Claims cannot be submitted with both Medicare covered and Medicare non-covered services on the same claim. Claims will be denied so the provider can split bill services.

An exception to this rule is if modifier GY and/or GZ are reported on Medicare non-covered services. These services will be allowed to be billed together on the same claim with a Medicare covered service.

Sometimes claims are billed to Medicare with more lines than will fit on the paper claim form. To create a matching paper claim, the claim must be split. If the Medicare Remittance Notice (MRN) has more detail lines than will fit on the claim form, split the claim. Submit two claims with the first lines on one claim form and the remaining lines on additional claim forms. Write *Split Claim* in **Field/Box 19** of the CMS-1500 claim form or in **Field/Box 80** of the UB-04 claim form. Leave the fields for amount paid and balance due blank. Attach a separate copy of the EOMB to each split claim. Total each claim.

When billing electronically, it is not necessary to split a claim unless the provider is submitting more than the maximum number of details allowed on the claim.

- Professional claims: Up to 50 details
- Institutional claims: Up to 999 details

2.11.3. Crossover Errors

Occasionally, a claim from Medicare does not automatically crossover to Molina. This occurs when the Medicare and Medicaid participant numbers on file do not match. If a claim does not appear on the Medicaid remittance advice (RA) within four weeks after Medicare payment, submit a claim to Medicaid for processing. Call Molina Provider Enrollment at 1(866) 686-4272 to verify that all provider numbers are on file to allow for automatic crossover.

Note: Medicaid claims must be submitted within six months of the EOB date or payment date of the Medicare EOB.

2.11.4. Resubmitting Crossover Claims

Dually eligible claims returned to the provider for any reason by Medicare must be resubmitted as a claim. Attach the original claim and any other supporting documentation to a copy of the MRN. Be sure to include your provider number and the participant's Medicaid identification (MID) number.

The claim dates of service, billed amounts and the MRN must match. Occasionally, Medicare combines or splits claims to expedite processing. When this happens, change the Medicaid claim form to match the Medicare Remittance Notice. The services Medicare processes as a single claim under one claim number must match exactly the service billed on the claim submitted to Medicaid.

Lab services are usually paid at 100 percent of the approved amounts. The claim total will differ from the total billed on the MRN if you do not bill these charges to Medicaid. A notation on a claim (**Field / Box 19** of the CMS-1500 claim form) stating that the lab charges were paid reduces the chance of a claim being returned in error.

Note: Providers who qualify for Medicare payment but have not applied to Medicare must register their National Provider Identifier (NPI) with Medicare and bill Medicare before billing Medicaid for all Medicare-covered services. See Section *2.11.6 Medicare/Medicaid Crossover Inquiries,* for Medicare phone numbers and addresses.

2.11.5. Qualified Medicare Beneficiaries (QMB) Medicare/Medicaid Billing

Participants who are enrolled only as QMB are eligible for Medicare covered services only up to Medicare's allowed amount from Idaho Medicaid. Claims filed secondary to Medicare and sent to us electronically by Medicare are called crossover claims. On the RA the payment of these charges appears on the first detail line of the paid claim on the Professional Crossover Claims page.

Services denied or not covered by Medicare for QMB participants will be denied if billed to Medicaid. Services denied or not covered by Medicare for participants who are dually eligible may be submitted electronically or on a separate paper form. These claims are not considered crossover claims. Medicaid processes these charges as the primary payer.

Each claim form must be submitted with a MRN attached. All claims submitted online or on paper must match the MRN exactly.

When a MRN contains covered and non-covered services (for dually eligible QMB participants only), submit two separate claims to Medicaid.

- One claim for the covered Medicare dually eligible portion with the MRN attached.
- Second claim for the non-covered Medicare services with the MRN denial attached. Indicate *Medicare Non-Covered Benefit* in comments or remarks field of your claim form.

2.11.5.1. Electronic Crossover Claims

Medicare Part B services billed by Idaho providers cross over electronically from the Medicare carrier to Molina. This process occurs automatically when the Medicare claim shows:

- Assignment was accepted
- Participant's Idaho MID number
- Provider's Medicare number

Providers may submit Part B services directly to Idaho Medicaid.

2.11.5.2. Paper Claims for Dually Eligible Participants

Information on dually eligible claims submitted on paper must match the information on the MRN exactly. The dates of service and dollar amounts must be the same as those on the MRN. File a separate claim for each claim on the MRN. Participants with both Medicare and private insurance must have an EOB from both carriers attached to the Medicaid claim form. When billing paper claims for dually eligible participants:

- Use the participant's MID number.
- Use the Idaho Medicaid provider number.
- Fill in all of the same required fields as on standard Medicaid claims.
- Sign and date all claims.
- Attach the MRN to the claim and make sure that the MRN is clearly identified as Medicare, Medicare HMO, or Medicare Supplement on the claim form or MRN; include any explanations of the remark code(s).
- Make sure all attachments are on 8 1/2" x 11" paper.

If the participant is not Medicaid eligible for a certain date of service, do not enter those charges on the claim. Put a note on the front of the claim explaining that this is why the MRN does not match the claim.

2.11.6. Medicare/Medicaid Crossover Inquiries

For inquiries regarding Medicare/Medicaid crossover claims, write or call the related fiscal intermediary or carrier listed below.

Part A Medicare:

Noridian Administrative Services
P.O. Box 6726
Fargo, ND 58108-6726
Provider Number: 1 (866) 497-7857 or TTY Line 1 (866)967-7902
Beneficiary Number: 1 (800) 633-4227

Part B Medicare:

Noridian Administrative Services
P.O. Box 6701
Fargo, ND 58108-6701
Provider Number: 1 (877) 908-8431 or TTY Line 1 (877) 261-4163
Beneficiary Number: 1 (800) 633-4227 or TTY/TDD Line 1 (877) 486-2048

CIGNA Health Care: DMERC, Region D

CIGNA processes all claims for durable medical equipment (DME), immunosuppressive drugs, enteral/parenteral nutrients (PEN), prosthetics, orthotics, and supplies.

CIGNA DMERC — Region D
P.O. Box 690
Nashville, TN 37202
Provider Number: 1(866) 243-7272
Participant Number: 1(800) 899-7095

2.12. Adjustments

2.12.1. Overview

Adjustments can be done only on **paid** claims when the information on the original claim must be updated but no new service lines are being added. If the claim requires additional line items, or changes to the initial date of service, a new claim must be submitted. These claims are listed in the paid claims section of the Remittance Advice (RA). For more information on an RA see the *Remittance Advice Analysis*.

Providers have two years after the payment was made to request an adjustment. In accordance with the provider agreement, providers are required to immediately repay identified overpayments.

2.12.1.1. Electronic Adjustments

Providers can submit electronic adjustments to Molina using Health PAS-OnLine or their vendor software. Attachments can be submitted via EDI and attachments are necessary to support and explain the adjustment. Please see the *Claim Status* section of the *Trading Partner Account (TPA) User Guide* for instructions. When submitting electronic adjustments, use claim frequency 8 to void a claim or claim frequency 7 to replace a claim.

2.12.1.2. Paper Adjustments

When a claim is paid incorrectly, resubmit a completed claim form indicating the original claim number and claim frequency code. If resubmitting on a CMS 1500, the frequency code of eight (8) to void a claim, or claim frequency seven (7) to replace a claim is placed in **Field/Box 22** along with the original claim number. If resubmitting on a UB-04 claim form, the last digit of the bill type is considered the frequency code. In **Field/Box 4**, the bill type must show a seven (7) or eight (8) in the frequency position and the original claim number in **Field/Box 64**. See the Claim Form Instructions for detailed information.

2.12.2. Denied Claims

Adjustments can be done on a denied claim when the information on the original claim must be updated but no new service lines are being added. If the claim requires additional line items or changes to the initial date of service, the claim must be resubmitted as a **new** claim with any corrections that are needed to obtain payment.

2.12.3. Claim Refund Payments

Idaho Medicaid will no longer accept full or partial claim refund payments from providers. Providers need to adjust claims through their Trading Partner Account or by an EDI 837 claim transaction. If you are unable to adjust your claims online, you may download a Claim Review Request form. Claims payment checks will be returned and providers will be asked to complete adjustments via their Trading Partner Account or EDI 837 transaction.

2.12.4. Claim Review Request

The Claim Review Request process is available to providers who want someone to physically review their claim. Timely filing, recoupment, and Coordination of Benefits (COB) payment are some examples of types of reviews that a provider may request.

To request a Claim Review, submit a Claim Review Request form found online on the Molina Medicaid website. Click on the link in the left navigation pane and follow the procedure outlined below.

Check **Claim Review Request** on the **Claim Review Request** form, and complete the necessary information:

- New or corrected claim form
- Original claim ID requiring review
- Provider information
- Participant information
- Comments – any explanation needed to help in review
- Attachments – any attachments you feel will help support your request as well as any required documentation (such as EOB with remark codes, timely filing, medical records, chart notes, or reports).

Mail the Claim Review Request form and attachments to:

Molina Provider Correspondence
P. O. Box 70082
Boise, ID 83707

2.12.5. Medicaid Review of Claim Determination

A pre-appeal process is available to providers who want someone at the Medicaid Central Office to physically review their claim. To initiate a pre-appeal follow the procedure outlined below.

Check **Medicaid Review** on the **Claims Review Request** form, and complete the necessary information:

- Original claim ID requiring review
- Provider information
- Participant information
- Comments – any explanation needed to help in review
- Attachments – any attachments you feel will help support your request as well as any required documentation (such as timely filing, medical necessity, notes, or reports)
- ***You must include a copy of the Molina claim Review Determination Letter***

Mail the Claim Review Request form and attachments to the following address.

Molina Provider Correspondence
P. O. Box 70082
Boise, ID 83707

2.12.6. Formal Appeal

To formally appeal Medicaid's Review of Claim Determination, send a written request for appeal to DHW.

Submit the flowing information for the formal appeal.

- Cover letter detailing why the formal appeal is requested
- Copy of Medicaid Review of claim Determination Letter
- Copy of Molina review letter
- Copy of claim and all attachments or new claim for possible resubmission
- Copy of the applicable RA

Send formal appeal documents using the following contact information.

Administrative Procedures Section
Idaho Department of Health and Welfare
450 West State Street 10th floor
P.O. Box 83720
Boise, ID 83720-0036
Fax: 1 (208) 334-6558

Medicaid will review the claim and respond in writing with the final determination.