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General Information and Requirements for Providers

The General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, is applicable to all provider types, and must be followed except where otherwise stated for a specific provider type. Should the handbook ever appear to contradict relevant provisions of Idaho or federal rules and regulations, the rules and regulations prevail. Any paper or digital copy of these documents is considered out of date except the version appearing on DXC Technology's [Idaho Medicaid](#) website.

Providers must follow their provider type or service specific handbook as located in the [Provider Guidelines](#). Handbooks in addition to this one which always apply to providers include:

- [General Billing Instructions](#); and
- [Glossary](#).

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3(a) The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3(a).

1. Provider Responsibilities

Providers are required to adhere to all applicable provisions of federal law including, but not limited to, the following as amended:

- Title VI of the Civil Rights Act of 1964;
- Title IX of the Education Amendments of 1972 regarding education programs and activities;
- The Age Discrimination Act of 1975;
- Section 504 of the Rehabilitation Act of 1973;
- The Americans with Disabilities Act of 1990;
- Section 1557 of the Patient Protection and Affordable Care Act;
- Health Insurance Portability and Accountability Act (HIPAA);
- Sections 262 and 264 of Public Law 104-191;
- 42 USC Section 1320d;
- 45 CFR Subchapter C Administrative Data Standards and Related Requirements;
- False Claims Act (31USC 3729-3733); and
- 42 CFR §455 Subpart B Disclosure of Information by Providers and Fiscal Agents.

Providers have the following, but not limited to, ongoing responsibilities:

- To review and abide by the contents of all [Idaho Medicaid rules](#) governing items and services under Medicaid;
- To abide by their provider agreement;
- To review and abide by the [Idaho Medicaid Provider Handbook](#);
- To review and abide by periodic provider [Information Releases](#) and other program notification issued by Medicaid such as the [MedicAide Newsletter](#);
- To make records available to Medicaid upon request per the [Documentation](#) subsection;
- To abide by [Provider Enrollment](#) requirements including, but not limited to:
- Being licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with professionally recognized standards;
- To comply with the disclosure of [Ownership and Controlling Interests](#);
- To keep Medicaid and DXC Technology advised of the provider's current address and telephone number per the [Maintenance of Contact Information](#) subsection;
- To sign every claim form submitted for payment or complete a signature-on-file form (including electronic signatures). See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information;
- To acknowledge when Medicaid is a secondary payer and agree to seek payment from other sources. See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about third party liability;
- To accept Medicaid payment for any item or service as payment in full and to make no additional charge to participants or other parties for the difference. See the [Participant Financial Responsibility](#) section for more information;
- To not bill a Medicaid participant unless the item or service is non-covered or excluded by Medicaid, and the provider complies with the [Participant Financial Responsibility](#) section. See [Non-Covered and Excluded Services](#), which includes a list of excluded services, for more information; and
- Medicaid participants cannot be billed for "no-show" or missed appointments nor can they enter into an agreement to be responsible for any resulting fees.

1.1. Employees and Contractors

Providers are responsible for the recruiting, hiring, firing, training, supervision, scheduling, and payroll for their employees, subcontractors, or agents. The Provider shall maintain general liability insurance coverage, worker's compensation, and unemployment insurance, and shall pay all FICA taxes and state and federal tax withholding for its employees. The Provider agrees to bill only for service providers who have the qualifications required for the type of service that is being delivered.

Furthermore, providers assume sole responsibility for the actions of their employees and contractors on their behalf. This includes the accuracy of claims submitted as specified in the [Idaho Medicaid Provider Agreement](#). The provider shall immediately repay the Department for any items or services determined to be improperly provided, documented, or claimed. In cases of suspected fraud, the Department may refer individual employees to the Medicaid Fraud Control Unit for further investigation and possible prosecution. Providers may also contact local law enforcement or take independent civil action against employees to recover losses caused by the employee.

1.1.1. References: Employees and Contractors

"Medicaid Program Integrity Unit: Provider Responsibilities Regarding Overpayments."
MedicAide Newsletter, January 2014,

<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202014%20MedicAide.pdf>.

1.2. Documentation

Providers are required to generate records at the time the service is delivered and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. This includes documentation of referrals made or received on behalf of Medicaid participants enrolled in the Healthy Connections (HC) Program. Services that haven't been documented are considered to not have occurred and are not reimbursable. The person delivering the services and any supervising providers must legibly sign, date and time the documentation to attest that the records are a true and accurate account of the services delivered. Any records requiring amendment or corrections must be clearly and permanently identified as such while leaving the original contents of the document legible. Amendments and corrections are intended to provide clarification and cannot be used to add new services for billing or retroactively establish medical necessity. Amendments and corrections separately require the author to be clearly identified with their credentials, a signature and the date of the changes. Documentation created after a Department records request is made will not be accepted. Intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit constitutes fraud, and offending individuals will be referred for prosecution.

Handwritten or electronic signatures are acceptable. Electronic signatures must meet the requirements in the [Electronic Signatures](#) subsection. Stamped and typed signatures are only allowed for providers with proof of a physical disability that prevents their signing. Records should be signed shortly after the service is provided with time allowed for transcription by a scribe. Signatures cannot be added to documents beyond that time frame, and scribes do not need to sign documents. If a handwritten signature is illegible, a provider may submit a signature log or attestation with requested records to support the identity of the signer. A signature log should have a typed list of provider names, titles and credentials followed by the corresponding handwritten signature. Signature attestations must be signed and dated by the author of the illegible signature. Attestations must include a statement of the document's validity, the name and credentials of the author, the date of service being attested to and the participant's name and Medicaid Identification Number (MID). Attestations can also be used as documentation for missing signatures.

Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years after the date of service. Upon request from the Department, Centers for Medicare and Medicaid Services (CMS), and any Department or CMS contractor providers must immediately provide documentation sufficient to substantiate the amount, duration, scope, and medical necessity of billed services. Documentation to support claims for services includes, but is not limited to, medical records, treatment plans, medical necessity justification, assessments, appointment sheets, patient accounts, financial records or other records regardless of its form or media. Medicaid may recoup the payment and apply a penalty if proper documentation cannot be produced by the provider.

Additional documentation requirements may vary by provider type and are listed in the appropriate sections of the Idaho Medicaid Provider Handbook.

1.2.1. Electronic Signatures

Idaho Medicaid will accept electronic signatures for provider orders and records to meet the requirements for documentation. The individual whose name is on the electronic signature and the provider bear the responsibility for authenticity. Each provider must develop written policies and procedures to assure complete, accurate, and authenticated records and at a minimum include:

- Security provisions to protect the use of an electronic signature by anyone other than the person to which the electronic signature belongs;
- The privacy and integrity of the record is protected;
- A list of which records will be maintained and signed electronically;
- How an e-signature code is assigned;
- How passwords are assigned and the frequency for which they are changed; and
- Access to the records for participants, the Department and others who are authorized by law.

As required by HIPAA-covered entities, the provider must ensure that the software program used is set up so that the signer cannot deny having signed the document in the future, the signer's identity is guaranteed at the time the signature was generated, and that the document has not been altered since it was signed.

1.2.2. References: Documentation

a) CMS Guidance

"Chapter 3 – Verifying Potential Errors and Taking Corrective Actions." *Medicare Program Integrity Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>.

"Medical Documentation Signature Requirements." *Noridian Healthcare Solutions*, 27 July 2018, <https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirements>.

b) Idaho Medicaid Publications

"Documentation of Services Provided – Signature Required." *MedicAide Newsletter*, October 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202018%20MedicAide.pdf>.

"If it is not documented, it has not been done, CMS.gov." *MedicAide Newsletter*, October 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202018%20MedicAide.pdf>.

"**Medicaid Program Integrity Unit:** Documentation Requirements." *MedicAide Newsletter*, February 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/February%202019%20MedicAide.pdf>.

"**Medicaid Program Integrity Unit:** Medical Record Entries." *MedicAide Newsletter*, October 2013, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202013%20MedicAide.pdf>.

c) Regulations

Administrative Remedies, Idaho Code 56-209h (1998). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209h>.

"Criminal Penalties for Act Involving Federal Health Care Programs." Social Security Act, Sec. 1128B (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm.

"Documentation of Services and Access to Records." *IDAPA 16.05.07*, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Sec. 101. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160507.pdf>.

Failure to Grant Immediate Access, 42 CFR 1001.1301 (1992). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-sec1001-1301.pdf>.

Failure to Retain Records, Idaho Code 56-209o (2007). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-209o/>.

The Rehabilitation Act. H.R. 8070 (1973). U.S. 93rd Congress, <https://www.congress.gov/bill/93rd-congress/house-bill/8070>.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(27) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

1.3. Ordering, Referring and Prescribing Providers

As a condition of payment provider's claims designated in the [Provider Types and Specialties](#), Idaho Medicaid Provider Handbook, require inclusion of an enrolled ordering, referring or prescribing (ORP) provider's name and NPI. If the claims are submitted without an enrolled provider's name and NPI, they will deny. Claims that come directly from Medicare to Idaho Medicaid will not require an enrolled ORP, but if the provider has to submit a claim manually it will deny without one.

Based on the State of Idaho's medical licensing structure and statutes, the following individual provider types may order, refer, or prescribe healthcare services or supplies for participants of the Idaho Medicaid program. These services or supplies must be requested in accordance with the provider's scope of practice and their licensure, which includes any certifications or credentials they possess. Eligible healthcare professionals are:

- Dentists;
- Licensed midwives;
- Nurse practitioners;
- Optometrists;
- Pharmacists;
- Physicians;
- Physician assistants;
- Podiatrists; and
- Psychologists (except school-based psychologists, who are exempt).

ORP providers must:

- Enroll with Idaho Medicaid as a billing provider, a non-billing ORP, or a crossover provider;
- Complete enrollment application;
- Complete Idaho Medicaid Provider Agreement; and
- Retain all documentation to support services ordered including the establishment of medical necessity for the services, equipment or supplies.

Billing providers must:

- Ensure all ORP providers are enrolled with Idaho Medicaid;
- Obtain the name and the NPI of the ORP provider and include it on claims; and
- Retain all documentation to support services billed

Interns, students and non-licensed residents are not eligible to enroll as ORP providers. The teaching, admitting or supervising physician, however, can review their documentation and perform the order or referral on their behalf.

Note: Enrolled pharmacists will be able to prescribe and provide medical services within the specifications allowed under the Idaho Pharmacy Act. Actual billing for Idaho Medicaid payable drugs, medical supplies and services will continue to be billed under the enrolled Medicaid pharmacy or other associated business provider number.

1.3.1. References: Ordering, Referring and Prescribing Providers

"Edits Will Change from Warn to Deny on October 1, 2017." *MedicAide Newsletter*, September 2017,
<https://www.idmedicaid.com/MedicAide%20Newsletters/September%202017%20MedicAide.pdf>.

Enrollment and Screening of Providers, 42 CFR 455.410 (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

"1.5.1.B. Ordering or Referring Physicians or Other Professionals (ORP)." *Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/sites/default/files/2019-12/mpec-7242018.pdf>

"Ordering, Prescribing, and Referring Providers." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 210.06. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"1.5.2. When Screening is Required." *Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

1.4. Prohibition on Gifts to Participants

Providers are prohibited from offering gifts or incentives to participants and may be liable for a civil monetary penalty up to \$10,000 per occurrence as well as exclusion from Federal programs for a period not to exceed ten (10) years. This includes waivers of co-payments and the transfer of items or services for free or below the fair market value. There are some allowances such as:

- Nominal gifts other than cash with a value up to \$15 per item, but not more than \$75 annually;
- Items or services that are offered on equal terms to the general public, regardless of insurance status;
- Payments between an employer and employee;
- Waivers of cost-sharing amounts without advertisement based on financial need;
- Incentives to promote the delivery of preventive care services for pre-natal or post-natal well-baby care or services in the Guide to Clinical Preventive Services by the United States Preventive Services Task Force (USPSTF);
- Drug manufacturers that do not file claims with Medicaid; and
- A provider funded independent entity that furnishes services to the financially needy so long as the benefits are not dependent on using any particular provider's services.

1.4.1. References: Prohibition on Gifts to Participants

a) Idaho Medicaid Publications

Federal Anti-Kickback Statute, Information Release MA07-24 (12/13/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA07-24%20Federal%20Anti-Kickback%20Statute-signed.pdf>.

b) Office of the Inspector General Publications

Offering Gifts and Other Inducements to Beneficiaries (08/2002). Office of Inspector General, Department of Health and Human Services, <https://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf>.

Office of Inspector General Policy Statement Regarding Gifts of Nominal Value to Medicare and Medicaid Beneficiaries (12/07/2016). Office of Inspector General, Department of Health and Human Services, <https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf>.

c) Regulations

"Civil Monetary Penalties." Social Security Act, Sec. 1128A(a)(5) (1996). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm.

CMPs, Assessments, and Exclusions for Beneficiary Inducement Violations, 42 CFR 1003 Subpart J (2016). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-part1003-subpartJ.pdf>.

Definitions, 42 CFR 1003.110 (2016). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-sec1003-110.pdf>.

Health Insurance Portability and Accountability Act of 1996. Public Law 104-191 (1996). Government Printing Office, <https://www.govinfo.gov/content/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf>.

Permissive Exclusions, 42 CFR 1001 Subpart C (2017). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-part1001-subpartC.pdf>.

1.5. Services for Immediate Family or Household Member

The Department reimburses providers based on the lesser of reasonable costs or customary charges for services and items. The definition for customary charges includes the provision for Medicare rates, which considers items and services furnished to an immediate family or household member to be without charge due to the relationship between the participant and the provider. Unless otherwise stated providers cannot be reimbursed for services rendered to a participant within their immediate family or household.

For physicians and non-physician practitioners this also includes services that would be incidental to their care. This section does not apply to a non-professional corporation regardless of the relationship with any employee, stockholder, officer or director. It does apply to a professional corporation, which is any corporation owned by healthcare professionals for the purpose of practicing medicine, midwifery, dentistry, podiatry, optometry or chiropractic care.

Providers are encouraged to consult their professional organization's stance on these services as many organizations such as the American Medical Association consider the treatment of self or a close personal relationship to violate their ethical standards.

1.5.1. Immediate Family Definition

An immediate family member would be:

- A spouse;
- A natural, step, in-law or adopted child;
- A natural, step, in-law or adopted parent;
- A person acting in loco parentis;
- A natural, step, in-law or adopted sibling;
- A natural, step, in-law or adopted grandchild; or
- A natural, step, in-law or adopted grandparent.

The spouse of a brother-in-law or sister-in-law would not be considered an immediate family member. Familial bonds are considered to remain in effect in the event of the death of one of the parties.

1.5.2. Household Member Definition

A household member is anyone living in the provider's residence with a relationship based on blood, adoption, marriage or employment. Roommates and renters are not considered a member of the provider's household. However, services provided for a roommate or renter can still be excluded from reimbursement if they are an immediate family member.

1.5.3. References: Services for Immediate Family or Household Member

a) CMS Guidance

"Chapter 16 – General Exclusions from Coverage." *Medicare Benefit Policy Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf>.

b) Idaho Medicaid Publications

"Providers of Medical, Surgical, and DMEPOS, Medicaid Does not Pay for Services Rendered or Performed by Spouses and Legally Responsible Parents of Minors." *MedicAide Newsletter*, January 2019,
<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202019%20MedicAide.pdf>.

c) Professional Organizations

American College of Physicians Ethics Manual: Seventh Edition, Lois Snyder Sulmasy, Thomas A. Bledsoe, American College of Physicians Ethics, Professionalism and Human Rights Committee, <https://annals.org/aim/fullarticle/2720883/american-college-physicians-ethics-manual-seventh-edition>.

"Treating Self or Family: Opinion E-1.2.1." *Code of Medical Ethics: Patient-physician Relationships*, American Medical Association,
<https://www.ama-assn.org/delivering-care/ethics/treating-self-or-family>.

d) Regulations

"Customary Charges." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 010.19. Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Lower of Cost or Charges." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 230.06. Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

1.6. Payment Error Rate Measurement (PERM) Audits

The Centers for Medicare and Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid and the State Children's Health Insurance Program (SCHIP) by reviewing claim payments and participant eligibility determinations every three (3) years. CMS uses a Review Contractor (RC) to perform medical records collection, statistical calculations and medical data processing review of fee-for-service (FFS) claims. The RC will select a sample of claims and call affected providers to explain the process and establish a point of contact for the audit. The RC will then send the provider by fax or mail a written request detailing what documents are needed.

Documentation must be submitted with the PERM coversheet by providers per the RC's instructions within seventy-five (75) calendar days. If the documentation submitted is insufficient to support the claim, additional documentation will be requested. Providers only have fourteen (14) days to comply with any additional requests. It is important that providers cooperate by submitting all requested documentation within the designated timeframe. Failure to provide the requested documentation in the designated time frame is in violation of Idaho Code Section 56-209h and the Idaho Medicaid Provider Agreement, which may result in disenrollment, investigation, recoupment and/or civil penalties.

The RC will have the claims and documentation reviewed by medical staff and certified coders to ensure payment was appropriate based on the Department's policy, state and federal regulations and rules. Claims out of compliance will be recouped by the Department, and providers may be required to submit a corrective action plan to prevent the issue in the future. Additionally, the Medicaid Fraud Control Unit or the Medicaid Program Integrity Unit may investigate providers for suspected fraud or abuse. Providers are still entitled to their normal appeal rights with the Department.

The Department will monitor PERM audits and follow-up with providers and the RC as necessary. This includes reviewing the result of the audit and providing the RC additional information if it believes their findings are incorrect. Providers may email their State PERM contact at SchellB@dhw.idaho.gov or CMS at PERMProviders@cms.hhs.gov for any provider specific questions.

1.6.1. References: Payment Error Rate Measurement (PERM)

Administrative Remedies, Idaho Code 56-209 (2016). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209h/>.

HHS Agency Financial Reports. Department of Health and Human Services, <https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html>.

Improper Payments Elimination and Recovery Act of 2010. P.L. 111-204 (2010). Government Printing Office, <https://www.govinfo.gov/content/pkg/PLAW-111publ204/pdf/PLAW-111publ204.pdf>.

Improper Payments Information Act of 2002. P.L. 107-300 (2002). Government Printing Office, <https://www.govinfo.gov/content/pkg/PLAW-107publ300/pdf/PLAW-107publ300.pdf>.

Payment Error Rate Measurement (PERM). Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Research-Statistics-Data->

[and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index?redirect=/PERM.](#)

1.7. Prevention of Waste, Fraud and Abuse

Providers are responsible to establish, disseminate and enforce written policies to their employees, contractors and subcontractors that detect and prevent waste, fraud and abuse. Employee handbooks shall include reference to the laws in the written policies, protections for whistleblowers, and specific discussion of policies and procedures to comply with the False Claims Act of 1863 and Deficit Reduction Act of 2005. These handbooks must be available to all employees, contractors and agents.

Additionally, providers receiving payments of \$5,000,000 or more must provide the Department annually with a written affidavit to attest their compliance with these laws. Each year the Division of Medicaid sends reminder letters to entities determined to meet this requirement.

Compliance with these laws is a condition of payment. Failure to comply will result in termination of your provider contract, and potential recoupment and penalties. Providers are encouraged to make use of the Office of Inspector General's [Compliance Resource Portal](#) for best practices and complimentary trainings.

1.7.1. References: Prevention of Waste, Fraud and Abuse

a) Idaho Medicaid Publications

Changes in Federal Legislation Affecting Medicaid Providers, Information Release MA07-01 (01/05/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA07-01%20signed%20copy.pdf>.

"Provider Responsibilities for the Prevention of Waste, Fraud and Abuse." *MedicAide Newsletter*, January 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202019%20MedicAide.pdf>.

b) Regulations

Deficit Reduction Act of 2005. S. 1932 (2006). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-109s1932enr/pdf/BILLS-109s1932enr.pdf>.

The False Claims Act. 12 Stat. 696 (1863). The Library of Congress, <https://www.loc.gov/law/help/statutes-at-large/37th-congress/session-3/c37s3ch67.pdf>.

False Claims Amendments Act of 1986. 100 Stat. 3153 (1986). Government Printing Office, <https://www.govinfo.gov/content/pkg/STATUTE-100/pdf/STATUTE-100-Pg3153.pdf#page=1>.

Federal Anti-Kickback Statute, Information Release MA07-24 (12/13/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA07-24%20Federal%20Anti-Kickback%20Statute-signed.pdf>.

Fraud Enforcement and Recovery Act of 2009. 123 Stat. 1617 (2009). Government Printing Office, <https://www.govinfo.gov/content/pkg/STATUTE-123/pdf/STATUTE-123-Pg1617.pdf#page=1>.

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

1.8. Self-Reporting Overpayments

Providers that are aware of an overpayment by the Department must immediately repay the improper amounts. If an overpayment is identified within the time frame allowed for a claim adjustment, providers should adjust their claims per the [General Billing Instructions](#), Idaho Medicaid Provider Handbook. If the overpayment is identified beyond the allowed adjustment period, providers must submit the [Overpayment Form](#) to DXC Technology. Providers will be contacted by the Medicaid Program Integrity Unit within five (5) working days to discuss repayment.

Incentives are extended to providers who responsibly self-report including:

- Extended repayment terms;
- Waiver of civil monetary penalties;
 - Civil monetary penalties cannot be waived for criminal history background compliance cases, but an audit would not be done on all employees; and
- Quick resolution of overpayments.

Situations that could cause an overpayment include, but are not limited to:

- Incorrect coding or billing;
- Services provided by an unlicensed or excluded individual; and
- Claims submitted for services that didn't occur.

1.8.1. References: Self-Reporting Overpayments

"Provider Self-Report of Overpayments." *MedicAide Newsletter*, June 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf>.

2. Participant Financial Responsibility

Providers enrolled with Idaho Medicaid that provide items or services to a participant must bill any third-party liable payor and Idaho Medicaid. Any payment made by Idaho Medicaid must be accepted as payment in full. This also includes claims with third-party liability where Medicaid's reimbursement methodology considers the third-party payment to have covered the claim in full and no additional amount is paid by Medicaid.

Unless stated otherwise by the Department (e.g. Idaho Medicaid co-pays and share of cost) no additional payment may be collected from the participant either before or after Medicaid payment, regardless of a separate contract between the participant and the provider for assumption of liability. This includes, but is not limited to:

- No-show or missed appointment fees;
- Other insurer's co-pays;
- Failure on the part of the provider to submit a complete and correct claim to the Department or other payor;
- Failure by the provider to submit a complete and correct request for prior authorization from the Department or other payor;
- Claims voided by the provider;
- Failure of the provider to follow any payor's policy or procedure; or
- Any recoupment or penalties the provider receives as a result of their action or inaction.

Providers may bill a participant when a third-party payment (e.g. automotive insurance adjustment) was made to the participant instead of the provider, in which case the participant may be billed for an amount equal to that payment.

Providers can bill participants for non-covered or excluded items and services. Prior to rendering services or providing items that are non-covered or excluded, providers must inform participants that what they are receiving is not covered under Medicaid. Providers may only bill non-covered and excluded services and items to the participant if the provider has notified the participant of their responsibility to pay in writing prior to rendering services. Idaho Medicaid does not have an official format, but the notice must specify the non-covered/excluded service or item, the cost of each service or item, and be signed by the participant. If the participant chooses to obtain services not covered or excluded by Medicaid, it is the participant's responsibility to pay for the services. See the [Non-Covered and Excluded Services](#) section for more information.

Providers are exempt from the requirement to notify the participant in writing for services provided during any period where the participant was later found retroactively eligible for Medicaid coverage. However, providers must adhere to all other requirements of being a Medicaid provider. If the provider previously collected a payment that would not be allowed by Idaho Medicaid from a participant later found eligible, the payment must be refunded.

See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about third-party liability, co-payments, share of cost and reimbursement methodologies.

2.1. Co-payments

Some participants may be subject to a co-pay. When verifying a participant's eligibility a co-pay indicator of "Exempt" or \$3.65 will be provided. Participants can only be charged a co-pay as specified by the provider handbook and when the reimbursement amount for the service is more than \$36.50 in the Medicaid Fee Schedule.

Preventive services for wellness including exams for babies and children, immunizations or family planning services are excluded from co-pay. These services, however, are subject to a co-pay:

- [Ambulance services](#) for a non-emergency;
- [Chiropractic](#);
- [Emergency room services](#) for a non-emergency;
- [Podiatric](#);
- [Eye and vision services](#) provided by an optometrist;
- [Physical and Occupational Therapy](#);
- [Speech Language Pathology](#);
- [Physician and Non-physician practitioner](#) services;
- [Federally Qualified Health Centers \(FQHC\)](#); and
- [Rural Health Clinics \(RHC\)](#).

The provider of services is responsible for collection of the copayment. 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. If a participant subject to a co-pay is unable to make a payment, the provider may:

- Bill the participant for the co-pay;
- For participants with incomes above 100% of the federal poverty level (FPL), refuse to provide services at that time; or
- Waive the co-pay if the provider has a written policy describing the criteria for waiving and enforcing collection of co-pays.

2.1.1. References: Co-payments

a) Idaho Medicaid Publications

Co-payment for Non-Emergency Use of Ambulance Transportation Services, Information Release MA07-04 (1/08/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA07-04.pdf>.

Co-payment for Non-Emergency Use of an Emergency Room, Information Release MA07-03 (1/05/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA07-03.pdf>.

Co-payments, Information Release MA11-26 (10/24/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA11-26.pdf>.

Co-payments (Co-pays), Information Release MA11-29 (11/22/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA11-29%20Co-payments%20phase%202.pdf>.

b) Regulations

Co-payments, Idaho Code 56-257 (2011). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-257/>.

"Collection of Copayments." *IDAPA 16.03.18, "Medicaid Cost Sharing,"* Sec. 330. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

"Criminal Penalties for Acts Involving Federal Health Care Programs." Social Security Act, Sec. 1128B(b)(3)(D) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916A.htm.

"Exception to Charging a Copayment." *IDAPA 16.03.18, "Medicaid Cost Sharing,"* Sec. 325. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

"Medicaid Outpatient Services Subject to Copayments." *IDAPA 16.03.18, "Medicaid Cost Sharing,"* Sec. 320. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

Medicaid Premiums and Cost Sharing, 42 CFR 447.50—447.90 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part447-subpartA.pdf>.

"State Option for Alternative Premiums and Cost Sharing." Social Security Act, Sec. 1916A (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916A.htm.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(14) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

"Use Of Enrollment Fees, Premiums, Deductions, Cost Sharing, And Similar Charges." Social Security Act, Sec. 1916 (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916.htm.

2.2. 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/IID 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; and
- Rate Code 17: Skilled Nursing Facilities (Long Term Care) or ICF/IID 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 [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.

2.2.1. 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 Idaho DXC Technology Medicaid website, under [DXC Technology Forms](#).

2.2.2. 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 [DXC Technology Forms](#). The instructions to fill out the form are in the same location. All fields in the forms are **required**.

2.2.3. References: Participant Financial Responsibility

Acceptance of State Payment as Payment in Full, 42 CFR 447.15 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec447-15.pdf>.

"Responsibility for Keeping Appointments." *IDAPA 16.03.09*, "Medicaid Basic Plan Benefits," Sec. 160. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

3. Surveillance and Utilization Review

Medicaid has a statewide surveillance and utilization review program that safeguards against unnecessary utilization of care and services and excessive payments. It provides for the control of the utilization of all services provided under the plan and assesses the quality of those services.

3.1. Provider Program Abuse

The Medicaid Program Integrity Unit (MPIU) conducts reviews and investigations to determine whether or not a provider is incorrectly billing Medicaid. The MPIU also conducts random studies of provider payment histories to detect billing errors and over-utilization. They perform on-site visits and obtain records to verify that services billed correspond to services rendered to participants. Once services are reviewed, issues may be resolved by provider education or policy revision, recovery of funds from the provider, and/or assessment of civil monetary penalties. In more serious cases, the Department can take any or all of the following actions:

- Suspend payment pending further investigation;
- Terminate provider numbers;
- Exclude entities/individuals;
- Refer individuals/providers for criminal prosecution.

If you believe that a particular Medicaid provider is abusing the program, you may contact:

Medicaid Program Integrity Unit
PO Box 83720
Boise, Idaho 83720-0036
prvfraud@dhw.idaho.gov
Fax 1(208) 334-2026

3.2. Retrospective Review

A retrospective review is a determination of coverage after a claim has been submitted. It may even occur after payment has been made. Should a review find that payment for a claim was inappropriate, it may be recouped. The review checks for appropriate documentation, medical necessity, and adherence to all applicable rules, regulations, and statutes. Receipt of documentation and claim payment is not certification that the Department has conducted a review or verified the appropriateness of a claim.

Providers may appeal a finding on a retrospective review by Medicaid or its designee by requesting a reconsideration. If the provider disagrees with the result of the reconsideration, they may file a formal appeal.

3.2.1. Reconsideration Request

Prepare a written Request for Reconsideration including additional documentation to support the validity of your claim. Documentation may include medical records, guidance from the Centers for Medicare & Medicaid Services, Idaho Provider Handbooks, Idaho statute, or Idaho Administrative Procedure Acts (IDAPA). Resubmit to the reviewing agent within 28 days from the mailing date of the Notice of Decision.

Upon completion of the reconsideration review, Medicaid will issue a second Notice of Decision. If the provider or participant disagrees with the 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 to submit a formal appeal.

3.2.2. Appeal Request

A formal appeal must be submitted in writing with supporting documentation within 28 days of the reconsideration's Notice of Decision to:

Hearings Coordinator
Idaho Department of Health and Welfare Administrative Procedures Section
P.O. Box 83720
Boise, ID 83720-0036
FAX 1 (208) 334-6558

Documentation may be faxed but copies of the original documents must be provided to the Department in the mail. Documentation must include:

- A copy of the first Notice of Decision from the reviewing agent;
- A copy of the Request for Reconsideration from the provider;
- A copy of the second Notice of Decision from the reviewing agent showing that the request for reconsideration was performed;
- An explanation of why the reconsideration remains contested by the provider; and
- Copies of all supporting documentation.

You will be notified in writing by a Hearing Officer to set up a date, time, and location of for the hearing.

4. Services for Providers

DXC Technology is the fiscal agent for the Idaho Medicaid Program. The primary objective for DXC Technology is to process Medicaid claims efficiently and accurately for Idaho Medicaid providers. The DXC Technology Provider Enrollment Department enrolls providers into the Idaho Medicaid Program and responds to providers' requests for information not currently available through Idaho's Medicaid Automated Customer Service (MACS). The DXC Technology Provider Services Department helps to keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid and to answer any questions regarding claims and eligibility.

4.1. Idaho Medicaid Automated Customer Service (MACS)

Medicaid Automated Customer Service (MACS) is the interactive voice response system (IVR) that allows a computer to recognize voice and telephone keypad inputs. MACS will allow users to access a database via a telephone touchtone keypad or by speech recognition, after which they can service their own inquiries by following the instructions. MACS will respond with pre-recorded audio to further direct users on how to proceed. MACS can be used to control almost any function where the system can be broken down into a series of simple menu choices.

The following table shows the information available through MACS. The phone number for MACS is 1 (866) 686-4272.

Information Available in MACS				
Claims Information	Last Payment Amount	Mailing Addresses	Participant Information	Security Code
Claim status	Amount and date of payment	Paper claims	Copay/Deductible	Create a new code
Procedure code coverage	Number of claims paid	ResHab/PCS PA	Eligibility	Change an existing code
PA required for procedure code	Warrant/EFT number	Medical or Surgical PA	HC enrollment and referrals	
Units remaining		Dental PA	Lock-In	
Revenue code coverage		DME PA	Other Insurance/TPLs	
PA required for revenue code		Inpatient or Outpatient PA	Prior Authorizations	
Diagnosis code coverage		Transportation PA	Service Limits	
		All other PAs		
		Web Portal address		

4.2. Information Releases

Information releases (IR) are issued to update providers on policy, billing and claims processing changes. An IR can be published at any time to the provider portal and then will be republished in the next [MedicAide Newsletter](#). Providers are required to adhere to information communicated by an IR as part of the Compliance section of their provider agreement. The Department maintains IRs from 2001 to the present on the [Information Releases](#) webpage. IRs from before 2001 can be requested by fax or letter to:

Information Release Coordinator
Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0036
Fax: 208-364-1811

4.2.1. References: Information Releases

"Agreements with Providers: In General." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 205.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

4.3. MedicAide Newsletter

The MedicAide newsletter is a monthly publication that communicates information to Medicaid Providers and other interested parties. The newsletter contains policy, program and billing changes as well as [Information Releases](#) published since the last edition. Providers are required to adhere to information in newsletter articles as part of the Compliance section of their provider agreement.

The newsletter is published electronically by the 5th business day of the month at DXC Technology's [Idaho Medicaid](#) website. Paper copies may be requested by calling 1 (866) 686-4272. Subscriptions are unavailable at this time. Back issues from May 2010 to the present are available at DXC Technology's website. Issues before May 2010 are available on the Department's [MedicAide Newsletter](#) webpage.

4.3.1. References: MedicAide Newsletter

"Agreements with Providers: In General." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 205.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

4.4. Provider Handbooks

The [Idaho Medicaid Provider Handbook](#) is the primary repository for policy and billing instructions. The handbook is updated periodically with program changes and to incorporate information communicated in [Information Releases](#) or the [Medicaid Newsletter](#). Providers are required to adhere to information in the handbook as part of the Compliance section of their provider agreement. Should the handbook ever appear to contradict relevant provisions of state or federal rules and regulations, the rules and regulations prevail.

Any paper or digital copy of these documents is considered out of date except the version appearing on DXC Technology's [Idaho Medicaid](#) website.

4.4.1. References: Provider Handbooks

"Agreements with Providers: In General." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 205.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

4.5. Provider Service Representatives (PSRs)

Provider service representatives are available Monday through Friday from 7 A.M. to 7 P.M. Mountain Time by calling MACS at 1 (208) 373-1424 or 1 (866) 686-4272, and saying representative or rep. DXC Technology provider service representatives are trained to promptly and accurately respond to requests for information on:

- Adjustments;
- Billing instructions;
- Claim status;
- Participant benefit information;
- Participant eligibility information;
- Form requests;
- Payment information;
- Provider participation status information;
- Recoupments; and
- Third party recovery information.

When calling with questions about claim status, please have the following information ready:

- Billing provider's Idaho Medicaid provider number;
- Participant's Medicaid identification number; and
- Date(s) of service.

When calling for questions about participant eligibility, have the following information ready:

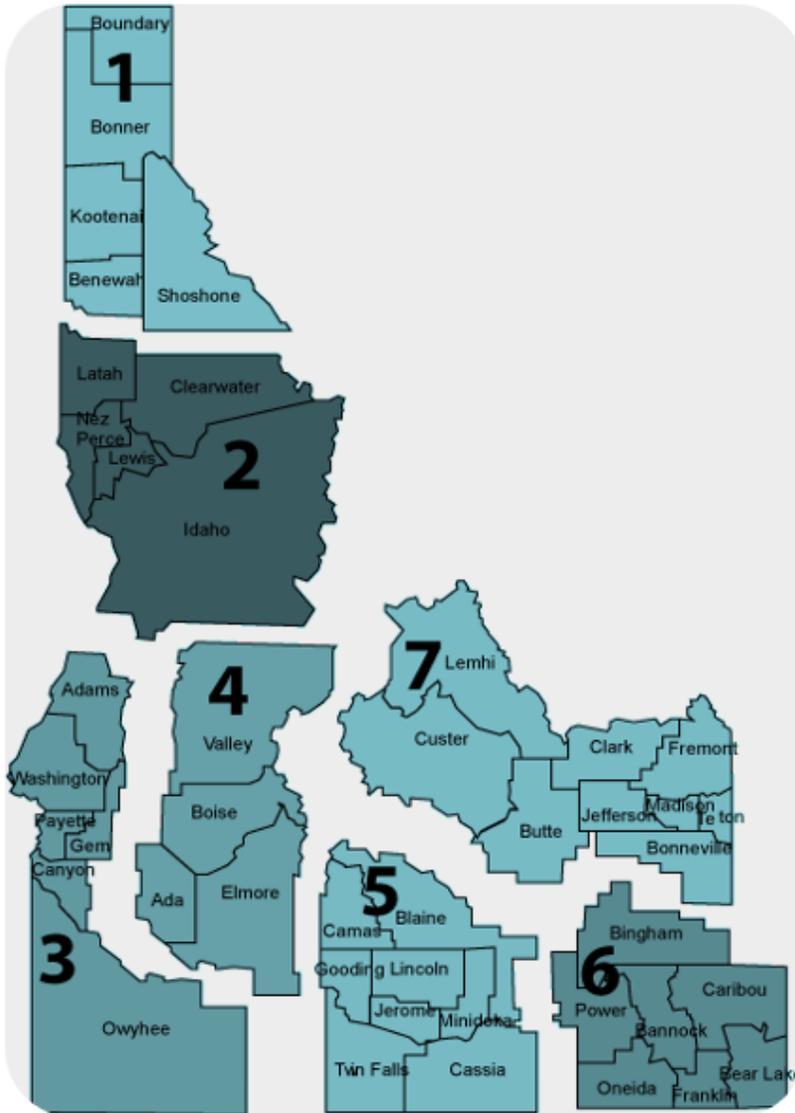
- Billing provider's Idaho provider number;
- Participant's first and last name; and
- Participant's Medicaid identification number, date of birth, or Social Security number.

4.6. Provider Relations Consultants (PRC)

DXC Technology Provider Relations Consultants help keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid. Provider Relations Consultants accomplish this by:

- Conducting provider workshops;
- Conducting live meetings for training;
- Visiting a provider's site to conduct training; and
- Assisting providers with electronic claims submission.

Provider Relations Consultant (PRC) Contact Information



Region 1 and the state of Washington
Region.1@DXC.com

Region 2 and the state of Montana
Region.2@DXC.com

Region 3 and the state of Oregon
Region.3@DXC.com

Region 4 and all other states
Region.4@DXC.com

Region 5 and the state of Nevada
Region.5@DXC.com

Region 6 and the state of Utah
Region.6@DXC.com

Region 7 and the state of Wyoming
Region.7@DXC.com

5. Provider Enrollment

Idaho Medicaid enrolls two types of providers, billing and non-billing (e.g., [crossover only providers](#), and [non-billing ordering, referring and prescribing providers](#)). All providers wishing to participate in the Idaho Medicaid Program must first register for a Trading Partner Account (TPA) at <https://www.idmedicaid.com> and then follow the link for the Provider Enrollment Application upon logging in. A complete application includes a Medicaid Provider Enrollment Agreement and a W-9, which must be signed by the provider and submitted with the enrollment application along with other attachments to DXC Technology through the website.

Individual providers enrolling must disclose information, including, but not limited to:

- Date of birth (DOB);
- Social Security Number (SSN);
- Licensure;
- National Provider Identifier (if applicable); and
- Convictions of any criminal offense related to the person's involvement in any program under Medicare, Medicaid, or CHIP since those programs began.

All owners, corporate officers, directors, or shareholders of legal entities to include the following: general or limited corporations; partnerships; professional corporations or associations; limited liability companies with a direct, indirect or control interest; managed care organizations AND managing employees or fiscal agents who exercise day-to-day operational or managerial control or operations must also disclose information upon enrollment in Medicaid. A disclosing entity is defined as "a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent." Disclosing entities must disclose:

- Names and addresses of any persons with an ownership or control interest in the entity;
- Names, addresses, DOBs, and SSNs of any managing employee or fiscal agent of the disclosing entity;
- Whether a person with an ownership interest is related to another person with an ownership or control interest;
- Names of other disclosing entities in which the owner, managing employee or fiscal agent has an ownership or control interest regardless of the percentage of ownership;
- Convictions of persons who have ownership or control interests in the provider entity;
- Convictions of persons who are managing employees or fiscal agents of the provider entity; and
- Whether any person with an ownership or control interest, a managing employee or a fiscal agent has voluntarily revoked, terminated or been subject to revocation or termination action of a Medicare, Medicaid or CHIP enrollment as defined by 42 CFR 455.107.

Both individuals and entities must disclose family relationships between persons with ownership or control interests in the disclosing entity.

The provider must meet all applicable state and Medicaid licensure/certification and insurance requirements to practice their profession. In addition, the provider qualification requirements for the service(s) to be provided must be met. Information supplied will be used to validate credentials. Other certification/licensure and proof of insurance may be required as provided for in [IDAPA 16.03.09, "Medicaid Basic Plan Benefits"](#) and [IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits"](#).

Continued provider participation is contingent on the ongoing maintenance of such licensure/certification and proof of insurance. The loss of, or failure to renew, the required license/certification and proof of insurance is cause to terminate a provider's participation in the Idaho Medicaid Program.

Additional information about Idaho administrative rules is available on Access Idaho at the Legislative Branch link under the Government heading. See [Appendix A Provider Agreement Example](#) for provisions that apply to all providers.

5.1. Non-billing Ordering, Referring and Prescribing Providers

Healthcare professionals that do not wish to be Medicaid providers can instead choose to enroll as non-billing entities for the sole purpose of ordering services and items. This allows participants to fill prescriptions or an Idaho Medicaid provider to accept a referral. Providers wishing to enroll as non-billing ordering, referring and prescribing providers must complete an enrollment application, sign the Idaho Medicaid Provider Agreement, and retain all documentation to support services ordered including the establishment of medical necessity. The Department has established a streamlined process to enroll non-billing individuals whose only relationship with the Idaho Medicaid program is to refer for specialized care or order items or services. This enrollment is for individuals only, not facilities or group provider entities. Call Idaho Medicaid Provider Enrollment toll free at 1 (866) 686-4272 for a non-billing provider enrollment form. This enrollment method *is not* for individuals who want to submit claims to Idaho Medicaid for reimbursement for their services. If an enrolled non-billing provider later chooses to start billing Idaho Medicaid, they can contact Provider Enrollment for instructions on converting their account.

5.1.1. References: Non-billing Ordering, Referring and Prescribing Providers

"Edits Will Change from Warn to Deny on October 1, 2017." *Medicaid Newsletter*, September 2017, <https://www.idmedicaid.com/Medicaid%20Newsletters/September%202017%20Medicaid.pdf>.

Enrollment and Screening of Providers, 42 CFR 455.410 (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

"1.5.1.B. Ordering or Referring Physicians or Other Professionals (ORP)." *Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicare.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

"Ordering, Prescribing, and Referring Providers." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 210.06. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"1.5.2. When Screening is Required." *Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicare.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

5.2. Crossover Only Providers

Healthcare professionals that do not wish to be a Medicaid provider can instead choose to enroll as crossover only providers to receive coinsurance and deductible payments for participants dually eligible for Medicare and Medicaid. Enrollment as a crossover only provider also allows the professional to be an [ordering, referring and prescribing provider so long as they meet all other the requirements](#). This enrollment option *is not* for individuals who want to submit claims to Idaho Medicaid for reimbursement for non-Medicare services or participants with Medicaid only.

Providers wishing to enroll as a crossover only provider must complete an enrollment application with their Medicare certification, sign the [Idaho Medicaid Provider Agreement](#), and retain all documentation to support services ordered including the establishment of medical necessity. This enrollment is for professional services only. If an enrolled provider later chooses to start billing Idaho Medicaid for these services, they can contact Provider Enrollment for instructions on converting their account.

See [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about reimbursement for participants dually eligible for Medicare and Medicaid.

5.2.1. Mental Health Clinics

Idaho Medicaid's outpatient mental health and substance use disorder services are usually covered under the [Idaho Behavioral Health Plan \(IBHP\)](#) with benefits administered under contract by [Optum Idaho](#). However, participants with only [Medicare Coinsurance and Deductible](#) eligibility, benefits are not received under the IBHP. Mental Health Clinics providing services to these participants are reimbursed through Fee-For-Service Medicaid. The clinic must enroll as a crossover only provider with a group NPI or service location with all Medicare certified staff as rendering providers (e.g. Licensed Clinical Social Workers).

5.3. Medicaid Provider Identification Numbers

5.3.1. Individual Provider Numbers

The National Provider Identifier (NPI) is a requirement of HIPAA. The NPI must be used on all electronic claims and will identify healthcare providers to health plans with a unique 10-digit numeric provider identifier. An NPI can only be associated to one Tax ID, but a Tax ID can be associated to many NPI numbers or Idaho Medicaid Provider numbers. Providers who registered in the MMIS with an NPI will use that NPI on all their transactions, whether paper or electronic. Reimbursement for providers with an NPI is sent to the pay-to address associated with the NPI. Providers that do not have an NPI can apply for one online at <https://nppes.cms.hhs.gov/#/> or by calling 1 (800) 465-3203 for a paper application.

Provider-types that do not meet the HIPAA definition of a healthcare provider are considered atypical provider types. Atypical providers are generally not eligible to receive a NPI number. Instead a unique 8-digit Idaho Medicaid Provider Number is assigned during enrollment. Claim reimbursement is sent to the pay-to address associated with the Medicaid provider number. The types of providers Idaho Medicaid recognizes as atypical are listed below:

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

5.3.2. Multiple Service Locations

When billing claims, providers with multiple service locations must enter a three-digit site number (i.e. 001, 002) to identify the specific location, in addition to their NPI/Medicaid ID. The three-digit location code is identified on the provider enrollment approval letter. Providers can also obtain this number by logging into their Trading Partner Account to view the information.

This information will be entered in the following fields:

- Paper UB04, enter in field 2;
- Paper CMS-1500, enter in field 32a; or
- Electronic claims refer to [837 Professional/Institutional](#) companion guide.

5.3.3. Group Practice

The Centers for Medicare and Medicaid Services (CMS) requires the identification of the individual who actually performs a service when billing under a group number. The performing

provider's individual NPI/Medicaid provider number must be on the claim as well as the provider's group NPI/Medicaid number.

5.4. Provider Licensing

Medicaid Providers are required to be licensed, certified, or registered with the appropriate state authority. The claims processing system verifies the effective dates of the provider's license against the date of service. Provider licensure must be up to date in their provider file or claims will be denied at the header level. Providers are required to split claims for covered and non-covered dates of service, or update their license with DXC Technology and resubmit the claim.

5.5. Ownership and Controlling Interests

Providers with any type of partnership, corporation or nonprofit entity are obliged in the Idaho Department of Health and Welfare Medicaid Provider Agreement that the entity and the partners, directors, officers, members, or individuals with an ownership interest of 5% or greater, are jointly and severally liable for any breach of this Provider Agreement, and that action by the Department against the Provider may result in action against all such individuals in the entity.

The agreement also stipulates that providers will furnish the Department or the U.S. Department of Health and Human Services, within thirty-five (35) days of the request, full and complete information related to certain business transactions, specifically about:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Providers are also required in their Provider Agreement to comply with the disclosure of ownership requirements in 42 CFR Part 455, Subpart B, and 42 CFR 411.361, when applicable, and to notify the Department thirty (30) days prior to any change of ownership. The Provider Agreement is not transferable to the new owner.

5.6. Provider Risk Levels

42 CFR 455.450 requires states to assign a categorical risk level for each provider type. The screening level determines the processes the state must use for enrollment of new providers and revalidation of existing providers. Whenever appropriate, Idaho uses the risk levels assigned by Medicare. States are allowed to use the same risk level assigned by Medicare, but may not assign a risk level lower than Medicare. The screening requirements listed below are in addition to all other provider enrollment requirements already established.

Screening Required by the Affordable Care Act by Provider Risk Level			
Type of Screening Required	Limited	Moderate	High
Verification of any provider/supplier-specific requirements established by Medicare	X	X	X
Conduct license verifications (may include licensure checks across States)	X	X	X
Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	X	X	X
Pre and post enrollment Site Visits (Unscheduled/Unannounced)		X	X
Criminal Background Check			X
Fingerprinting			X

5.6.1. Limited Risk Providers

Adult Day Care
Ambulatory Surgical Center (ASC)
Assistive Tech Supplier
Audiologist
Behavior Consultation/Crisis Management
Certified Family Home (CFH)
Children's Service Coordination (CSC)
Chiropractor
Chore Services
Classic Optical
Clinic/Center - Hearing & Speech
Clinic/Center - Rehab, SA - Division of Behavioral Health
Critical Access Hospital (CAH)
Developmental Disability (DD) Case Management
Developmental Disability (DD) Child Independent Crisis Intervention/Professional
Developmental Disability (DD) Independent Therapeutic Consultation
Developmental Disability Agency (DDA)
Developmental Disability Agency (DDA) - Support Only Child Services

Diabetes Educator
Diagnostic Services
Dialysis Unit
Dietician
End-stage Renal Disease (ESRD) Facilities
Federally Qualified Health Clinic (FQHC)
Groups (Idaho has groups of physicians, non-physician practitioners, and therapists)
Home Modifications
Home-Delivered Meals
Hospital
Indian Health Service (IHS)
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – private
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – state
Mental Health Case Management
Mental Health Clinic
Nurse Non-Physician Practitioner
Occupational Therapist
Optician
Optometrist
Personal Care Services (PCS) Aged and Disabled (A&D) Agency
Personal Care Services (PCS) Family Alternate Care Home
Personal Care Services (PCS) Homes - DD children
Personal Emergency Response System (PERS)
PHA – Weight Management Dietician
PHA – Weight Management
Pharmacy (clinic, retail, institution, specialty, mail, unit dose)
Pharmacy Infusion Therapy
Physician
Physician Assistant
Podiatrist
Pregnant Women Clinic (PWC) – CLIA
Private Duty Nursing (PDN) Agency
Public Health
Radiology/Other Techs
Rehab Mental Health
Residential Assisted Living Facility (RALF)
Residential Habilitation Agency
Respite Care
Rural Health Clinic (RHC)
School Based Services (SBS)
Skilled Nursing Facility (SNF)
Social Worker
Speech Language Pathologist (SLP)
Supported Employment Services
Support Brokerage-Fiscal Employer Agent (FEA)

Swing Bed Units
Transportation

5.6.2. Moderate Risk Providers

Idaho Moderate Risk Provider Types
Lab CLIA
Ambulance
Physical Therapist
Hearing Aid Vendor
Clinic/Center – Physical Therapy (PT)
Clinic/Center – Mobile Radiology
Home Health (Existing Idaho Providers)
Hospice
Pharmacy – Durable Medical Equipment (DME)
Durable Medical Equipment (DME) (Existing Idaho Providers)
Prosthetics & Orthotics–existing
Portable X-ray

5.6.3. High Risk Providers

In addition to the provider types below, any provider will individually be considered high risk when the provider:

- Has a payment suspension based on a credible allegation of fraud occurred within the last ten years;
- Was excluded within the last ten (10) years by HHS-OIG or any state Medicaid agency;
- Has a qualifying Medicaid overpayment; or
- Is enrolling within six months of the date of the lifting of a temporary moratorium that at the time would have barred the provider’s enrollment.

Idaho High Risk Provider Types
Home Health (New to Idaho Medicaid)
Durable Medical Equipment (DME) (New to Idaho Medicaid)

5.6.4. References: Provider Risk Levels

“Medicaid Provider Enrollment Requirements.” *MedicAide Newsletter*, October 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf>.

Screening Levels for Medicaid Providers, 42 CFR. 455.450 (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

5.7. Provider Enrollment Moratoria

At its discretion the Department may request from CMS a temporary prohibition on provider enrollment for a provider type when necessary to prevent or combat fraud, waste and abuse. The moratorium lasts for a six-month increment initially and may be repeatedly extended for the same. Any providers requesting enrollment under such a provider type during a moratorium must be denied by the Department. At this time Idaho Medicaid does not have a moratorium in place.

5.7.1. References: Provider Enrollment Moratoria

"Medicaid Provider Enrollment Requirements." *MedicAide Newsletter*, October 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf>.

Temporary Moratoria, 42 CFR 455.470 (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

5.8. Maintenance of Contact Information

Providers shall notify the Department of any changes to the information contained in the Enrollment Application, including but not limited to their mailing address and service locations, within 30 days of the date of the change. The Department is required by Federal regulations to terminate a provider's enrollment for failure to submit timely and correct information, which may also affect the provider's enrollment in other states' Medicaid programs. The Department may allow a provider to keep their enrollment if it documents in writing that termination would not be in the best interests of the Medicaid program. Failure to keep information current may also result in recoupment and penalties.

All correspondence sent to the mailing address on file with the State's fiscal agent shall be deemed to be received by the Provider. Department correspondence will not be forwarded by a change of address with the U.S. Postal Service. See the [Provider File Updates](#) subsection for instructions on updating contact information.

5.8.1. References: Maintenance of Contact Information

Provider Screening and Enrollment, 42 CFR. 455 Subpart E (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

"Reminder to All Providers." *MedicAide Newsletter*, November 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202016%20MedicAide.pdf>.

5.9. Provider File Updates

After enrolling, any updates that need to be made to the provider file can be done through the online portal at the Idaho [DXC Technology Medicaid](#) website. Once logged into your Trading Partner Account (TPA), select the **Provider Enrollment Application** link and choose either Provider Maintenance-Demographic or Provider Maintenance (Full) to electronically maintain your provider record. If you are unable to make updates via the online portal, providers must notify Provider Enrollment, in writing, when there are changes in their status. Provider maintenance forms may also be accessed through your TPA account. The written notice must include the provider name and current NPI or Medicaid provider number.

Status changes include:

- Change in address (or change in any other provider’s address, if a group practices);
- New phone number;
- Name change (individual, group practice, etc.);
- Change in ownership;
- Change in tax identification information;
- Change in provider status (voluntary inactive, retired, etc.) must be written notification;
- Add/update/end date of rendering providers; and
- Add/update/end date of service locations.

Provider File Updates	
Provider Maintenance	Provider Maintenance–Demographic
Screen: Business Information Update the FEIN Update the Name Check the box to update the provider name	Screen: Business Information Update Office Contact Information Phone Numbers Fax Number Gender (Individual only)
Screen: Pay-To Address Update the Pay-To Physical Address Update the Pay-To Correspondence Mailing Address Update W-9 Information Update the Type of Tax Entity Update the Exempt Payee Status Update Sanctions (Individual only)	Screen: Pay-To Address No updates available
Screen: Ownership Update and Add Owners & Board Members Update the Owner/Board Member Type Update the Owner/Board Member Address Info Update Sanctions	Screen: Ownership No updates available
Screen: Owner Relationship Update Relationship to Owner/Board Members Add Owner/Board Relationships Add Ownership or Control Interest Information	Screen: Owner Relationship No updates available
Screen: Service Location Summary Add Service Location	Screen: Service Location Summary Edit Site Information

Provider File Updates	
Provider Maintenance	Provider Maintenance–Demographic
Terminate a Service Location Change Site Name	
Screen: Service Location Address No updates available	Screen: Service Location Address Update physical address phone number Update additional Languages Spoken Update Office Hours Update other Office Information
Screen: Service Location Provider Type and Specialty (PTSP) Add/Update Specialties Add/Update Specialty Details	Screen: Service Location Provider Type and Specialty (PTSP) No updates available
Screen: PCCM Information Update Service Location Details Update Other Restrictions Update Special Accommodations Update After Hours Coverage Update After Hours Phone Number Update NPI/Medicaid IDs of covering Medicaid Providers	Screen: PCCM Information No updates available
Screen: Financial Agreement Update routing of payments automatically Update the Account Details Terminate current banking information	Screen: Financial Agreement No updates available
Screen: Documentation Provider Agreement Enrollment Application Acknowledgement W-9 Ownership & Conviction Signature on File Authorization for Electronic Funds Transfer (if necessary) Staff Affiliation Roster (if necessary) Group Affiliation Roster (if necessary) Driver Roster (if necessary) Vehicle Roster (if necessary)	Screen: Documentation No updates available

Note: The postal service will not forward mail or checks. All mail and checks will be returned to DXC Technology.

To apply for additional provider numbers, contact DXC Technology Provider Enrollment.

5.10. Provider Recertification

In accordance with state and federal regulations, Medicaid monitors the status of provider participation requirements that apply to each individual provider type. Continued licensure, certification, insurance, and other provider participation requirements are verified on an ongoing basis.

5.11. Provider Termination

Medicaid is required to deny applications for provider status or terminate the Medicaid Provider Agreement of any provider suspended from the Medicare Program or another state's Medicaid program. The Department of Health and Welfare (DHW) may also terminate a provider's Medicaid status when the provider fails to comply with any term or provision of the Medicaid Provider Agreement. This includes failing to notify Medicaid or DXC Technology in writing of any changes in address or ownership.

Continued provider participation is contingent on the ongoing maintenance of current licensure, certification, or insurance. Failure to renew required licenses, certification, or insurance is cause to terminate a provider's participation in the Idaho Medicaid Program.

5.12. References: Provider Enrollment

Disclosure of Information by Providers and Fiscal Agents, 42 CFR 455 Subpart B (1979). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartB.pdf>.

Medicaid Provider Enrollment Compendium (MPEC). Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

"Medicaid Provider Enrollment Requirements." *MedicAide Newsletter*, October 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf>.

Provider Screening and Enrollment, 42 CFR 455 Subpart E (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

"Reminder to All Providers." *MedicAide Newsletter*, November 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202016%20MedicAide.pdf>.

Reporting Requirements, 42 CFR 411.361 (2016). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol2/pdf/CFR-2018-title42-vol2-sec411-361.pdf>.

6. Participant Eligibility and Benefit Plan Coverage

Medicaid is a medical assistance program that is jointly funded by the federal and state governments to assist in providing medical care to individuals and families. Applicants must meet each of the financial and non-financial requirements of a program to participate in its benefit plan, which may include a review of income, resources and other assets. Self-Reliance's field offices determine Medicaid eligibility and enroll eligible applicants in the appropriate benefit package.

General information for participants on services covered under the Idaho Medicaid Program are listed in the booklet, [Idaho Health Plan Coverage](#), which is available in English and Spanish from the Division of Medicaid, Department Regional Offices, or online. All services fall under either the [Medicaid Basic Plan](#) or [Medicaid Enhanced Plan](#). However, some participants' eligibility to receive those services may provide additional restrictions, limitations or benefits not otherwise available as described below.

See the [Provider Guidelines](#) for specific service coverage and billing details for individual programs and specialties. The guidelines are available online in the Provider Handbook.

6.1. Medicaid Identification Card

An identification card is issued when the participant is determined eligible for Medicaid benefits. All Medicaid participants, except otherwise ineligible non-citizens or presumptive eligibility (PE) participants, receive an identification card. Possession of a Medicaid ID card does not guarantee Medicaid eligibility. Providers should request the Medicaid ID card with additional picture identification and retain copies of this documentation for their records.

The participant’s Medicaid identification (MID) number is on the card. Cards issued after June 1, 2010 are a 10-digit number with no letters or symbols. Cards issued prior to June 1, 2010 are seven digits. Providers should convert the older versions by adding three zeroes to the front of the MID number.



Participants enrolled in the Idaho Medicaid Plus (IMPlus) plan or Medicare Medicaid Coordinated Plan (MMCP) are issued an alternative Medicaid card by their chosen or assigned health plan.

IMPlus Health Cards



MMCP Health Cards

Healthy Advantage Plus HMO
 Member: GURBAX K GREWAL
 Member #: 8000880001486
 Issue ID: 80840

PCP: RUSSELL M SMITH RxBIN: 004336
 RxPCN: MEDDADV
 PCP Tel: (801)571-7777 RxGRP: RX5002
 RxID: 8000880001486

Medical Copays:
 Office Visits: 5
 Specialist Visits: 40
 Urgent Care: 40
 ER Visits: 75

MedicareRx
 Prescription Drug Coverage
 H5628-007

HealthyAdvantagePlus

Issued Date: 09/28/2016




John Q Public
 H1350 009
 Primary Care Physician
 Welby, Marcus C.
 PCP Phone (208) 999-9999

Enrollee Identification Number
 XN09L23456789

Group Number	0100000	Office Visit Copay	\$0
RxBIN	004336	ER Visit Copay	\$0
RxPCN	MEDDADV	Dental	Yes
RxGROUP	RX5027	Card Effective Date	09/01/2014

An Independent Licensee of the Blue Cross and Blue Shield Association.



6.2. Verifying Participant Eligibility

Participant eligibility is determined on a month-to-month basis. Providers are required to verify and document participant eligibility on the date of service prior to rendering services to qualify for reimbursement. Medicaid only reimburses for services rendered while the participant is eligible for Medicaid benefits. Deceased participants are not eligible for services or items. Providers will not receive reimbursement for services or items provided after the participant's date of death.

Example

A participant is eligible and has Medicaid coverage during the months of April and June. The participant was found ineligible and didn't have coverage during May.

Eligibility information can be accessed three different ways:

- Trading Partner Account (TPA) on [DXC Technology's Idaho Medicaid](#) website;
- MACS 1 (866) 686-4272; or
- HIPAA compliant vendor software (tested with DXC Technology).

To obtain eligibility information from one of these systems, submit two participant identifiers from the following list:

- MID number;
- Social Security number (SSN);
- Last name, first name; or
- Date of birth.

Available participant eligibility information includes eligibility dates and Healthy Connections (HC) enrollment data, Medicaid special program limitations, certain service limitations, procedure code inquiries, third party recovery (TPR), Medicare coverage information, co-payments, and lock-in data. When viewing participant eligibility on a trading partner account Healthy Connections information is listed on the "Network" tab. If no information is available, then the participant is not enrolled with Healthy Connections.

6.2.1. Medicaid Automated Customer Service (MACS)

Providers can use MACS to check participant eligibility. Eligibility information is available on:

- Healthy Connections Program;
- Eligibility with special programs;
- Service limits;
- Prior authorization (PA);
- Co-payments; and
- Other health coverage.

MACS informs providers of the type of Medicaid benefits a participant is eligible for on the dates of service. More information about MACS can be found in the [Idaho Medicaid Automated Customer Service \(Idaho MACS\)](#) section of this handbook.

Participants who are eligible for the full range of Medicaid services have their benefit plans communicated as eligible for Medicaid benefits. Participants who are not eligible for the full range of Medicaid services have their restrictions reported according to their benefit plan.

Example

A participant eligible for the Medicaid Basic Plan would have their eligibility communicated as eligible for basic Medicaid benefits, and only benefits restricted to the basic plan are communicated.

The benefit plans for Presumptive Eligibility (PE), Lock-in, and Co-pay remain unchanged and the restrictions for participants on these plans are communicated accordingly.

6.2.2. Trading Partner Account (TPA)

Information regarding online billing and eligibility verification can be found in the [Trading Partner Account \(TPA\) User Guide](#).

6.2.3. Vendor Supplied Software

Providers may contract with a software vendor and use software supplied by the vendor. Software specifications can be found on the Idaho [DXC Technology Medicaid](#) website by selecting [Companion Guides](#) under the *Reference Material* menu. The specifications assist the vendor in duplicating the program requirements and allows providers to obtain the same information available as the Idaho DXC Technology Medicaid website. All vendor software must successfully test transactions with DXC Technology before use. Providers can check eligibility using vendor software, if the software is modified to meet the requirements of the HIPAA ASC X12 270/271, version 5010 format, and if the vendor successfully tests the transactions with DXC Technology.

6.2.4. Medicaid Participants with Medicare

When verifying eligibility for Idaho Medicaid participants with Medicare one of the coverage codes in the following subsections will be returned. See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information on third-party liability and Medicaid participants with Medicare.

a) Part B Premium Coverage

If the participant only has Part B Premium Coverage, they have eligibility under Specified Low-Income Beneficiary (SLMB)/Part B Premium. This coverage is to pay for the participants Medicare Part B Premium only. These participants do not have Medicaid benefits and should be considered a Medicare only member.

b) Part B Premium Coverage/Enhanced Coverage

These are participants with dual eligibility under Medicaid and Medicare. The Department pays their Medicare premium up to the lowest allowed amount for coinsurance and deductible. These participants also have Medicaid benefits for services that are not covered by Medicare.

c) Medicare Coinsurance & Deductible

These are participants with eligibility under QMB/Medicare Coinsurance. This coverage is to pay for the participant's Medicare Part B Premium, and any coinsurance and deductible amounts for Medicare covered services. These participants do not have access to benefits outside Medicare coverage.

d) MMCP Coverage/IMPlus

These participants are enrolled with a managed care organization (MCO). The Network ID will have the name of the administrator. Unless otherwise stated claims should be billed to the MCO administrator instead of DXC Technology.

6.2.5. References: Verifying Participant Eligibility

"Clarification on Dual Eligible Participants." *MedicAide Newsletter*, April 2019,
<https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf>.

"Conditions for Payment." *IDAPA 16.03.09*, "Medicaid Basic Plan Benefits," Sec. 210.01.
Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

6.3. Participant Program Abuse/Lock-In Program

Medicaid reviews participant utilization to determine if services are being used at a frequency or amount that may be delivered at a level harmful to the participant and to identify services that are not medically necessary. Abuse can include frequent use of emergency room facilities for non-emergent conditions, frequent use of multiple controlled substances, use of multiple prescribing physicians and/or pharmacies, excessive provider visits, overlapping prescription drugs with the same drug class, and drug seeking behavior as identified by a medical professional.

To prevent abuse, Medicaid has implemented the participant lock-in program. Participants identified as abusing or over-utilizing the program may be limited to emergency services only, or the use of one physician/provider and one pharmacy. Services outside of documented emergencies by other providers will not be reimbursed. This prevents these participants from going from doctor to doctor, or from pharmacy to pharmacy, to obtain excessive services.

Participants entered in the Lock-in program will be notified by the Department in writing and have thirty-five (35) days to designate a physician/provider and pharmacy or twenty-eight (28) days to file an appeal. If a participant does not make a selection or file an appeal, they will be restricted to services for documented emergencies only and may be suspended from receiving Medicaid if abuse continues.

If a provider suspects a Medicaid participant is demonstrating utilization patterns, which may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or drug seeking behavior in obtaining prescription drugs, they should notify Medicaid of their concerns. Medicaid will review the participant's medical history to determine whether the participant is a candidate for the lock-in program.

6.3.1. Primary Care Physician (PCP)

The PCP for lock-in participants is responsible for coordination of routine medical care and making referrals to specialists as necessary. The PCP explains to the lock-in participant all procedures to follow when the office is closed, or there is an urgent or emergency situation. This coordination of care and the participant's knowledge of office procedures should help reduce the unnecessary use of the emergency room.

If the participant needs to see a physician other than the PCP, the PCP gives the participant a referral to another physician or clinic to ensure payment. See the [Referrals](#) section for more information.

If a PCP no longer wishes to provide services to the lock-in participant, the PCP must send a written notice to the participant stating the reasons for dismissal with a copy of the letter sent to the Healthy Connections Representative for that region.

6.3.2. Designated Pharmacy

A designated pharmacy has the responsibility of monitoring the participant's drug use pattern. The pharmacy should only fill prescriptions from the PCP, or from referred physicians the pharmacy confirms with the PCP.

6.3.3. References: Participant Abuse/Lock-in Program

"Participant Lock-in." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 910 – 918.
Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

6.4. Medicaid Basic Plan

The Medicaid Basic Plan has been designed to achieve and maintain wellness by emphasizing prevention and proactively managing health. It is the default plan for Medicaid participants.

Under some circumstances, participants in the Medicaid Basic Plan with a medical necessity for enhanced services may be eligible for reassignment to the Medicaid Enhanced Plan. This determination will be a joint decision made by the Self Reliance Unit in the Division of Welfare and the appropriate unit in the Division of Medicaid.

6.5. Medicaid Enhanced Plan

The Medicaid Enhanced Plan includes all of the benefits found in the Medicaid Basic Plan, and additional benefits to cover needs of people with disabilities or special health needs. Participants enrolled in this plan will be eligible for the full range of Medicaid covered services.

6.6. Presumptive Eligibility (PE)

Presumptive Eligibility (PE) assists Idaho residents not currently receiving medical assistance from the state or county, who do not have sufficient resources for private medical coverage. Presumptive eligibility provides immediate, presumed coverage for qualified candidates. The maximum coverage period is 45 days while the participant applies for coverage. A Medicaid enrolled hospital with a current Memorandum of Understanding (MOU) with the Department for PE may provide assistance to individuals in completing and submitting applications for health coverage. Staff must receive Department approved training in PE before they can complete an application and make a PE determination. A record of this training must be maintained and available to the Department upon request. For more information on the training process, please contact your local DHW eligibility office or visit the [Presumptive Medicaid Eligibility Providers](#) webpage.

PE is only available for the groups below when they meet all other eligibility criteria:

- Children up to age nineteen (19);
- Parents or caretaker relatives of eligible children;
- Pregnant women (See the [Presumptive Eligibility for Pregnant Women \(PW\)](#) section for restrictions);
- Adults eighteen (18) to twenty-six (26) who received Idaho Medicaid through the foster care program on their 18th birthday; and
- Individuals twenty-one (21) through sixty-five (65) years of age requiring treatment for breast and cervical cancer diagnosed under the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) (See the [Breast and Cervical Cancer \(BCC\) Program](#) section for more information).

PE determinations are reimbursable using HCPC T1023 (Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter). Claims must include the participant's full name, MID number and date of birth.

6.6.1. References: Presumptive Eligibility (PE)

Options for Coverage of Special Groups under Presumptive Eligibility, 42 CFR 435 Subpart L (2001). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part435-subpartL.pdf>.

"Presumptive Eligibility for Certain Breast or Cervical Cancer Patients." Social Security Act, Sec. 1920B (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1920B.htm.

"Presumptive Eligibility for Children." Social Security Act, Sec. 1920A (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1920A.htm.

"Presumptive Eligibility for Children and Parents." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 545–546. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(47) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

"Women Diagnosed with Breast or Cervical Cancer." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD),"* Sec. 802. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

6.7. Breast and Cervical Cancer (BCC) Program

The Breast and Cervical Cancer (BCC) program allows the state to provide Medicaid benefits to uninsured participants, who are not otherwise eligible for Medicaid, when they are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. In order to be eligible, an applicant must be initially screened and diagnosed through a local Women's Health Check Office (usually the district health department) participating in the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Medicaid coverage lasts for the duration of their cancer treatment, and ends when a participant's plan of care reflects a status of surveillance, follow-up or maintenance. Additionally, coverage will end if a participant's treatment relies on an unproven procedure in lieu of primary or adjuvant treatment methods.

The applicant can be presumed eligible as described in [Presumptive Eligibility \(PE\)](#) before a formal Medicaid determination. Although Medicaid resource limits do not apply, the applicant must:

- Have an income between 138% and 250% of the federal poverty level;
- Be diagnosed with breast or cervical cancer through the Women's Health Check Program;
- Be at least twenty-one (21) years old and under the age of sixty-five (65);
- Have no creditable health insurance (if insured, the plan does not cover the same type of cancer);
- Be an Idaho resident;
- Be a U.S. citizen or meet requirements for legal noncitizen;
- Not reside in an ineligible institution; and
- Not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole.

6.7.1. References: Breast and Cervical Cancer (BCC) Program

Breast and Cervical Cancer Mortality Prevention Act of 1990. H.R. 4790 (1990). Government Printing Office, <https://www.govinfo.gov/app/details/STATUTE-104/STATUTE-104-Pg409>.

Breast and Cervical Cancer Prevention Act of 2000. H.R. 4386 (2000). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-106hr4790rh/pdf/BILLS-106hr4790rh.pdf>.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Centers for Disease Control and Prevention. <https://www.cdc.gov/cancer/nbccedp/>.

Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001. S. 1741 (2001). Government Printing Office, <https://www.govinfo.gov/app/details/CREC-2001-12-19/CREC-2001-12-19-pt2-PgH10904>.

"Woman Diagnosed with Breast or Cervical Cancer." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, & Disabled (AABD),"* Sec. 802. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

6.8. Early & Periodic Screening, Diagnostic & Treatment (EPSDT)

The EPSDT benefit, or Children's Medicaid, was designed to help ensure that all Medicaid-eligible children up to the age of twenty-one (21) receive preventive health care and early intervention services needed to maximize each child's potential for healthy growth and development. The benefit allows children to receive additional services that are not covered for adults and increase access to services that have limitations on amount, duration, frequency and location (e.g., hourly and location limits on Personal Care Services). Services that would not typically be allowed due to duplication, overlap or multiple services at the same time or date of service may be considered if the services are medically necessary. Idaho Medicaid does not have an expenditure cap or wait list for services under EPSDT, however, providers may have a waitlist for appointments or scheduling procedures.

Providers of EPSDT services have all of the same requirements as other providers of their type and specialty.

Services can only be covered under EPSDT when the service is:

- Determined to be medical in nature;
- Safe, effective and generally recognized as an accepted method of medical practice or treatment;
- Not determined to be experimental, investigational or cosmetic in nature;
- Under a category of service listed in 1905(a) of the Social Security Act;
- Medically necessary to correct or ameliorate (needed to sustain or support) an illness or a health condition;
- For an illness or health condition diagnosed by a physician, therapist, or other licensed practitioner operating within the scope of their licensure; and
- Supported as medically necessary by the utilization of other services to treat the illness or health condition.

All claims for services approved under EPSDT must have the EP modifier on the claim line.

6.8.1. EPSDT and Waiver Services

Participants up to the age of twenty-one (21) on a waiver have the same access to EPSDT services as a non-waiver participant. Services designated as habilitative or rehabilitative are covered under the State Plan for these participants with increased access under EPSDT. Services are considered for coverage under both EPSDT and their waiver. Support type services are not covered under EPSDT as they fail to meet the requirement for a 1905(a) service. Any service provided under EPSDT will not impact a participant's budget or share of cost.

6.8.2. EPSDT Request Procedure

See the subsection below for the request procedure for services under State Plan, outside of State Plan, outpatient behavioral health and dental services. The parent, guardian or participant will receive a Notice of Decision from the Department or their designee informing them whether the request was approved or denied. The Notice of Decision may also list alternative services that are available. If the request is denied, the parent, guardian or participant, if over eighteen (18), may appeal the decision. Instructions for appeals are on the Notice of Decision.

6.8.3. Request Procedure: Services Under State Plan

Services that require a prior authorization are considered under EPSDT during the prior authorization process. However, if a service does not usually require a prior authorization, a request can be submitted with a note on the coversheet requesting a review under EPSDT and the reason for the request (e.g., for not meeting criteria, over limitations, etc.). Prior authorization requests without a legitimate cause will be returned unreviewed. Services covered under the State Plan should be requested through the service's normal request channel with all regularly required documentation (e.g., durable medical equipment through the Medical Care Unit). Requests are usually completed in fifteen business days or less.

6.8.4. Request Procedure: Services Not in State Plan

If services not covered under the State Plan are needed, a [Request for Additional Services \(RAS\) form](#) must be submitted to the Department for prior authorization. All services under EPSDT must fall into a category of service listed in 1905(a) of the Social Security Act, be considered safe, effective, and meet acceptable standards of medical practice.

The Request for Additional Services form must be completed and signed by a competent participant over eighteen (18) or their parent or guardian. All requests must be submitted with supporting documentation and an order from a physician or non-physician practitioner. This may require coordination with other providers to obtain. Services not under State Plan may take longer to review if:

- A new provider must be secured to perform the treatment;
- Additional documentation is needed to determine medical necessity;
- Providers fail to submit requested materials in a timely manner;
- Research is necessary to determine impacts to care; or
- The case is particularly complex and requires coordination between multiple agencies and providers to guarantee appropriate care.

For other questions, or general information, please email your request to EPSDTrequest@dhw.idaho.gov.

6.8.5. Request Procedure: Outpatient Behavioral Health

Community-based mental health services are provided under the Idaho Behavioral Health Plan by Optum Idaho's provider network. EPSDT requests for community-based mental health services must be completed on the [Optum Idaho EPSDT Form](#). For more information contact Optum Idaho by calling 1-855-202-0973 or visit the [Optum Idaho](#) website. Prior authorization requests for behavioral health services not provided in the community under the Idaho Behavioral Health Plan should be requested through the Division of Medicaid.

6.8.6. Request Procedure: Dental Services

Preventive and restorative dental services are provided under the Idaho Smiles plan by Managed Care of North America's (MCNA) provider network. EPSDT requests for dental services must be designated on the MCNA prior authorization form. For more information or the prior authorization form contact Idaho Smiles by calling 1-855-233-6262 or visit [Idaho Smiles](#) website.

6.8.7. References: Early & Periodic Screening, Diagnostic & Treatment (EPSDT)

a) CMS Guidance

"Chapter 5 – Early and Periodic Screening." *The State Medicaid Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

Early and Periodic Screening, Diagnostic, and Treatment. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.

EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

b) Regulations

"Definitions." Social Security Act, Sec. 1905(r) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 880 – 883. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

EPSDT and Other Required Benefits, 42 CFR 440.35 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-345.pdf>.

State Plans for Medical Assistance, 42 U.S.C. Sec. 1396a (1984). Government Printing Office, <https://www.govinfo.gov/content/pkg/USCODE-2017-title42/pdf/USCODE-2017-title42-chap7-subchapXIX-sec1396a.pdf>.

6.9. Incarcerated Persons

Medicaid benefits are not available for inmates of government jails or prison facilities, unless the inmate, the medical institution and the services rendered meet all the provisions for reimbursement as provided within the ["Reimbursement Policy for Individuals under the Authority of Idaho's Public Institutions"](#).

Inmates of a public institution operated under the authority of the State of Idaho, or its political subdivision, may be eligible for select Medicaid benefits in a hospital, freestanding psychiatric hospital or institution for mental disease enrolled with Idaho Medicaid and open to the public. Inmates must otherwise be eligible for Medicaid and be inpatient status for a minimum of twenty-four (24) hours. Healthcare services provided to residents of Idaho who are eligible for Idaho Medicaid and who are residing in Public Institutions outside of the territorial boundaries of the State of Idaho are excluded from reimbursement under this policy and are the responsibility of the Public Institution with authority over that individual.

When all provisions are met, the applicant's incarceration status no longer disqualifies them from Medicaid eligibility. The applicant is then evaluated for Medicaid eligibility as if they were not incarcerated. Providers should come to an agreement with the Public Institution responsible for the individual to determine which entity will apply for Medicaid on the applicant's behalf when they meet these requirements.

Eligibility for incarcerated participants is available retroactively. Medicaid coverage begins the day the inmate is admitted into the medical institution and ends the day of discharge from the medical institution. However, incarcerated participants do not have the same benefits as other participants. Only these services are covered for inmates, and only when all other Idaho Medicaid requirements for the service are fulfilled:

- Inpatient room and board;
- Ancillary services directly related to the inpatient stay; and
- Emergency transportation services for transfers occurring after inpatient status has been determined and only when directly between hospitals, freestanding psychiatric hospitals and institution for mental diseases for continued inpatient treatment.

6.9.1. Incarcerated Persons: Third-Party Liability

In addition to all regular third-party liability requirements in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook, healthcare services related to the negligent acts of a third-party, including correctional institutions or law enforcement agencies, are their responsibility. [Non-covered and excluded services](#) are the responsibility of the Public Institution with custody of the inmate. This includes any service not mentioned in the section above and expenses related to law enforcement personnel or security.

6.9.2. References: Incarcerated Persons

a) CMS Guidance

"Beneficiaries in Custody Under a Penal Authority." *MLN Fact Sheet ICN 908084, March 2018*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-Services-Furnished-to-Beneficiaries-in-Custody-Under-Penal-Authority-Fact-Sheet-ICN908084.pdf>.

"Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity

Exclusion." *MLN Matters MM6880*, July 2016, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6880.pdf>.

"To Facilitate successful re-entry for individuals transitioning from incarceration to their communities." *Survey and Certification Letter# 16-21-ALL*. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-21.pdf>.

"Updated Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals." *State Health Official Letter# 016-007*. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>.

b) Idaho Medicaid Publications

"Medicaid Program Integrity Unit: Billing for Incarcerated Clients." *MedicAide Newsletter*, November 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf>.

Reimbursement Policy Change for Individuals who are Incarcerated (Residents) of Correctional Facilities (Public Institutions) within Idaho, Information Release MA19-15 (12/18/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1915.pdf>.

c) Regulations

Definitions relating to institutional status, 42 CFR 435.1010 (1986). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec435-1010.pdf>.

"Definitions." Social Security Act, Sec. 1905(a)(29)(A) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Medical Exception for Inmates." *IDAPA 16.03.01*, "Eligibility for Health Care Assistance for Families and Children," Sec. 281. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

State Charitable Institutions, Idaho Code Title 66. Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title66/>.

6.10. Katie Beckett Medicaid Eligibility

Katie Beckett Medicaid, also known as Home Care for Certain Disabled Children, enables children under the age of nineteen (19) with special health care needs or disabilities to be cared for at home instead of an institution. Eligibility for Medicaid is based on the disabled child's income and assets without taking into account the income of their parents or guardians. The cost of care at home is compared to the cost of institutionalization when determining eligibility. Once approved for Medicaid, participants have all the benefits on the Enhanced Plan. In the event that a participant becomes institutionalized, the family should contact Self Reliance to update their eligibility.

6.10.1. References: Katie Beckett Medicaid Eligibility

"Certain Disabled Children." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, & Disabled (AABD),"* Sec. 785. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

6.11. Medicare Savings Program

The Department has agreements with the Social Security Administration and Centers for Medicare and Medicaid Services (CMS), which allows the state to enroll people in the Premium Hospital Insurance Program (also referred to as Premium HI or Medicare Part A) and Supplementary Medical Insurance (also referred to as SMI or Medicare Part B). The agreements allow Medicaid participants who are entitled to Medicare to have their Part A and/or Part B Medicare premiums paid by Medicaid. Participants do not have to be 65 years old or older to be eligible for Medicare. See the subsections below for the different kinds of Part A and Part B Medicare Savings Programs.

See the “Qualified Medicare Beneficiaries (QMB) Medicare/Medicaid Billing Information” subsection of the [General Billing Instructions](#), Idaho Medicaid Provider Handbook, for more information.

6.11.1. Part A Medicare Savings Programs

There are two types of Part A Medicare Savings Programs:

- Regular Type Part A; and
- Qualified Disabled Working Individual (QDWI) Part A

The Regular Type Part A Medicare Savings Program is for individuals who are not entitled to premium-free Medicare Part A benefits. These individuals must apply for Medicare with the Social Security Administration and be determined eligible for self-pay type Medicare. These individuals have a Medicare claim number with a Beneficiary Identification Code (BIC) of M. This code is found at the end of the Medicare claim number.

The Qualified Disabled Working Individual (QDWI) Part A Medicare Savings Program is for individuals that have lost Medicare Part A (HI) entitlement solely because of work and are entitled to enroll in Part A Medicare under §1818A of the Social Security Act. The Qualified Disabled Working Individual Program does not include state payment of Part B Medicare premiums.

6.11.2. Part B Medicare Savings Programs

The various types of Part B Medicare Savings Programs are listed in the table below.

Part B Medicare Savings Program							
Part B Medicare Savings Program	Individual is entitled to Medicare	Individual is entitled to Medicaid	Medicaid Pays the Medicare Premium	Individual is entitled to Medicaid	Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.	Medicaid Prior Authorization Rules Apply for Medicare Covered Services	Medicaid Claim Editing Applies
Qualified Medicare Beneficiary (QMB-Only)	Y	N	N	N	N	N	

Part B Medicare Savings Program							
Part B Medicare Savings Program	Individual is entitled to Medicare	Individual is entitled to Medicaid	Medicaid Pays the Medicare Premium	Individual is entitled to Medicaid	Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.	Medicaid Prior Authorization Rules Apply for Medicare Covered Services	Medicaid Claim Editing Applies
Qualified Medicare Beneficiary with Medicaid QMB + (QMB Plus)	Y	Y	N	Y	N	Y	
Specified Low Income Medicare Beneficiary (SLMB)	Y	N	N	Y	N	N	
Specified Low Income Medicare Beneficiary with Medicaid eligibility SLMB + (SLMB Plus)	Y	Y	N	Y	N	Y	
Medicaid (with deemed Cash Assistance Recipient)	Y	Y	N	Y	N	Y	
Medicaid – Non-Cash (also known as Medical Assistance Only) (MAO)	Y	Y	N	Y	N	Y	
Qualified Individual 1 (QI1)	Y	N	N	Y	N	N	

6.11.3. Dually Eligible Medicare Beneficiaries

Individuals that are enrolled in Medicare, and eligible for Medicaid benefits, are considered dually eligible participants. Dually eligible participants receive Medicare Part A and/or Part B premium coverage, and coinsurance and deductible reimbursement consideration for Medicare covered services. Pharmacy items or other services not covered by the dually eligible participant’s Medicare benefits may be covered under the participant’s Medicaid benefits.

6.11.4. Medicare Part D

Under the Medicare Modernization Act, dually eligible individuals no longer receive their drug coverage from Medicaid and instead select or are automatically enrolled into private Medicare prescription drug plans. Medicaid may still cover certain essential drugs excluded by law from the Medicare Part D, Prescription Drug Program. Medicare must be billed prior to submitting drug claims to Medicaid. If the Medicare Explanation of Benefits (EOB) indicates that the requested medication is one of the medications not covered by law, then Medicaid may reimburse.

6.11.5. References: Medicare Savings Program

Medicare Catastrophic Coverage Act of 1988. H.R. 2470 (1988). Government Printing Office, <https://www.congress.gov/bill/100th-congress/house-bill/2470>.

“State Agreements for Coverage of Eligible Individuals Who are Receiving Money Payments Under Public Assistance Programs or are Eligible for Medical Assistance.” Social Security Act, Sec. 1843 (1935). Social Security Administration,
https://www.ssa.gov/OP_Home/ssact/title18/1843.htm.

6.12. Managed Care Programs for Dual Eligible Participants

The Idaho Medicaid Plus (IMPlus) plan and Medicare Medicaid Coordinated Plan (MMCP) are managed care service delivery program options for dual eligible participants. The purpose of these plans is to integrate care for individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. These programs are designed to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports.

Participants will continue to use their Medicaid ID (MID) numbers as established under the [General Participant Eligibility Information](#) section. Participating Medicare Advantage Plans offering MMCP programs will also issue a plan identification number specific to their company.

6.12.1. Idaho Medicaid Plus (IMPlus)

Participants who are 21 years old or older, enrolled in both Medicare Part A and Part B, eligible for full Medicaid, who reside in an IMPlus coverage area, who do not voluntarily enroll in MMCP, and who are not in an excluded or exempt population are required to enroll in IMPlus. Participants who do not make an active selection of a health plan to administer their IMPlus coverage will be automatically enrolled in IMPlus and auto-assigned to a participating health plan.

6.12.2. Medicare-Medicaid Coordinated Plan (MMCP)

Participants who are 21 years old or older, enrolled in Medicare Part A and Part B, eligible for full Medicaid, and reside in an MMCP coverage area are eligible to voluntarily enroll in MMCP through an MMCP health plan.

6.12.3. Billing Procedures for Managed Care Participants

These services must be billed to an MMCP health plan using participant's health plan-specific identification number:

- Hospital services;
- Medical services;
- Prescription drug services;
- Behavioral health services;
- Aged & Disabled (A&D) Waiver Services;
- Personal Care Services (PCS);
- Nursing Home (NH);
- Community-Based Rehabilitation Services; and
- Transition Management and Transition Services.

These services must be billed to an IMPlus health plan using participant's health plan-specific identification number:

- Behavioral health services;
- Aged & Disabled (A&D) Waiver Services;
- Personal Care Services (PCS);
- Nursing Home (NH);
- Community-Based Rehabilitation Services; and
- Transition Management and Transition Services.

Providers may bill Medicaid for services listed below using the Medicaid ID (MID) number assigned to the participant for either managed care program.

Adult Developmental Disability (DD) Waiver:

- Non-Medical Transportation provided by an Agency;
- Non-Medical Transportation provided by an Individual;
- Non-Medical Transportation provided through a Bus Pass;
- Specialized Medical Equipment;
- Individual Supported Living;
- Group Supported Living;
- Daily Supported Living Services Intense Support;
- Daily Supported Living Services Intense Support School Based, School Days;
- Daily Supported Living Services High Support;
- Daily Supported Living Services High Support School Based, School Days;
- Behavioral Consultation by a QIDP/Clinician;
- Behavioral Consultation by a Psychiatrist;
- Behavioral Consultation Emergency Intervention Technician;
- Supported Employment;
- Adult Day Health;
- Chore Services (Skilled);
- Residential Habilitation – CFH;
- Personal Emergency Response System Installation and first month's rent;
- Personal Emergency Response System Rent/monthly;
- Environmental Accessibility Adaptations;
- Home Delivered Meals;
- Skilled Nursing Services, Independent RN;
- Skilled Nursing Services, Agency LPN;
- Skilled Nursing Services, Agency RN;
- Nursing Oversight Services of LPN;
- Nursing Oversight Services of Agency RN;
- Nursing Oversight Services of Independent RN;
- Respite Care; and
- Respite Care Daily.

Adult DD State Plan HCBS:

- Developmental Therapy Evaluation;
- Home/Community Individual and/or Group Developmental Therapy for Adults;
- Center Based Individual and/or Group Developmental Therapy for Adults;
- Community Crisis Supports;
- Interpretive Services, oral (to assist Enrollees to receive DD services); and
- Interpretive Services, sign language (to assist Enrollees to receive DD services).

Consumer Directed Services:

- Fiscal Employer Agent; and
- Community Supports (to include Support Broker services).

6.13. Otherwise Ineligible Non-citizens (OINC)

Individuals who do not meet the citizenship or qualified non-citizen requirements may be eligible for medical services necessary to treat an emergency medical condition. An emergency medical condition exists when the condition could reasonably be expected to seriously harm the person's health, cause serious impairment to bodily functions, or cause serious dysfunction to any body part or organ, without immediate medical attention. Childbirth qualifies as an emergency, but ante and postpartum services do not. Medicaid eligibility for OINC begins no earlier than the date the participant experiences the medical emergency and ends the date the emergency condition stops. A length of stay review by the Quality Improvement Organization, Telligen, is not required for participants with eligibility under OINC. The Medical Care Unit will make determinations on the appropriate length of stay during the eligibility review process.

6.13.1. Applying for Eligibility

The general application used to apply for Medicaid is also used for OINC applicants. Applications should be submitted after the emergency condition has ended. Hospitals may attach medical records with applications if they are helping the applicant apply for assistance. Completed applications are submitted to:

Self-Reliance Program
PO Box 83720
Boise, ID 83720-0026

Phone: 1 (877) 456-1233
Fax: 1 (866) 434-8278

The Division of Medicaid's Medical Care Unit determines whether the condition is an emergency and if the treatment services will be covered by Idaho Medicaid.

6.13.2. Prior Authorizations: Otherwise Ineligible Non-Citizens

Services requiring a prior authorization should be submitted to the designated reviewer for that service after the participant is approved for eligibility. Providers should note on the prior authorization request that a retrospective review is being requested for a participant with retroactive eligibility. A prior authorization for length of stay is not necessary.

6.13.3. References: Otherwise Ineligible Non-Citizens

"Emergency Medical Condition." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 250. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Ineligible Non-Citizen." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 402.03. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Individuals Who Do Not Meet The Citizenship or Qualified Non-Citizen Requirements." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 240. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Ineligible Non-Citizen with Emergency Medical Condition." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD),"* Sec. 801. Department of Administration, State of Idaho,

<https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

"Non-Citizen." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 11.05. Department of Administration, State of Idaho,

<https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Non-Citizen Emergency Medical." *MedicAide Newsletter, June 2009,*

<https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/June%20Newsletter%20Final.pdf>.

6.14. The Pregnant Women (PW) Program

The Pregnant Women (PW) program was developed to provide medical assistance to encourage individuals to seek prenatal care early in a pregnancy and preserve the health of both mother and infant. The program assists Idaho residents with a verified pregnancy not currently receiving medical assistance from the state or county, and without sufficient resources for private medical coverage. Participants found eligible under the PW program have the same coverage as participants on the Medicaid Basic Plan. Coverage through the program continues after delivery during the postpartum period for sixty (60) days, and extends until the last day of the month in which the sixtieth day occurs. Participants on the PW program will be evaluated for other Medicaid eligibility at the end of their coverage.

6.14.1. Presumptive Eligibility for Pregnant Women (PW)

Presumptive eligibility for pregnant women is designed to provide participants prenatal care between being diagnosed pregnant and receiving an eligibility determination. PE for pregnant women only covers outpatient prenatal care and not deliveries, miscarriages, or abortions. Medical coverage for the PW Program during the PE period is restricted to ambulatory outpatient, pregnancy-related services only. Pregnancy-related services may be rendered by any qualified Medicaid provider.

Routine prenatal services are covered, as well as some additional services such as nutrition counseling, risk-reduction follow-up, and social service counseling. Providers are not required to bill another insurance resource, if it exists, before billing Medicaid for prenatal services during the PE period.

The PE Program does not cover PW inpatient services. Medicaid does not pay for any type of abortion for participants on the PE Program. Also, PE participants are not covered for any delivery services. Services not covered under Medicaid are the participant's responsibility. If the PE participant has applied for the PW Program or any other Medicaid program, and is determined eligible, hospital inpatient services may be covered.

6.14.2. References: Pregnant Women (PW)

"Extended (Postpartum) Medicaid for Pregnant Women." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, & Disabled (AABD),"* Sec. 786. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

Medicare Catastrophic Coverage Act of 1988. H.R. 2470 (1988). Government Printing Office, <https://www.congress.gov/bill/100th-congress/house-bill/2470>.

"Presumptive Eligibility for Pregnant Women." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 502. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Presumptive Eligibility for Pregnant Women." Social Security Act, Sec. 1920 (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1920.htm.

Required Services for the Categorically Needy, 42 CFR 440.210 (1995). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-210.pdf>.

6.15. Refugee Medical Assistance Program

The Refugee Medical Assistance Program provides eligibility to certain refugees who are not otherwise eligible for Medicaid or CHIP. Coverage is limited to eight months, beginning when the refugee arrives in the United States. Children born to the refugee during that time period are also eligible for the Refugee Medical Assistance Program, but only as long as their parent's coverage remains in effect. At the conclusion of the program's coverage, participants will be evaluated for coverage under other eligibility programs.

In order to qualify for Medicaid eligibility through the Refugee Medical Assistance Program, the applicant must:

- Meet the federal definition of refugee for the purposes of the program;
- Not be otherwise eligible for Medicaid or CHIP; and
- Have an income under 150% of the federal poverty level (FPL).

Refugees whose income exceeds 150% of the FPL may still be eligible under a special "spend down" consideration if the remainder of their income after medical expenses are deducted drops their income below 150% of the FPL.

Coverage under the Refugee Medical Assistance Program is contingent on Idaho's receipt of federal funding. In the event that funds are not received, this program will be suspended without advance notice.

6.15.1. References: Refugee Medical Assistance Program

Cuban/Haitian Entrant Program, 45 CFR 401 (1982). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title45-vol3/pdf/CFR-2019-title45-vol3-part401.pdf>.

IDAPA 16.03.06, "Refugee Medical Assistance." Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160306.pdf>.

Refugee Act of 1980. 8 U.S.C. 1521 (1979). Government Printing Office, <https://www.govinfo.gov/content/pkg/USCODE-2018-title8/pdf/USCODE-2018-title8-chap12-subchapIV-sec1521.pdf>.

Refugee Medical Assistance, 45 CFR 400 Subpart G (1989). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title45-vol3/pdf/CFR-2019-title45-vol3-part400-subpartG.pdf>.

6.16. Youth Empowerment Services (YES)

Youth Empowerment Services (YES) provides a doorway to Medicaid eligibility for children under the age of eighteen (18) with a serious emotional disturbance (SED) and functional impairment. Once approved for Medicaid, participants have all the benefits on the Enhanced Plan, plus respite care through the [Idaho Behavioral Health Plan](#) and person-centered service planning. The participant must complete an assessment and update the person-centered service plan at least every 12 months to maintain eligibility under the program.

In order to qualify for Medicaid eligibility through YES, the applicant must:

- Have a verified SED and functional impairment;
- Have an income under 300% of the federal poverty level (FPL);
- Be under the age of eighteen (18);
- Be an Idaho resident;
- Be a U.S. citizen or meet requirements for legal noncitizen;
- Cooperate with obtaining a medical support order for a non-custodial parent unless good cause can be established;
- Not reside in an ineligible institution; and
- Not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole.

A serious emotional disturbance is defined as a diagnosable mental health, emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability. The diagnosis must be made in alignment with the Diagnostic and Statistical Manual of Mental Disorders (DSM). A disability caused by the diagnosis is considered serious if it causes a substantial impairment of thought, perception, affect or behavior in family, school or community settings, and requires sustained treatment interventions. A substance use disorder does not, by itself, constitute a serious emotional disturbance, although it may coexist with serious emotional disturbance.

The SED and functional impairment must be verified by Medicaid's Independent Assessment contractor (Liberty Healthcare) using a Comprehensive Diagnostic Assessment (CDA) and the Child and Adolescent Needs and Strengths (CANS) tool. Liberty Healthcare will complete the CDA and CANS in the applicant's home and contact them within one business day with the results and next steps. These assessments are provided at no cost to the family or applicant seeking eligibility. A CDA completed by another provider can be used if it was completed in the last six (6) months.

Providers can direct potential applicants to contact Liberty Healthcare at 1 (877) 305-3469 for the free assessment. Other services may be available for children with an SED who do not meet the additional requirements for Medicaid eligibility; e.g., family income exceeding 300% FPL. See the [Youth Empowerment Services](#) website for more information.

6.16.1. References: Youth Empowerment Services

a) Idaho Medicaid Publications

"New Independent Assessment Contractor for Children's Mental Health Services." *MedicAide Newsletter*, March 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

"YES Project Update for Healthy Connections and the September MedicAide Issue." *MedicAide Newsletter*, September 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf>.

b) Regulations

Children's Mental Health Services: Definitions, Idaho Code 16-2403 (2019). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title16/t16ch24/sect16-2403/>.

Eligibility for Medical Assistance, Idaho Code 56-254 (2017). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-254/>.

"Premiums for Participation Under the Youth Empowerment Services (YES) Program." *IDAPA 16.03.18, "Medicaid Cost-Sharing,"* Sec. 207. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

"Youth Empowerment Services (YES) Home and Community-Based Services (HCBS) State Plan Option." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 635 – 638. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160310.pdf>.

"Youth Empowerment Services (YES) Program Children." *IDAPA 16.03.01, "Health Care Assistance for Families & Children,"* Sec. 540. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

c) Settlement Agreement

Idaho Implementation Plan (2016). Jeff D., et al. v. Clement Leroy Otter, et al., <https://youthempowermentservices.idaho.gov/Portals/105/Documents/YESImplementationPlan.pdf>.

Jeff D., et al. v. Clement Leroy Otter, et al. (2015). Case No. 4:80-CV-04091-BLW, <https://youthempowermentservices.idaho.gov/Portals/105/Documents/JeffDOfficial%20Agreement.pdf>.

7. Healthy Connections (HC)

Healthy Connections (HC) is the Idaho Medicaid primary care program in which a primary care provider or team provides comprehensive and continuous medical care to a participant with the goal of improving health outcomes. Our mission is to ensure Medicaid participants receive the care they need, when they need it, and in the appropriate setting. The Healthy Connections program is structured to incentivize HC providers to transform to the Patient Centered Medical Home (PCMH) model of care whereby a participant's treatment is coordinated through their primary care provider or their team.

The goals of HC are to:

- Ensure access to healthcare;
- Improve the quality of healthcare and overall well-being of Medicaid participants;
- Emphasize care coordination and continuity of care;
- Encourage participants to be involved in their healthcare decisions; and
- Achieve cost efficiencies for the Idaho Medicaid Program.

Medicaid participant enrollment into HC is required in the majority of counties statewide. Individuals qualifying for Idaho Medicaid will receive correspondence requesting they identify their current Primary Care Provider (PCP) or choose an HC clinic.

7.1. Importance of Verifying Medicaid Eligibility and Healthy Connections Enrollment

Medicaid providers should always verify participant eligibility and Healthy Connections enrollment status prior to rendering services, as described in the [Provider Responsibilities](#) section. When verifying eligibility on HealthPAS on www.idmedicaid.com, the following information will be provided for enrolled participants:

- Network of HC clinic
 - Healthy Connections
 - Healthy Connections Access Plus
 - Healthy Connections Care Management
 - Healthy Connections Medical Home
 - Exempt from Healthy Connections
- Demographics of the HC clinic
 - Name of HC clinic
 - Address of HC clinic
 - Phone number of HC clinic
 - Hours of operation of HC clinic

If an HC clinic is not indicated or the participant is exempt from HC, a referral for services rendered is not required.

7.2. Healthy Connections Provider Enrollment

Idaho Medicaid primary care providers participate in Healthy Connections by signing a Coordinated Care Provider Agreement in addition to the Idaho Medicaid Provider Agreement. Coordinated Care Provider Agreements are available from the Regional Healthy Connections Representatives. Addresses and telephone numbers for the regional HC offices are listed in the [Directory](#), Idaho Medicaid Provider Handbook, and at <https://healthyconnections.idaho.gov>.

In the Healthy Connections (HC) Program, Primary Care Providers qualify for tiers and are incentivized to implement a Patient Centered Medical Home (PCMH) model of care. HC service locations offering enhanced access to care and/or PCMH characteristics may qualify for higher tier placement. Upon approval of tier placement, the HC service location is issued an HC Coordinated Care Agreement Addendum B which outlines requirements to maintain tier status and monthly primary care case management fee.

The following are the HC Tiers and the primary care case management fee (per member per month) assigned:

1. Tier I - Healthy Connections | Basic: \$2.50; Enhanced: \$3.00;
2. Tier II - Healthy Connections Access Plus | Basic: \$3.00; Enhanced: \$3.50;
3. Tier III - Healthy Connections Care Management | Basic: \$7.00; Enhanced: \$7.50;
4. Tier IV - Healthy Connections Medical Home | Basic: \$9.50; Enhanced: \$10.00.

HC staff evaluates compliance of the Coordinated Care Agreement and applicable tier addendum at least annually via HC service location site visits and/or phone calls.

To ensure accurate participant enrollment, it is important for HC providers to timely inform HC Staff of any changes in the clinic's ability to accept new Medicaid participants. In addition, providers are required to keep their record current and notify DXC Technology of any changes in their record in accordance with their Idaho Medicaid Provider Agreement, including but not limited to, the addition or removal of any providers, address changes, etc. within twenty-eight (28) days of the date of change. See the [Provider File Updates](#) section for information about updating a provider's information.

7.2.1. Healthy Connections Tier Requirements

TIER I – HEALTHY CONNECTIONS:

- Provide timely access to primary, preventive, and urgent care services.
- Monitor and manage the participant's care.
- Provide medication management and documentation.
- Provide 24-hour telephone access to a medical professional.
- Ensure prompt and timely access to services by making referrals for medically necessary services not provided by the HC PCP.
- Enroll all rendering PCPs and each HC service location in the MMIS system for the purposes of assigning participants at the location where they receive primary care services.
- Keep all of the provider enrollment information current in the MMIS system by completing any maintenance items within 30 days of the change as required in the Idaho Medicaid Provider Agreement.

TIER II - HEALTHY CONNECTIONS ACCESS PLUS – In addition to Tier I requirements, the HC clinic must provide a minimum of 30 hours per week of access to primary care and meet one of the additional requirements:

- Offer a minimum of forty-six (46) hours per week of access to primary care for participants.
- Meet the extended hours requirement at a nearby service location with the same organization and have shared electronic medical records.
 - The form to meet this requirement, as well as additional information, can be found on the HC website at <https://healthyconnections.idaho.gov>.
- Make available a patient portal with the following functionality:
 - Offer two-way communication with provider response expectation outlined in policy and procedures.
 - Ability to request appointments.
 - Ability to request medication refills.
 - One of the following optional features:
 - Access to lab results
 - Access to imaging results
 - Access to visit summaries
- Provide Telehealth services, resulting in expanded access to primary and specialty care for Healthy Connections participants.
- Provide other enhanced access to care options – to be approved by the Department.

TIER III - HEALTHY CONNECTIONS CARE MANAGEMENT – In addition to the requirements in Tiers I & II, the HC clinic must demonstrate the following PCMH capabilities:

- Create a well-defined 1-3 year plan to achieve national PCMH recognition. This plan must be submitted within six months of Tier III status and will be monitored by Medicaid primary care staff.
 - If you have achieved National Committee for Quality Assurance (NCQA) PCMH recognition, or another nationally recognized PCMH accreditation, you have met this criterion.
 - Three months after achieving Tier III preliminary HC PCMH Tracker, or an equivalent, is to be submitted to demonstrate understanding of PCMH transformation and assess PCMH status.
 - At six months the finalized tracker is to be submitted which must include assignment of work and projected deadlines for completion.
 - Every six months thereafter a newly updated HC PCMH Tracker or equivalent must be submitted until clinic achieves recognition by the three-year deadline.
- Provider will submit a readiness assessment, which can be found at <https://healthyconnections.idaho.gov>.
- Established view capability via the Idaho Health Data Exchange (IHDE) portal for the purposes of care coordination. On-going utilization of the IDHE portal will be required and monitored by the Department.
- Provide physician leadership for PCMH efforts.
 - A physician champion's primary role is to serve in a leadership capacity, promoting and implementing changes to transform to the PCMH model of care. They are knowledgeable of PCMH and committed to leading and supporting the staff during the transformation, as well as providing leadership to sustain the effort.
- Provider employs adequate dedicated care coordinator staff or equivalent support for care management of individuals with chronic illnesses.
 - Care Coordination is an essential component of the patient centered medical home that requires appropriately trained staff and additional resources, such

as health information technology to provide coordinated care through a team-based model.

- And one of the following optional requirements:
 - Enhanced care management activities – community health emergency medical services or community health workers, promotora model, home visiting model, or similar enhanced care coordination model with proven results.
 - Population health management capabilities - registry reminder system or other proactive patient management approach.
 - Behavioral health integration – co-located or highly integrated model of behavioral and physical health care delivery, as demonstrated by scoring a minimum of a 3 on the Integrated Practice Assessment Tool (IPAT).
 - Referral tracking and follow-up system in place.
 - NCQA recognition or Utilization Review Accreditation Commission (URAC), Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC) or other PCMH national recognition.

TIER IV - HEALTHY CONNECTIONS MEDICAL HOME – In addition to the requirements in Tiers I & II, the HC clinic must demonstrate the PMCH model of care by meeting the following:

- Employ an adequate, dedicated care coordination staff or equivalent support for care management of individuals with chronic illness.
 - Care Coordination is an essential component of the patient centered medical home that requires appropriately trained staff and additional resources, such as health information technology to provide coordinated care through a team-based model.
- Provides physician leadership for PCMH efforts.
 - A physician champion's primary role is to serve in a leadership capacity, promoting and implementing changes to transform to the PCMH model of care. They are knowledgeable of PCMH and committed to leading and supporting the staff during the transformation as well as providing leadership to sustain the effort.
- Proof of achieving NCQA recognition, URAC, Joint Commission, AAAHC, or other PCMH national recognition.
- Established bi-directional connection to the Idaho Health Data Exchange (IHDE) to:
 - Enhance care coordination by access to real time clinical data and provide effective patient-centered care.
 - Provide data to continue the development of a statewide IHDE to measure, report and move towards value-based reimbursement
 - This requirement is met by the following connections to the IHDE:
 - Inbound (Clinic sending data to IHDE):
 - TRN – Transcriptions (required if supported by EMR) and
 - CCDs – Continuity of Care Document
 - ADTs (admissions, discharges, and transfers) alone do not meet the inbound requirement
 - Outbound (IHDE sending data to Clinic):
 - LAB results **and**
 - RAD – radiology results **and**
 - TRN – transcriptions
 - Outbound query and review of data through clinics EMR is acceptable
 - Other options to meet the outbound requirement may be considered and must be approved by the HC team
 - To ensure outbound transfer of HC affiliated patient records, all HC PCPs should be licensed with the IHDE.

- The clinic must demonstrate integration of IHDE data into clinic workflows and will be monitored for active use of this resource for purposes of care coordination.
- Tier IV Clinics should license all HC providers with the IHDE to ensure all pertinent participant records are outbound into clinic's EHR.
- Well established quality improvement process.
 - Clinics will be required to demonstrate a quality improvement program is in place and activities to monitor clinic performance, quality and PCMH sustainability are occurring in alignment with current national PCMH program standards.

HC Clinic Tier Movement Process

- HC clinics must complete a Tier Application for the higher tier they wish to apply for. The tier application can be found at <https://healthyconnections.idaho.gov>.
- Completed tier applications, along with required documentation, should be faxed to the Healthy Connections Consolidated Unit at 1 (888) 532-0014, or scanned and e-mailed to HCCR7@dhw.idaho.gov.
- Tier applications must be received with all required documentation **and approved by the 15th of the month** for the change to be effective the first of the following month.
- HC clinics will receive official notice of action taken on tier applications.
- Applications will be processed in the order received.
- The clinic's new network name will appear on the date processed by DXC Technology; however, the higher case management payment will not apply until the first of the following month,
- Tier placement changes will not be processed more frequently than every three months.

Provider Reporting Requirement

As stated in Addendum B, Tier III & IV HC clinics are required to validate they meet and sustain PCMH activities for tier placement by submitting the following for each Healthy Connections service location:

- Tier III HC clinics undergoing PCMH transformation and not yet nationally recognized:
 - Three months after achieving Tier III status, preliminary HC PCMH Tracker or an equivalent is to be submitted to demonstrate understanding of PCMH transformation and assess PCMH status.
 - At six months the finalized tracker is to be submitted, which must include assignment of work and projected deadlines for completion.
 - Every six months thereafter a newly updated HC PCMH Tracker or equivalent must be submitted until clinic achieves recognition within the three-year deadline.
 - These reports can be found at <https://healthyconnections.idaho.gov>.
 - Tier III clinics that do not achieve national PCMH recognition within three years will be restored to the Tier for which they are eligible.
- Tier III & IV nationally recognized PCMH clinics must demonstrate a well-established quality improvement process:
 - Clinics will be required to demonstrate a quality improvement program is in place and activities to monitor clinic performance, quality and PCMH sustainability are occurring in alignment with current national PCMH program standards. This requirement is met by submitting documentation of PDSA activity aligned with one of the eight PCMH change concepts: Care Coordination, Continuous Team-Based Healing, Empanelment, Engaged Leadership, Enhanced Access, Organized, Evidence-Based Care, Patient-

Centered Interactions, Quality Improvement. Clinic may select the competency area to address.

- Template worksheets can be found at <https://healthyconnections.idaho.gov> and must be submitted to HC QI staff every six months and the PCMH must demonstrate progress in selected competency area.

7.2.2. Healthy Connections Case Management Payment

In addition to payment for services rendered, HC clinics are paid a monthly case management fee. The monthly case management fee is paid for every participant enrolled with the HC clinic effective the first day of the month. The case management payment is based both upon the medical complexity of the participant and the tier level that the HC clinic has reached, demonstrating their PCMH capabilities.

The case management payment is generally processed on the first Saturday of the month. Healthy Connections rosters are then available the Monday or Tuesday following the processing of the case management payment.

HC clinics qualify for one of the following four tiers of reimbursement for all attributed participants:

Medicaid Plan	Tier I Healthy Connections	Tier II Healthy Connections Access Plus	Tier III Healthy Connections Care Management	Tier IV Healthy Connections Medical Home
Basic Plan participants	\$2.50	\$3.00	\$7.00	\$9.50
Enhanced Plan participants	\$3.00	\$3.50	\$7.50	\$10.00

7.2.3. Healthy Connections Participant Rosters

The following two Primary Care rosters are available to PCPs.

- An online Primary Care Roster is available on the [DXC Technology Medicaid](#) website through your Trading Partner Account. This is a list of currently enrolled HC participants and the PCP is able to verify eligibility or issue a referral from this roster.
- To further support HC providers in coordinating their patient care, the following fields have been added to the exportable Excel or PDF list of participants:
 - Phone Number;
 - Address;
 - City;
 - State;
 - Zip;
 - Head of Household; and
 - Enrollment Indicator (Mandatory or Voluntary enrollment).
- The Monthly Healthy Connections Roster is a list of participants enrolled to a Healthy Connections PCP or service location effective the first day of the month, including the case management payment information. This report has been modified to serve as the HC Case Management Payment report. Specific participant demographic information has been removed and can now be found on the HC dynamic Online PCP Roster exportable listing. For providers with a Trading Partner Account (TPA) and receiving an electronic remittance advice (RA), this monthly roster is uploaded to their secure portal under the 'Reports' section and is available in both PDF and Excel formats. For PCPs not receiving electronic RAs, this roster report is mailed.

- An announcement will be posted to the DXC Technology Health PAS website when the rosters become available.
- The monthly HC roster is available online in Excel format and includes mailing information for each participant. This information should be used to contact participants and encourage them to be engaged in their healthcare.

7.2.4. Provider Network Lists

A listing of Healthy Connections (HC) clinics sorted by Region and County, is made available on the [Healthy Connections](#) webpage. Any time there is a change to a clinic's record, the clinic is required to submit those updates to DXC Technology Provider Enrollment. Changes to the network listing will be posted to the webpage on a weekly basis. Failure to keep the clinic's records up to date could result in inaccurate information on the HC Provider Network List.

Some common changes or updates submitted to DXC could include:

- Change of ownership;
- Change of address or phone number;
- Adding or closing a service location;
- Clinic hours;
- Adding or removing rendering providers; and
- Provider contact information.

Please refer to the [Provider Enrollment](#) section for more information.

For changes or questions regarding HC clinic panel limits (e.g. not accepting new Medicaid), please contact the Healthy Connections staff directly instead of DXC.

7.3. Participant Enrollment

Medicaid providers should always verify participant eligibility and Healthy Connections enrollment prior to rendering services, as described in the [Verifying Participant Eligibility](#) section. For participants enrolled in Healthy Connections, the PCP information will be provided through the automated and/or online system. If an HC PCP is not indicated, an HC referral is not required.

Enrollment in HC is mandatory for most Medicaid participants and required in the majority of counties statewide. Participants not enrolled in HC are mailed an enrollment form and given up to 90 days to inform us of their choice of PCP. When a Medicaid participant does not choose a PCP and they live in a mandatory county, the participant is assigned to an HC PCP.

7.3.1. Enrollment in Healthy Connections

If a participant is not enrolled in Healthy Connections (HC), please have them complete an enrollment form at your clinic and fax it to HC at 1 (888) 532-0014 or e-mail to HCCR7@dhw.idaho.gov. Assisting participants to enroll to your clinic will help avoid the possibility of them being assigned to a different HC clinic and will help ensure your clinic receives the case management fee.

Healthy Connections clinics have the option to request a closed panel and not accept new Medicaid participants or request panel limitations for enrollment. Participants not meeting panel limitations set by the clinic will only be enrolled if clinic contacts HC directly.

Limited or closed panel clinics may arrange with HC to process enrollments without prior approval when any of the following conditions are met:

- Participants are currently established as shown by claims within last 12 months.
- Participants have an upcoming scheduled appointment or recent appointment.
- Participants with family members currently established.

If the above conditions are not met, or the clinic is closed to new Medicaid, participants will be directed to the clinic for enrollment approval. The clinic must then contact Healthy Connections for the participant to be enrolled.

It is the responsibility of the organization to communicate panel limitations to all locations participating in Healthy Connections.

Enrollment Guidelines:

- Enrollment for the participant's chosen HC clinic will be effective the date the enrollment request is approved.
- Enrollment requests must be submitted by the participant or an authorized representative as identified in the Medicaid participant eligibility system.
- Each enrolled participant is sent a written notice listing the name, phone number, and address of their HC PCP. This notice is generated and mailed the day after the participant's enrollment is entered.
- Family participants are not required to choose the same HC PCP.
- Enrollment in HC is mandatory for most Medicaid participants.
- Medicaid participants may choose an HC PCP in one of the following ways.
 - Complete and return an HC Enrollment form received in the mail;
 - Complete an HC Enrollment form at the PCP's clinic. The clinic then faxes it to the Healthy Connections Consolidated Unit at 1 (888) 532-0014;
 - Call the HC Consolidated Unit at 1 (888) 528-5861 to enroll over the phone; or

- Visit the Live Better Idaho website at www.livebetteridaho.org to submit choice of PCP electronically.
- A participant requesting enrollment will be directed to the clinic if they do not meet the clinic's panel limitations, or the clinic is closed to new Medicaid. Clinic must then submit enrollment approval in one of the following ways:
 - HC enrollment form received from the clinic and signed by the participant or their authorized representative.
 - Phone call from clinic validating enrollment request received from participant.
- A list of HC clinics can be found at <https://healthyconnections.idaho.gov> under Provider Network Lists.
- Participants not submitting a choice of provider will be assigned to a HC clinic up to 90-days after eligibility, to be effective the first of the following month, based on the following criteria:
 - Assign participants to a PCP where they are currently receiving care.
 - Assign family members to a PCP where other family members are enrolled, if appropriate.
 - Assign participants to a prior Healthy Connections PCP, when applicable.
 - Assign participants to a PCP based on geographic location.
 - Assign participants based on rotation schedule agreed upon by PCPs.

7.3.2. Mandatory Assignment

If a PCP/clinic chooses to accept mandatory assignment participants, the assignments will occur within the panel limits the PCP/clinic has provided to HC (i.e., accepting new Medicaid, age limits, etc.).

The requirements for assignments are as follows:

- When a participant is assigned to PCP/clinic, the clinic is required to allow assigned participant(s) to establish care, even if the panel subsequently has closed to accepting mandatory assignments; and
- If a participant has not established care, and has an urgent medical need, PCP/clinic is required to provide "timely access to care" either by seeing the participant or providing a one-time referral.

It is recommended that PCP/clinics check the Healthy Connections roster each month to see list of newly assigned participants and conduct outreach to encourage establishing care.

7.3.3. Changing Enrollment in Healthy Connections

Healthy Connections participants will be enrolled based on a fixed enrollment process. A set period of time is designated during the year when participants are allowed to change their PCP without cause. This is commonly known as the "annual enrollment period". Fixed enrollment encourages a long-term provider-patient relationship resulting in the participant receiving a consistent source of care, provides for better patient outcomes and supports the value-based model of care.

Changes in enrollment are to be submitted by the participant or an authorized representative. HC clinics may submit HC enrollment forms on behalf of a participant, as long as the enrollment form is completed and signed by the participant or an authorized representative.

Participants or their authorized representatives are allowed to initiate a change without a special circumstance when it is:

- The annual enrollment period during January and February;
- Within the first ninety (90) days of enrollment with a *new* HC service location/clinic;

- Due to automatic re-enrollment and the participant misses any part of the annual open enrollment period; or
- A different service location/clinic within the HC Organization (same Tax ID).

Participants are allowed to initiate a change under the following special circumstances during the Fixed Enrollment Period:

- Participant requests different PCP than one assigned by the Department within the past 12 months;
- Participant moved outside of the PCP's service area;
- Participant requests change because the PCP does not, due to moral or religious reasons, cover the service the participant seeks;
- Participant requests different PCP to allow members of a household to be enrolled with the same PCP (one medical home);
- Participant requests change due to changing to/from a specialty provider (i.e., OB/GYN, Pediatrics, etc.);
- Participant chooses to follow PCP to a different HC organization, to maintain the existing relationship with the PCP;
- Participant requests change due to poor quality of care, as verified by the Department;
- Participant requests change due to lack of access to covered services, as verified by the Department;
- Participant requests change due to lack of access to providers experienced in dealing with the participant's health care needs, as verified by the Department;
- Participant requests change in PCP due to foster care placement;
- Participant requests different PCP due to incompatible primary insurance coverage;
- Participant requests change due to a provider determining related services are not available within the provider network and would result in putting the participant at unnecessary risk to receive services separately;
- Participant requests change due to administrative error of the Department; or
- Other reasons determined to be acceptable by the Department.

Requests to change providers will be verified and approved if they meet Fixed Enrollment criteria. A request to change is not guaranteed and may not be acted on immediately. As a result, it is important for providers to obtain referrals from the provider of record in the system prior to rendering services.

PCP/clinic is required to absorb any and all participants enrolled to their clinic regardless if a specific provider is no longer with the HC clinic.

The special circumstance request form can be found at <https://healthyconnections.idaho.gov>.

Failure to adhere to these policies may result in investigation by the Medicaid Program Integrity Unit.

a) References: Changing Enrollment in Healthy Connections

Fixed Enrollment Changes for the Idaho Medicaid Healthy Connections Program, Information Release MA19-12 (8/1/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1912.pdf>.

7.3.4. Exceptions & Exemptions to HC Enrollment

Participants meeting the exception or exemption criteria in this section are not required to enroll in the Healthy Connections Program. A referral is not needed for services rendered to participants not enrolled in Healthy Connections.

Participants are not required to enroll in Healthy Connections who meet the following exception criteria:

- The participant has an eligibility period that is less than three (3) months;
- The participant has an eligibility period that is only retroactive;
- The participant only has Qualified Medicare Beneficiary eligibility;
- The participant is enrolled in one of the managed care programs for Dual Eligible participants;
- The participant resides in long-term care or ICF/IID facility; or
- The participant resides in a non-mandatory county where there are not adequate numbers of providers to deliver primary care case management services.

Participants may opt out of Healthy Connections by requesting and qualifying for one of the following exemption reasons:

- Participant is unable to access a Healthy Connections provider within a distance of thirty (30) miles or within thirty (30) minutes to obtain primary care services;
- Participant has an existing relationship with a primary care provider or clinic who is not participating in Healthy Connections;
- Participant chooses an obstetrical provider not participating in the Healthy Connections program;
- Participant has Medicare as their primary healthcare plan;
- Participant is a member of a federally recognized tribe; or
- Participant is under 19 years of age and is:
 - Eligible for SSI under Title XVI;
 - Eligible under section 1902(e)(3) of the Act, qualified disabled children; or
 - Receiving foster care or adoption assistance.

Exempted participants not enrolled in Healthy Connections will appear as "Exempt from Healthy Connections" when checking eligibility. At any time, a participant with an exemption, but not an exception, may opt to enroll with a Healthy Connections provider. However, once the participant chooses to enroll, the participant no longer qualifies for an exemption.

a) References: Exceptions & Exemptions to HC Enrollment

"Exemption from Participation." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 561.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

7.3.5. Participant Disenrollment by the Provider

A PCP may choose to withdraw as the participant's primary care provider and must give written notice to both the participant and the Department at least (30) days prior to the date of disenrollment. Failure by the PCP to notify Healthy Connections will result in continued obligation to provide care and/or referrals until notice is received. *The Department may waive this notice on a case-by-case basis.* The written notice from the PCP must give the enrollee the reason for the request for disenrollment.

A PCP may request disenrollment of a participant because:

- Participant has been previously discharged from the practice – PCP to provide copy of dismissal notice sent to participant
- A documented, ongoing pattern of failure on the part of the participant to keep scheduled appointments or meet other participant responsibilities
- A documented situation where there is an inability by the PCP, after making a reasonable effort to establish or maintain a mutually satisfactory PCP/participant relationship
- Behavior of the participant that is disruptive or abusive (and not related to his/her special needs) to the extent that the PCP’s ability to furnish services to the participant or other participants is impaired.

A PCP may not request disenrollment because of:

- An adverse change in the participant’s health status
- The participant’s over/under utilization of medical services
- The participant’s diminished mental capacity
- The participant’s uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs a PCP’s ability to furnish services to the participant or other participants)

Upon the reassignment of the participant to a new PCP, the former PCP must transfer a copy of the participant’s medical records to the new PCP when requested by the participant.

7.4. Referrals

A referral is a documented communication from a participant's PCP of record to another Medicaid provider for a specific covered service. The participant's HC clinic is responsible for providing primary care, managing the participant's care and making referrals for **medically necessary services**. The PCP plays a key role in linking participants with community resources to facilitate referrals and respond to the participant's medical and social needs.

7.4.1. Important Referral Policy Reminders

- Referrals must always be received **prior** to delivery of care.
- Backdated or retroactive referrals are not acceptable. Any service provided with a backdated or retroactive referral is considered to be non-covered and may be subject to recoupment and civil monetary penalties.
- Referral requirements apply regardless of Medicare or other insurance coverage.
- The referral must be documented in the records of both the referring and receiving providers to be valid.
- Referrals entered online in the HealthPAS portal meet the referral documentation requirements.
- Once received a referral remains active even if the participant changes their enrollment with an HC clinic.
- Providers receiving referrals may also forward the referral to another Medicaid provider as long as the date and scope of the referral meets the condition stated in the original referral.
- The referral requirement for primary care services accessed between HC clinics affiliated either by the same NPI or Tax ID is at the discretion of the HC clinic/organization of record.
- Referral authority may be externally delegated to an "outside organization" for the purposes of care coverage. However, externally delegated referral authority must be documented in the covering HC service location for the specific visit.
- In the event that a procedure not requiring a referral begins and must be changed to a procedure that requires a referral, one is not required. However, the medical documentation must support the procedure change.
- Referrals cannot be accepted in lieu of a prior authorization. PA's are for certain services that require review and approval prior to being provided.
- When verifying eligibility, if no HC clinic is indicated or "Exempt from Healthy Connections" is returned, no referral is required.

7.4.2. Referral Elements

Effective 2/1/2016, the following are the required core referral elements:

- Date issued;
- Name of HC PCP or clinic issuing referral;
- Participant information;
- Referred-to provider;
- Start and end date of the referral (not to exceed one year);
- Diagnosis and/or Condition; and
- Referral reason:
 - Consultation/diagnosis only;
 - Diagnose, treat, and/or forward to specialty provider;
 - One time visit until seen by PCP; and
 - Any additional referral limits or restrictions.

7.4.3. Method of Referral

A referral must be communicated by one of the following methods:

- **Electronic referral** (e.g., DXC Technology HealthPAS portal or HC clinic electronic Medical Record {EMR});
- **Paper referral** (e.g., HC Referral form, prescription pad, etc.);
- **Verbal Referral** (e.g., calling an order into a specialist); or
- **Admit Order** (e.g., hospital direct admit by participant's HC clinic PCP).

7.4.4. Advantages of Electronic Referrals

There are many advantages to submitting an online electronic referral, including:

- **Improved Accessibility and Communication of Data** - The PCP, referred-to-provider and Department staff can access the referral online anytime;
- **Enhanced Capacity** – Resource for PCP to provide better coordinated care by having access to participant referrals entered online;
- **Integrity** - Authorized visits and/or date span of specified services are clear and concise;
- **Secure** - HIPAA compliant referral process; and
- **Timesaver** - No handling or storage of a paper referral.

Refer to the *Referrals* section of the [Trading Partner Account \(TPA\) User Guide](#) found in the **User Guides** under the *Reference Material* menu on the DXC Technology's Idaho Medicaid website for instructions to enter or retrieve online referrals.

7.4.5. Follow-up Communication Requirements for Referrals

Providers who receive Healthy Connections referrals will communicate their assessment, recommendations, or progress back to the HC PCP of record within a timely manner. Services provided for an extended period shall be reported to the PCP with an annual report, or more frequently if significant changes occur in the patient's overall health. Failure to communicate findings to the PCP may result in services being considered non-covered and subject to recoupment.

7.4.6. Services Not Requiring an HC PCP Referral

The following services do not require a referral by the Healthy Connections Primary Care Provider. If the service is not on this list, it may require a referral. Services are hyperlinked where applicable to direct providers to the appropriate section of the Idaho Medicaid Provider Handbook. Services must meet the requirements below and the definition of the service category to qualify.

The following services do not require a referral by the PCP:

- [Anesthesiology Services](#), effective 04/01/2007;
- [Audiology Services](#) performed in the office of a certified audiologist;
- [Children's Developmental Disabilities Services](#), effective 09/01/2013;
- [Chiropractic Services](#) performed in the chiropractor's office;
- [Dental Services](#);
- [Durable Medical Equipment](#), effective 02/01/2016;
 - This service should be coordinated with the participant's primary care provider.
- **Emergency Services**, effective 01/01/2013;
 - As defined in [IDAPA 16.03.09.10.24](#) as a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent

layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child in serious jeopardy;
 - Serious impairment to bodily functions; or
 - Serious dysfunction of any bodily organ or part.
- **Family Planning Services**;
 - Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling and restricted sterilization for pregnancy prevention.
 - **Hospice Services**, effective 02/01/2016;
 - This service should be coordinated with the participant's primary care provider.
 - **Hospital Admissions** resulting directly from the facility's emergency room, effective 12/01/2012;
 - Discharge planning must be coordinated with the HC PCP.
 - **Immunizations** without an office visit, effective 04/01/2007;
 - Specialty physician and providers administering immunizations are asked to either provide the participant's PCP with immunization records, or to record administered immunizations in the Idaho Immunization Registry and Information System (IRIS) to assure continuity of care and avoid duplication of services.
 - **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services**;
 - This includes all services delivered to participants residing in an ICF/IID, regardless of place of service.
 - **Indian Health Clinic Services** provided to an American Indian/Alaskan Native;
 - **Infant Toddler Program Services**, effective 09/01/2013;
 - **Influenza Shots**;
 - Providers administering influenza shots are asked either to provide the participant's PCP with documentation of the shot, or to record the immunization in the Idaho Immunization Registry and Information system to assure continuity of care and avoid duplication of services.
 - **Laboratory Services** including pathology, effective 04/01/2007;
 - **Licensed Midwife Services**;
 - **Occupational Therapy Services**, effective 02/01/2016;
 - This service should be coordinated with the participant's primary care provider.
 - **Outpatient Mental Health Services** managed by Optum Idaho, effective 09/01/2013;
 - Mental Health Services not coordinated by the Department's Behavioral Health Managed Care Contractor, Optum Idaho, and billed directly to DXC Technology will require a Healthy Connections referral. For example, a referral would be required for a psychiatrist billing DXC Technology directly for physician services provided to a participant with only a mental health diagnosis. See Substance Use Disorder (SUD) Services below for referral information specific to SUD services.
 - **Personal Care Services (PCS)**;
 - **PCS Case Management**;
 - **Pharmacy Services** or [prescription drugs](#);
 - **Physical Therapy**, effective 02/01/2016;
 - This service should be coordinated with the participant's primary care provider.
 - **Podiatry Services** performed in the office;
 - **Pregnancy-Related Services**, effective 01/01/2013;
 - This service should be coordinated with the participant's primary care provider.

- [Radiology Services](#), effective 04/01/2007;
- **Respiratory Services**, effective 02/01/2016;
- [School Based Health Center \(SBHC\)](#) for acute services when coordinated with the participant's primary care provider within three business days, effective 01/01/2020;
- [School-Based Services](#);
 - Includes all health-related services provided by a school district under an Individual Education Plan (IEP).
- [Screening Mammography](#);
- **Services managed directly by the Department**, as defined in the Provider Handbook, Provider Guidelines;
- [Skilled Nursing Facility Services](#);
 - This includes all services delivered to participants residing in a skilled nursing facility.
- [Speech Language Pathology](#), effective 2/1/16;
- **Sexually Transmitted Disease Testing**;
- **Substance Use Disorder (SUD) Services**;
 - Pursuant to the Code of Federal Regulations at Title 42, Chapter I, Subchapter A, Part 2, "Confidentiality of Substance Use Disorder Patient Records" a Healthy Connections referral is not required to access or receive SUD services for any participant with a SUD diagnosis regardless of diagnosis position, primary, secondary or tertiary.
- [Transportation Services](#);
- [Urgent Care Services](#), effective 01/01/2020;
- [Vision Services](#) performed in the offices of ophthalmologists and optometrists and eyeglasses; and
- [Waiver Services for the Aged and Disabled](#).

7.4.7. School Based Health Centers

A School Based Health Center (SBHC) is defined as a health center located at an elementary, middle, or high school. College health services do not qualify as an SBHC. SBHCs do not require a referral for **acute care services** provided to a student so long as all requirements of this section are met:

- The participant's PCP must be contacted within three business days with written or electronic documentation for coordination of care.
- Documentation must include:
 - A visit summary;
 - Prescriptions or orders issued; and
 - Any other information the PCP may need to be aware of.
- If secondary or specialty care is medically necessary, the SBHC provider will refer the student back to their HC PCP.
- The student's parent/guardian must be contacted with the visit outcome and any follow-up care recommendations.

The SBHC will be subject to periodic evaluation of policy compliance for care coordination by Department staff to include patient medical record reviews.

7.4.8. Urgent Care Services

Effective January 1, 2020, Healthy Connection Referrals will not be required for urgent care services accessed at urgent care centers or Healthy Connections Clinics that meet the criteria below. Urgent care services for this purpose are medical services used in the treatment of acute illness or injury which require prompt attention, but generally are not serious enough to require an emergency room visit.

Participants are encouraged to always call their Primary Care Provider first as they may offer same day or walk-in appointments. If their Primary Care Provider's office is closed or they are unable to be seen immediately for an urgent medical need, they may be seen at a qualified Urgent Care or Healthy Connections Clinic. The Department encourages providers to work together within their medical neighborhoods to effectively coordinate patient care. Urgent care service providers have the option to treat participants or contact their PCP to determine if they have availability to treat an urgent medical need.

Providers that meet the criteria for urgent care services not needing a referral are:

1. **Urgent Care Centers** – for purposes of this referral policy, defined as:
 - a. Evaluates and treats a broad spectrum of illness and injury
 - b. Offers walk-in appointments as the primary scheduling model
 - c. Is open at least one additional hour per weekday outside the standard Monday-Friday 8:00-5:00, or an additional five hours on the weekend
2. **Healthy Connections Clinics** that meet the following enhanced access criteria:
 - a. Offers walk-in or same day appointments
 - b. Is open at least one additional hour per weekday outside the standard Monday-Friday 8:00-5:00, or an additional five hours on the weekend

In addition to meeting the above criteria, Urgent Care Centers or Healthy Connections Clinics are required to:

1. **Communicate** the visit summary directly to the patient's Healthy Connections Clinic of record within three (3) business days of the visit. At a minimum, this shall include:
 - a. Facts and Findings
 - b. Prescriptions and DME ordered
 - c. Other pertinent healthcare information
2. **Direct** the patient to their Healthy Connections Clinic of record:
 - a. For ongoing treatment or coordination of chronic/complex conditions
 - b. When specialty or follow-up care is needed
 - c. For those seeking wellness services
3. **Educate** patients when urgent care is appropriate

Providers required to meet these criteria will be subject to periodic evaluation of policy compliance. Compliance requirements to include:

1. Proof of direct communication must be documented by both the provider rendering the urgent care service AND the Healthy Connections clinic of record.
 - a. The communication requirement would be met when the urgent care service provider and Healthy Connections Clinic of record are under the same organization and share an Electronic Medical Record (EMR)
 - b. Record of visit in the Idaho Health Data Exchange (IHDE), while encouraged, without direct communication to the Healthy Connections Clinic of record does not meet the communication requirements.

2. Urgent Care Service Providers are required to, at a minimum, direct participants to their Healthy Connections Clinic of record for follow-up visits, wellness care or scheduled appointments.

Failure to meet these requirements may result in services considered non-covered and subject to recoupment and/or a civil monetary penalty.

a) References: Urgent Care Services

Healthy Connections Urgent Care Service Referral Policy effective January 1, 2020, Information Release MA19-17 (12/13/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho,
<https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1917.pdf>.

7.4.9. Reimbursement for Services Requiring Referral

It is the responsibility of the billing provider to ensure a referral is documented and meets the requirements of this handbook prior to rendering services. Claims will process regardless of referral status. The referral field in the claims processing system is a misnomer and is intended for prior authorization numbers. Entering a referral number will cause the claim to deny. Billing Medicaid for services without a correct and complete referral is not allowed. Any payments received as a result of a missing or incomplete referral are subject to recoupment and/or assessment of civil monetary penalties by the Department.

Providers may bill a participant that chooses to accept a service requiring a referral when there is not a correct and complete referral in place. See the [Participant Financial Responsibility](#) section for more information about when billing participants is permissible.

7.4.10. References: Referrals

"Changes in Children's Developmental Disability Services and Healthy Connections Referral Requirement." *MedicAide Newsletter*, August 2013,
<https://www.idmedicaid.com/MedicAide%20Newsletters/August%202013%20MedicAide.pdf>

.

"Healthy Connections Electronic Referral Option and Other Important Policy Updates – Effective 12/1/12." *MedicAide Newsletter*, December 2012,
<https://www.idmedicaid.com/MedicAide%20Newsletters/December%202012%20MedicAide.pdf>.

"Healthy Connections Primary Care Provider Webinars presented by Optum Idaho: Importance of Coordinating Behavioral Health Services with Primary Care Providers." *MedicAide Newsletter*, August 2013,
<https://www.idmedicaid.com/MedicAide%20Newsletters/August%202013%20MedicAide.pdf>

.

Reimbursement and Referral Changes for the Idaho Medicaid Healthy Connections and Health Home Programs, Information Release MA16-02 (02/05/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho,
<http://healthandwelfare.idaho.gov/Portals/0/Providers/IRMA1602.pdf>.

Removal of Requirement for Healthy Connections Referral for Outpatient Dental Services, Information Release MA07-18 (10/01/2017). Division of Medicaid, Department of Health and Welfare, State of Idaho,

<https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA07-18-signed.pdf>.

Removal of Requirement for Healthy Connections Referral for Select Services, Information Release MA07-19 (10/01/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho,

<https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA07-19-signed.pdf>.

7.5. Program Liaison

The HC Program provides staff to help resolve program related problems providers may encounter. Contact information for regional Healthy Connections Representative can be found at <https://healthyconnections.idaho.gov/>. Providers can also contact their local Provider Relations Consultant (PRC) with DXC Technology to obtain information, training, or to answer billing questions. Refer to the [Directory](#), Idaho Medicaid Provider Handbook for specific contact information.

8. Covered Services and Limitations: General

8.1. Medical Necessity

State Medicaid programs are mandated to only pay for medically necessary services and items covered in Idaho Medicaid's State Plan for adults twenty-one years of age and older. A service or item is considered medically necessary when it is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, cause functionally significant deformity or malfunction. Only effective treatments that are the most conservative (including setting, duration and frequency), or least costly, are considered eligible. The setting a participant receives services in, and the methods or items utilized must be safe and effective. The service or item must be of a quality that meets professionally-recognized standards of health care and substantiated by records including evidence of such medical necessity and quality. Items and services are not provided for the convenience of the patient, provider or caregiver. Diagnoses on claim submissions must support medical necessity for the services provided.

Children up to the age of 21 have an expanded definition for medical necessity to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Although services under EPSDT do not have to be within the State Plan, they must fall into a category of service listed in 1905(a) of the Social Security Act, be considered safe and effective, and meet acceptable standards of medical practice. If services not covered under the State Plan are needed, a [Request for Additional Services \(RAS\) form](#) must be submitted to the Department for prior authorization.

A service or item that has received FDA approval or its own CPT®/HCPCS code is not automatically considered a medically necessary service or item. It must be consistent with generally accepted professional medical standards of care and be verified through independent study published in peer-reviewed literature before being considered for medical necessity. In the absence of Idaho Medicaid direction for medical necessity criteria of covered items and services, the provider should default to Medicare standards.

Screening services are generally not medically necessary. Screening is used to detect an undiagnosed disease where early detection may prevent harm, and where the patient has no signs, symptoms, laboratory evidence, radiological evidence or personal history of the disease. Idaho Medicaid covers screening services as mandated by the Affordable Care Act (ACA) and recommended by the US Preventive Services Task Force (USPSTF) with an "A" or "B" recommendation, or when listed in the American Academy of Pediatrics Bright Futures periodicity schedule.

See [Non-Covered and Excluded Services](#) for information about items and services that may not be reimbursable. See the [Early & Periodic Screening, Diagnostic & Treatment \(EPSDT\)](#) section for more information and how to request services that may exceed those under State Plan for participants under the age of 21.

8.1.1. References: Medical Necessity

"Definitions." Social Security Act, Sec. 1905(r) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions: I Through O." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 011. Department of Administration, State of Idaho,

<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 880 – 883. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/>.

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

"Prevention Services." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 580 – 649. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

State Plans for Medical Assistance, 42 U.S.C. Sec. 1396a (1984). Government Printing Office, <https://www.govinfo.gov/content/pkg/USCODE-2017-title42/pdf/USCODE-2017-title42-chap7-subchapXIX-sec1396a.pdf>.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(30) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

Sufficiency of Amount, Duration, and Scope, 42 CFR 440.230(d) (1981). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-230.pdf>.

8.2. Experimental/Investigational Services

The Department uses the terms experimental and investigational interchangeably. Treatments and procedures are considered experimental if they are used to gain further evidence or knowledge, or to test the usefulness (i.e., efficacy) of a drug or treatment. All services and follow-ups directly associated with an experimental service are also excluded from reimbursement. The Department lists services it considers experimental throughout the handbook for provider convenience, however, on services without stated guidance from the Department providers bear a responsibility to determine if a service meets the definition of [Medical Necessity](#) and if it would be considered experimental. A service would be experimental if:

- It is being provided as part of a phase 1 clinical trial;
- There is inadequate data to provide the reasonable expectation that the service would be as effective as the standard treatment for a condition;
- Expert opinion suggests additional information is needed to assess the safety or efficacy of a treatment or procedure;
- It is determined experimental or investigational under Medicare or their local area contractor, Noridian Healthcare; or
- It is considered investigational by the Food and Drug Administration (FDA).

Services determined to be experimental are not eligible for coverage under Early & Periodic Screening, Diagnostic & Treatment (EPSDT). Procedures and treatments may be eligible for coverage with a prior authorization under a focused case review on a case-by-case basis for participants of any age with a life threatening medical illness and no other available treatment options. The Department may at its discretion seek an independent professional opinion if there is insufficient information to render a coverage decision. A focused case review involves a Department analysis of the proposed procedure or treatment and:

- The anticipated benefit and risks to the participant's health;
- Documentation of the participant's previous treatments and outcomes;
- Medicare's coverage in national coverage guidelines;
- The phase of clinical trial the procedure or treatment is in (if applicable);
- Written guidance from national organizations;
- Clinical data and peer-reviewed literature;
- Ethics Committee review, if appropriate; and
- A cost-benefit analysis consisting of:
 - Estimated long-term cost if the request is approved or denied; and
 - Potential long-term impacts to Idaho Medicaid if the request is approved.

Services approved under a focused case review that fall into Medicare's clinical trial policy, investigational device exemption policy or coverage with evidence development must use modifiers Q0 and Q1 on outpatient claims to differentiate between routine and investigational clinical services. ICD-10-CM Z00.6 must be included on the claim in the primary or secondary position.

Outpatient Experimental/Investigational Modifiers	
Modifier	Description
Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study. This modifier will price the claim line at zero.
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study. This modifier will not affect claim line pricing.

8.2.1. References: Non-Covered and Excluded Services

a) CMS Guidance

Items and Services Not Covered Under Medicare. Centers for Medicare & Medicaid Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf>.

"Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims." *MLN Matters MM8401*, June 2014, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf>.

"National Coverage Determination (NCD) for Routine Costs in Clinical Trials (310.1)." *Medicare National Coverage Determinations (NCD) Manual*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=1>.

"Non-Covered Services." *Noridian Healthcare Solutions*, 16 April 2018, https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered_statutorily_excluded.

b) Idaho Medicaid Publications

"Billing Idaho Medicaid with CMS Modifiers Q0 and Q1." *MedicAide Newsletter*, December 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202016%20MedicAide.pdf>.

c) Regulations

"EPSDT Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 880 – 889. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Excluded Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Investigational Procedures or Treatments: Procedural Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 443. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Medical Assistance Program – Services to be Provided – Experimental Services or Procedures Excluded, Idaho Code 56-209(d) (2006). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-209d/>.

8.3. Service Limitations

Service limitations restrict services based on state and federal rules and regulations. Each procedure and revenue code may be reviewed for a variety of limitations. Limitations include, but are not limited to:

- Services bundled when rendered by the same provider;
- Amount of services or items in a given time frame;
- Reimbursement caps during a time period;
- Medical necessity;
- Age of the participant; and
- Lifetime procedures.

Some services that exceed limitations may be covered with a prior authorization. Refer to your specific [Provider Guidelines](#) carefully for additional information.

Policy limitations can be reviewed on request if the allowed amount doesn't meet the average participants' needs. Supporting documentation should be submitted to demonstrate why the current limitation would not meet the average participant's medical needs. Requests may be submitted to MCPT@dhw.idaho.gov.

8.4. Non-Covered and Excluded Services

Specific non-covered services and circumstances are detailed throughout the provider handbook. Non-covered services are not excluded from coverage by statute and meet all technical requirements for coverage, but have been determined non-covered because of one of the following:

- The service is not within the scope of the participant's eligibility for coverage;
- The service requires a Healthy Connections referral and one isn't available;
- The participant has exhausted their allowed amount;
- The service is covered in a bundle with another service, and may not be unbundled; or
- The service is not reasonable and medically necessary. See the [Medical Necessity](#) section for more information.

Excluded services are those services that are not allowed to be covered by state or federal statute or rule. See the [List of Excluded Services](#) section for more information.

The following fees and situations do not fall under the Department's definition of a non-covered or excluded service and can never be billed to a participant:

- No-show or missed appointment fees;
- Other insurer's co-pays;
- Failure on the part of the provider to submit a complete and correct claim to the Department or other payor;
- Failure by the provider to submit a complete and correct request for prior authorization from the Department or other payor;
- Claims voided by the provider;
- Failure of the provider to follow any payor's policy or procedure; or
- Any recoupment or penalties the provider receives as a result of their action or inaction.

A service that is non-covered or excluded is not reimbursable regardless of the CPT® or HCPCS code selected for billing. Non-covered or excluded services billed under a CPT® or HCPCS defined as unlisted or miscellaneous will be subject to recoupment and penalties. See Idaho Medicaid Claim Standards in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about correct coding. See [Participant Financial Responsibility](#) section for information on when and how participants may be billed.

8.4.1. List of Excluded Services

Services excluded from coverage by statute or rule include:

Acupuncture

Biofeedback Therapy

Biofeedback for urinary incontinence, however, is a covered service.

Complications

The treatment of complications, consequences, or repair of any excluded medical procedure is not covered. Medicaid may authorize treatment with supporting documentation from a physician if the resultant condition is determined by Medicaid to be life threatening.

Cosmetic Surgery

All surgery that is generally cosmetic in nature is excluded from payment unless it is found to be medically necessary, such as reconstructive surgery, and is prior authorized.

Elective Treatments

Elective medical and surgical treatments are not covered without a prior authorization except for family planning services.

Eye Exercise Therapy

Fertility-Related Services

Fertility-related services are not covered. This includes: testing; artificial insemination; consultations; counseling; donation of ovum, sperm, or surrogate womb; genetic testing and/or counseling for family planning; in vitro fertilization; office exams; penile implants; or reversal of sterilization.

Group Exercise Therapy

Group Hydrotherapy

Experimental/Investigational Services

Laetrile Therapy

Naturopathic Services

Screening Services

Screening services are excluded except those with recommendations of "A" or "B" by the United States Preventive Services Task Force (USPSTF) or identified in the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule. In the event that recommendations from the USPSTF and AAP conflict, the Department follows the USPSTF.

Surgical Procedures on the Cornea for Myopia

Vitamin Injections

Vitamin injections are not covered if they are not needed for a specific diagnosis.

8.4.2. Exceptions to Non-Covered and Excluded Services

Some non-covered or excluded services and procedures that require treatment, services, or supplies not included in the regular scope of Medicaid coverage may be payable when identified as medically necessary during a Child Wellness exam, sometimes referred to as Early & Periodic Screening, Diagnostic & Treatment (EPSDT). Coverage under EPSDT must be prior authorized by Medicaid and is not available for experimental or investigational services. See the [Early & Periodic Screening, Diagnostic & Treatment \(EPSDT\)](#) section for more information.

8.4.3. References: Non-Covered and Excluded Services

a) CMS Guidance

Items and Services Not Covered Under Medicare. Centers for Medicare & Medicaid Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network->

[MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf](https://www.idmedicaid.com/MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf).

"Non-Covered Services." *Noridian Healthcare Solutions*, 16 April 2018, https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered_statutorily_excluded.

b) Idaho Medicaid Publications

"Screening Services Not Mandated are Statutorily Excluded from Reimbursement." *MedicAide Newsletter*, March 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

c) Regulations

"EPSDT Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 880 – 889. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Excluded Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

8.5. Dental

Dental services are administered through Idaho Smiles as of July 1, 2011. No other claims are payable through DXC Technology unless otherwise explicitly noted. All reimbursement for dental claims and services is handled through Idaho Smiles. Please call 1 (855) 235-6262 or visit the [Idaho Smiles](#) website for more information on this program.

See the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook for coverage of dental anesthesia for pediatrics provided in the office.

8.6. Early Intervention Services

Early Intervention Services are designed to work with families to meet the developmental needs of each child. Services are provided through Individuals with Disabilities Education Act (IDEA) Part C in accordance with 42 CFR 440.130(d). As the lead agency for IDEA Part C services, the Infant Toddler Program (ITP) may receive Medicaid reimbursement as detailed in the [Department Intra-Agency Agreement](#) for these medically necessary services through the following Medicaid benefits:

- Intake Screening;
- Developmental Screening;
- PT, OT, SLP Evaluations;
- Developmental Evaluation;
- Early Intervention Assessment;
- Early Intervention;
- Joint Visit;
- Teaming;
- Interpretive Services;
- Service Coordination;
- Transportation; and
- Assistive Technology.

8.6.1. Early Intervention Services Eligibility

Eligibility for Early Intervention Services is determined by ITP in accordance with IDEA Part C requirements and Medicaid regulations as specified in the [Department Intra-Agency Agreement](#) available at id.medicaid.com under the "Reference Material" tab. To be eligible for Medicaid reimbursement for covered services, the child must:

- Be age birth through the end of their 36th month; and
- Have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay; or
- Experience delays in one or more of the following areas:
 - Cognitive development;
 - Physical development, including vision and hearing;
 - Communication development;
 - Social or emotional development; or
 - Adaptive development.

8.6.2. Evaluations

Evaluations must support services billed to Medicaid, be updated as needed to accurately reflect the child's current status and be recommended by a physician. Evaluations completed for educational services only cannot be billed to Medicaid. Evaluations must include the following information:

- Summary of Findings;
- Recommendations for treatment; and
- Dated signature of professional completing the evaluation.

8.6.3. Assessments

Assessments must support services billed to Medicaid and be used to identify strengths and needs and services appropriate to meet those needs. Assessments must include the following information:

- Indication the parent or legal guardian of the child were included in the assessment process; and
- Dated signature of professional completing the assessment.

8.6.4. Documentation

The Infant Toddler Program must ensure a child's record contains information in accordance to IDEA Part C requirements and all Medicaid regulations as detailed in the [Department Intra-Agency Agreement](#). The following information must be included in the record of each child enrolled in ITP:

- Eligibility Determination;
- Physician recommendation;
- Evaluations/Assessments;
- Individualized Family Service Plan (IFSP);
- Continuing Service Report(s); and
- Other child specific documentation listed in the [Department Intra-Agency Agreement](#).

8.6.5. Provider Staff Qualifications

Early intervention services for infants and toddlers enrolled in Idaho Medicaid are provided by the ITP. The ITP must hold a valid Idaho Medicaid provider agreement and comply with all provider enrollment and screening requirements as specified in [IDAPA 16.03.09](#).

All personnel providing early intervention services must be employed by or contracted with the ITP, meet established certification or licensing standards, meet IDEA, Part C requirements and meet all Medicaid regulations as specified within the [Department Intra-Agency Agreement](#).

8.6.6. Medicaid Reimbursable IDEA Part C Services

IDEA Part C services reimbursed based on the [early intervention fee schedule](#) include:

- Intake Screening;
- Developmental Screening;
- PT, OT, SLP Evaluations;
- Developmental Evaluation;
- Early Intervention Assessment;
- Early Intervention;
- Joint Visit;
- Teaming; and
- Interpretive Services.

IDEA Part C services reimbursed in ways other than the [early intervention fee schedule](#) include:

- Service Coordination;
- Transportation; and

- Assistive Technology.

When providing services, the Infant Toddler Program must ensure early intervention services are provided in accordance to IDEA Part C requirements and Medicaid regulations as detailed in the [Department Intra-Agency Agreement](#).

8.6.7. Payment for Services

Medicaid reimburses for early intervention services in accordance with Medicaid established rates and reimbursement methodology. The ITP must:

- Accept Medicaid payment as payment in full and may not bill participants for the balance;
- Ensure contracted providers do not submit a separate claim to Medicaid as the performing provider for services billed under ITP's provider number;
- Pursue third party payments before billing Medicaid for all services except screening, evaluation and assessment; and
- Provide [Telehealth Services](#) in accordance with the Idaho Medicaid Provider Handbook.

Reimbursement is subject to pre-payment and post-payment review in accordance with [Section 56-209\(h\)\(j\)\(3\)](#), Idaho Code and recoupment in accordance with [IDAPA 16.05.07](#), "The Investigation and Enforcement of Fraud, Abuse and Misconduct."

8.6.8. Prior Authorization

Prior authorization is not required for services on the [early intervention fee schedule](#). Prior authorization is required for transportation and certain durable medical equipment and supplies. Prior authorization will be based on a determination of medical necessity made by DHW or its designee.

8.6.9. Procedure Codes

All claims submitted must contain a 5-digit health related service procedure code for billing. See the [early intervention fee schedule](#) for covered services and additional information. Treatment must be provided in accordance with the IFSP.

8.6.10. Place of Service Codes

Early Intervention services can only be provided in the following POS:

- 12 Home; or
- 99 Other (Community).

8.7. Interpretive Services

Providers are required by law to provide interpretive services to assist participants who are blind, deaf or who do not speak or understand English. This requirement may be waived if an emergency situation exists with an imminent threat to the safety and welfare of the participant or public, or it may be waived if the participant specifically requests an adult family member or friend be their interpreter/translator.

8.7.1. Interpretive Services Documentation

Documentation must be maintained to support reimbursement of interpretive services. At a minimum documentation must contain:

- The name and Medicaid Identification Number of the participant;
- If services are not for the participant, the name of the person and their relationship to the participant's care;
- The name, title and signature of the Medicaid provider rendering services;
- Description of the Medicaid service being received, and the type of interpretive service provided;
- The name, title and signature of the person rendering interpretive services;
- The date, time and duration of the interpretive services; and
- The necessity for any wait time being requested.

The need for interpretive services must be in the individualized education plan (IEP) if provided for a school-based service.

8.7.2. Interpretive Services for Sterilization Procedures

The interpreter/translator is responsible for ensuring the sterilization consent form is effectively, accurately and impartially communicated to the participant or their guardian. The statement certifies the interpreter/translator's discharge of their duty, their belief that the participant understood the procedure, and that the participant was allowed to ask questions. If the interpreter/translator fails to complete the statement correctly, all claims regarding the sterilization will be denied including claims from the hospital, physician and anesthesiologist. See Sterilization Procedures in the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook for more information.

8.7.3. Interpretive Services – Reimbursement

Idaho Medicaid will reimburse for interpretation, translation, Braille and sign language services provided to participants in person or through telehealth. Reimbursement is also available when interpretive services are provided to the parent or guardian of a child under 18. The participant is only eligible if the provider has no alternative means of oral or written communication. No additional reimbursement is available for multilingual providers that share a language with the participant. Interpreters and translators must meet state and professional licensure requirements and be at least eighteen years of age. See the [Telehealth Services](#) section for more information about reimbursement eligibility using telehealth services.

Idaho Medicaid does not reimburse for:

- Administrative services such as:
 - Scheduling or cancelling appointments;
 - Making reminder calls;
 - The interpreter's travel time; or
 - No show appointments;
- Services in conjunction with a non-covered, non-reimbursable, or excluded service;

- Services provided by an immediate family member such as a parent, spouse, sibling or child;
- Services provided through a Medicaid managed care contractor. Contact the managed care contractor to see if they reimburse separately for interpretive services;
- Teaching sign language;
- Providers not on the fee-for-service model;
- Services through institutional providers, hospitals or facilities; or
- The interpreter or translator's waiting time, except when the participant is in surgery or receiving other covered services such as radiology.

Interpretive Services are billed under T1013 (Language Interpretive – Oral Services, per 15 minutes) and T1013-CG (Sign Language Interpretive Services, per 15 minutes).

8.7.4. References: Interpretive Services

a) Idaho Medicaid Publications

"Interpretive Services." *MedicAide Newsletter*, December 2008, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/December%20Newsletter%20final.pdf>.

"Interpretive Services." *MedicAide Newsletter*, January 2010, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/January%202010%20MedicAide%20Newsletter%20Final.pdf>.

"New Code for Billing Sign Language Services." *MedicAide Newsletter*, December 2006, http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/2006_12.pdf.

"Providing Sign and Oral Language Interpretive Services." *MedicAide Newsletter*, September 2012, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202012%20MedicAide.pdf>.

"Reimbursement for Interpretation, Translation, and Sign Language Services." *MedicAide Newsletter*, January 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202017%20MedicAide.pdf>.

b) Regulations

American with Disabilities Act of 1989. 104 STAT. 327 (1990). Government Printing Office, <https://www.gpo.gov/fdsys/granule/STATUTE-104/STATUTE-104-Pg327/content-detail.html>.

Civil Rights Act of 1964, Title VI. 78 STAT. 241 (1964). Government Printing Office, <https://www.gpo.gov/fdsys/granule/STATUTE-78/STATUTE-78-Pg241/content-detail.html>.

Equal Opportunity for Individuals with Disabilities, 42 U.S.C. CH. 126 (1990). Government Printing Office, <https://www.gpo.gov/fdsys/pkg/USCODE-2009-title42/html/USCODE-2009-title42-chap126.htm>.

Nondiscrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance, 45 CFR 84 (1977). Government Printing Office,

<https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=pt45.1.84&rgn=div5>.

Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and... Under Title I of The Patient Protection and Affordable Care Act, 45 CFR 92 (2016). Government Printing Office, <https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=pt45.1.92&rgn=div5>.

Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services Effectuation of Title VI of the Civil Rights Act of 1964, 45 CFR 80 (1979). Government Printing Office, <https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=pt45.1.80&rgn=div5>.

Other Applicable Federal Regulations, 42 CFR 430.2 (1988). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=se42.4.430_12&rgn=div8.

Rehabilitation Act of 1973, Section 504. H.R. 8070 (1973). Government Printing Office, <https://www.gpo.gov/fdsys/pkg/STATUTE-87/pdf/STATUTE-87-Pg355.pdf>.

8.8. Non-Emergent Medical Transportation

Effective March 6, 2018, Idaho Medicaid has contracted with MTM (Medical Transportation Management Inc.) to handle all non-emergency medical transportation services. Please visit www.mtm-inc.net/idaho or call 1 (877) 503-1261 for more information.

8.9. Telehealth Services

Telehealth services are covered and reimbursable fee-for-service if delivered via two-way live video between the provider and the participant. Services must be equal in quality to services provided in-person, and comply with HIPAA privacy requirements, licensure requirements, [Medicaid Information Release MA18-07](#), and all Medicaid rules, regulations and policies. See the [Healthy Connections](#) section for information about when a referral is required. Reimbursement is not available for communication via telephone, electronic mail messages (e-mail), text messages or facsimile transmission (fax).

Any written information must be provided to the participant before the telehealth appointment in a form and manner which the participant can understand using reasonable accommodations when necessary. The participant must be informed and consent to the delivery models, provider qualifications, treatment methods, or limitations and telehealth technologies. The rendering provider at the distant site must also disclose to the participant their identity, current location, telephone number and Idaho license number. If the participant (or legal guardian) indicates at any point that he wants to stop using the technology, the service should cease immediately and an alternative (in-person) appointment should be scheduled. The partial, interrupted service is not reimbursable.

Telehealth providers must have a systematic quality assurance and improvement program that is documented, implemented and monitored. If an operator who is not an employee of the involved agency is needed to run the teleconferencing equipment or is present during the conference or consultation, that individual must sign a confidentiality agreement. Providers at the distant site, who regularly provide telehealth services to Idaho Medicaid participants are required to maintain current Idaho licensure.

Rendering providers must provide timely coordination of services, within three business days, with the participant's primary care provider. The PCP should be provided in written or electronic format a summary of the visit, prescriptions and DME ordered, if applicable, and any other pertinent information from the visit.

8.9.1. Telehealth Eligible Services

Children with Developmental Disabilities

- Crisis Intervention (HCPCS H2019)
- Therapeutic Consultation (HCPCS H2011)

See the [Agency Professional](#), Idaho Medicaid Provider Handbook for more information.

Early Intervention Services (EIS) through the Infant Toddler Program.

- Family Training and counseling for child development, per 15 minutes (HCPCS T1027)
- Home Care Training, family, per 15 minutes (HCPCS S5110)
- Medical Team Conference with Interdisciplinary Team, 30 minutes (CPT® 99366)

See [the Early Intervention Services \(EIS\)](#) section of this handbook for more information on these services.

Interpretive Services (HCPCS T1013, T1013-CG) See the [Interpretive Services](#) section of this handbook for more information on these services.

Occupational and Physical Therapists

Evaluations must be performed in-person. Therapeutic procedures and activities (CPT® 97110, 97530) are covered via telehealth. See the [Therapy Services – Occupational and Physical](#), Idaho Medicaid Provider Handbook for more information on these services.

Physician/Non-physician Practitioner Services

Physicians and non-physician practitioners enrolled as Healthy Connections primary care providers are eligible to provide primary care services via telehealth. Providers must be licensed by the Idaho Board of Medicine or the Board of Nursing. Other services available through telehealth:

- Primary Care and Specialty Services (CPT® 99201–99205, 99211–99215, 99354, 99355, 99495, 99496)
- Health and Behavior Assessment/Intervention (CPT® 96150–96154)
- Pharmacological Management
- Psychiatric Crisis Consultation (CPT® 90839 & 90840, Physicians and Psychiatric Nurse Practitioners only)
- Psychiatric Diagnostic Interview (CPT® 90791, 90792)
- Psychotherapy with evaluation and management (CPT® 90832–90834, 90836–90838)
- Tobacco Use Cessation (CPT® 99406, 99407)

School-based Services

Community Based Rehabilitation Services (CBRS) Supervision is covered via telehealth. Reimbursement is already included in CBRS payment. See the [Agency Professional](#), Idaho Medicaid Provider Handbook for more information.

Speech Language Pathologists

Evaluations must be performed in-person. Speech therapy services (CPT® 92507) are covered via telehealth. See the [Speech, Language and Hearing](#), Idaho Medicaid Provider Handbook for more information about these services.

8.9.2. Telehealth Services – Technical Requirements

Video must be provided in real-time with full motion video and audio that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication. Transmission of voices must be clear and audible.

8.9.3. Telehealth Services – Documentation

The individual treatment record must include written documentation of evaluation process, the services provided, participant consent, participant outcomes, and that services were delivered via telehealth. The documentation must be of the same quality as is originated during an in-person visit. These documentation requirements are specific to delivery via telehealth and are in addition to any other documentation requirements specific to the area of service (i.e., IEP requirements for school-based services).

8.9.4. Telehealth Services – Reimbursement

Only one eligible provider may be reimbursed per service per participant per date of service. No reimbursement is available for the use of equipment at the originating or remote sites. Reimbursement is also not available for services that are interrupted and/or terminated early due to equipment difficulties.

Place of service 02 (telehealth) is not used by Idaho Medicaid. All normal Place of Service codes are acceptable for telehealth. The place of service used should be the location of the participant. Claims must include a GT modifier (Via interactive audio and video telecommunications systems) on CPT® and HCPCS. FQHC, RHC or IHS providers should not report the GT modifier with encounter code T1015, but should include it with the supporting codes.

8.9.5. References: Telehealth Services

a) CMS Guidance

"Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.

"Chapter 12 – Physicians/Nonphysician Practitioners." *Medicare Claims Processing Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.

"Telehealth." Centers for Medicare and Medicaid Services, 3 January 2014, <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

b) Idaho Medicaid Publications

"Telehealth Place of Services (POS)." *MedicAide Newsletter*, July 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf>.

Telehealth Policy, Information Release MA16-20 (12/23/2017). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1620.pdf>.

Telehealth Therapies, Information Release MA16-07 (5/9/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IRMA1607.pdf>.

Updated Telehealth Policy, Information Release MA18-07 (7/2/2018). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1807.pdf>.

Updated Telehealth Policy, Information Release MA15-11 (12/31/2015). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA15-11.pdf>.

c) Regulations

"Children's Waiver Services." *IDAPA 16.03.10*, "Medicaid Enhanced Plan Benefits," Sec. 680 – 683. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160310.pdf>.

Idaho Telehealth Access Act, Idaho Code 54-57 (2015). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title54/t54ch57/>.

The Medical Consent and Natural Death Act, Idaho Code 39-4507 (2005). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title39/t39ch45/sect39-4507/>.

Payment for Telehealth Services, 42 CFR 414.65 (2001). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol3/pdf/CFR-2018-title42-vol3-sec414-65.pdf>.

"Physician Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 500 – 509.
Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"School-Based Service." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 850 – 859.
Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Telehealth Services, 42 CFR 410.78 (2001). Government Printing Office,
<https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol2/pdf/CFR-2018-title42-vol2-sec410-78.pdf>.

"Therapy Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 730 – 739.
Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

8.10. Weight Management Services

Weight management services are covered for Medicaid participants through the behavioral benefit of the Preventive Health Assistance (PHA) program. Weight management services are not administered through the Idaho Behavioral Health Plan. Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed for provider convenience. Providers of a type and specialty with a section of the [Idaho Medicaid Provider Handbook](#) under the Provider Guidelines heading must also follow that section. Additional handbook sections that always apply to providers of this service include the following:

- [General Billing Instructions](#); and
- [Glossary](#).

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3(a) The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3(a).

8.10.1. Eligible Participants: Weight Management Services

Medicaid participants with basic or enhanced benefit plans are eligible for weight management services through the behavioral benefit of the Preventive Health Assistance (PHA) program. Participants must indicate on their periodic Health Questionnaire a desire to change behaviors related to weight management and apply for PHA benefits to be added to their Medicaid eligibility. Medicaid participants enrolled in one of the [Managed Care Programs for Dual Eligible Participants](#) or eligible for Medicaid through [Katie Beckett](#) are not eligible for PHA benefits.

Participants interested in the Preventive Health Assistance (PHA) program begin by visiting their primary care provider (PCP). The primary care provider:

- Determines if the participant meets the BMI requirements for their age group to have one of the covered diagnoses in the table below;
- Confirms the participant is enrolled in either the Basic or Enhanced plan; and
- Discusses weight management programs with patient and help to identify obtainable goals.

Covered Diagnoses for Weight Management Services	
ICD-10-CM	Description
E66.01	Morbid (severe) obesity due to excess calories. 100lbs overweight.
E66.09	Other obesity due to excess calories. BMI of 30 or higher.
E66.1	Drug-induced obesity. BMI of 30 or higher.
E66.3	Overweight. BMI between 25 and 29.9. Participants over the age of 21 with this diagnosis are not eligible.
E66.8	Other obesity. BMI of 30 or higher.
E66.9	Obesity, unspecified. BMI of 30 or higher.
R63.6	Underweight

If the PCP determines the participant meets the criteria for the behavioral PHA benefit, the PCP prints and completes section 1 of the [Idaho Medicaid Preventive Health Assistance \(PHA\)](#)

[Weight Management Agreement Form](#) and provides it to the participant or their guardian. The PCP should also provide the [WM Provider List](#) if the participant hasn't already found an enrolled weight management services provider.

The participant must select a weight management program from an enrolled provider. The participant then completes and returns the form to the Medical Care Unit (MCU) within two months of the PCP documenting their height and weight on the form. The MCU will determine eligibility and send the participant a Notice of Decision (NOD). The NOD will contain a voucher that specifies the amount approved and designated weight management provider. The participant must then take the NOD and voucher to their weight management program to receive services.

a) Participants Under 21

Participants between five (5) and twenty-one (21) years of age may qualify for weight management services if they have a body mass index (BMI) that falls into either the overweight, obese or underweight category as determined by the Centers for Disease Control and Prevention's (CDC) [Child and Teen BMI Calculator](#).

b) Participants Over 21

Participants twenty-one (21) years of age and older with a body mass index (BMI) of 30 or higher, or 18½ or lower, may qualify for the weight management program.

c) References: Eligible Participants – Weight Management Services

"Behavioral PHA." *IDAPA 16.03.09*, "Medicaid Basic Plan Benefits," Sec. 621.01 Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

8.10.2. Provider Qualifications: Weight Management Services

Providers of weight management services include, but are not limited to, life style coaches and other suppliers in the National Diabetes Prevention program, gyms, health clubs and registered dietitians. Providers, including those that are already enrolled as another provider type, must enroll as an atypical provider with Idaho Medicaid prior to providing weight management services under the Preventive Health Program (PHA). Providers must be enrolled independently as the direct/pay-to and cannot bill as a rendering under a group NPI.

Registered dietitians, however, enrolled with Medicaid do not have to complete a separate enrollment to provide weight management services within the scope of their licensure. A registered dietitian can bill for their services as a rendering provider under a group NPI or be a direct/pay-to provider. If the dietitian offers services beyond nutrition and diet, such as operating a gym or health club, then the dietitian would need to enroll as an atypical provider type for those services.

Providers must follow the Idaho Medicaid Provider Handbook and all applicable state, and federal, rules and regulations including county and local business licensing requirements. They must also be established as a business that serves the general public. In addition, medication and pharmaceutical supply vendors must be a licensed pharmacy and meet the requirements under section 664 of [IDAPA 16.03.09](#), "Medicaid Basic Plan Benefits."

See the [Provider Enrollment](#) section for more information on enrolling as an Idaho Medicaid provider.

a) References: Provider Qualifications – Weight Management Services

"Preventive Health Assistance (PHA): Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 624. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

8.10.3. Covered Services and Limitations: Weight Management Services

The behavioral benefit of the Preventive Health Program (PHA) awards points to enrolled Medicaid participants to redeem for weight management services. All services must be prior authorized by the Medical Care Unit (MCU) through a voucher and notice of decision. Weight management services must either address physical fitness, balanced diet or personal health education. These can include services under the National Diabetes Prevention Program, gym fees, healthy lifestyle classes or nutrition classes. Participants can request coverage from the Department for an unidentified service. Participants can earn up to 200 points under the behavioral benefit during each benefit period. An initial one hundred (100) points are earned upon approval into the program. An additional one hundred (100) points are earned by completing the chosen program or one of the goals established with their primary care provider. The weight management services provider must verify the program or goal was completed and provide documentation to the MCU.

Benefit periods last twelve months from when the participant is approved for the program. Participants may reapply after or near the end of their benefit period if they still meet criteria for the program. Benefit periods cannot overlap. Points cannot be transferred to another participant. Any points not utilized during their issued benefit period, expire. Points can be redeemed by voucher with a Medicaid enrolled provider at a rate of one-point to one-dollar towards eligible services.

Weight management providers must verify eligibility when they receive the voucher. Providers can only verify eligibility for PHA weight management services by calling DXC Technology customer service at 1 (866) 686-4272.

a) References: Covered Services and Limitations – Weight Management Services

"Behavioral PHA." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 623. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Benefit Year." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 620.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Preventive Health Assistance (PHA): Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 622. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Prior Authorization." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 624.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

8.10.4. Reimbursement: Weight Management Services

Services must meet all Medicaid requirements to be eligible for reimbursement. Idaho Medicaid reimburses weight management services on a fee-for-service basis. Services are reimbursed at 100% of the invoiced amount up to the maximum on the participant's voucher, so long as the participant has points remaining to redeem. Once a participant has exhausted their benefit, the participant is liable for any remaining balance due from services provided under the PHA behavioral benefit that are not otherwise covered by Idaho Medicaid. See the [Participant Financial Responsibility](#) section for requirements on billing a participant.

Claims must be submitted on a CMS-1500 form to DXC Technology via mail or the provider portal for reimbursement. Covered services and the corresponding billing codes are found in the table below. Reimbursement is only available for participants with one of the diagnoses listed in the [Eligible Participants: Weight Management Services](#) section billed as the primary diagnosis on the claim. See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook regarding policy on billing, prior authorization and requirements for billing all other third-party resources before submitting claims to Medicaid.

PHA Weight Management Covered Codes	
HCPCS	Description
S9449	Weight management classes, non-physician provider, per session. Weight management classes are training and education related to nutrition, physical activity, stress management, and lifestyle and how they relate to health.
S9451	Exercise classes, non-physician provider, per session. Exercise classes are formal programs of bodily activities that maintain physical fitness and overall health. They are usually performed in a group. There are generally three types of exercise: flexibility, such as stretching; aerobic, such as cycling, tennis, and swimming; and anaerobic, such as weight lifting.
S9452	Nutrition classes, non-physician and non-physician practitioner provider, per session. Nutrition classes provide organized instruction in the food and foodstuffs necessary for life. Classes are usually group activities that discuss generalities.
S9970	Health club membership, annual. This code represents the annual fees for a health club, also known as a fitness club or gym. The club or gym is a location that houses exercise equipment, may offer exercise classes, and other educational opportunities.

a) References: Reimbursement – Weight Management Services

"Preventive Health Assistance (PHA): Provider Reimbursement." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 625. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

8.10.5. References: Weight Management Services

"Preventive Health Assistance (PHA)." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 620 – 626. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

8.11. CHIP Wellness Incentive

Children enrolled in the Children's Health Insurance Program (CHIP) are subject to a monthly premium of \$10 or \$15 per month. The Preventive Health Assistance (PHA) program as part of its wellness benefit provides ten (10) points a month to participants, who keep up-to-date on their well child exams and immunizations. Points are then converted into a \$10 credit towards the participant's monthly CHIP premium.

Points accumulated through the PHA wellness benefit are only redeemable towards CHIP premiums. A participant can only receive 120 points in a twelve-month period. Points cannot be transferred to another participant. Any points not utilized during their issued twelve-month period, expire.

Statements are mailed to parents on a monthly basis. If a parent knows their child is up-to-date on their well checks and immunizations, they may ask their primary care provider (PCP) to fax verification of the checkup or immunizations to the Medical Care Unit at 1 (877) 845-3956. If you have questions about the PHA program, please call the Medical Care Unit toll free at 1 (877) 364-1843.

See the Wellness Examinations section of the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook for more information.

8.11.1. References: CHIP Wellness Incentive

"Premiums for Participation Under the State Children's Health Insurance Program (SCHIP)." *IDAPA 16.03.18, "Medicaid Cost-Sharing,"* Sec. 200. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

"Preventive Health Assistance (PHA)." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 620 – 626. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Appendix A. Provider Agreement Example

Provider Agreement

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IDAHO DEPARTMENT OF HEALTH AND WELFARE (IDHW) MEDICAID PROVIDER AGREEMENT

Name and address of individual or entity applying to provide these items or services:

Current or previous Provider number for this provider type and specialty: _____
(Does not apply if this is an initial application)

As a condition of participation in Medicaid, the Provider agrees as follows:

1. Compliance.

To provide services in accordance with all applicable federal laws, and provisions of statutes, state rules, and federal regulations governing the reimbursement of services and items under Medicaid in Idaho, including IDAPA 16.03.09 – “Medicaid Basic Plan Benefits,” IDAPA 16.03.10 – “Medicaid Enhanced Plan Benefits,” IDAPA 16.03.13 – “Consumer Directed Services,” IDAPA 16.03.17 – “Medicare/Medicaid Coordinated Plan Benefits,” and IDAPA 16.03.18 – “Medicaid Cost Sharing,” as amended; the current applicable Medicaid Provider Handbook; any Additional Terms attached hereto and hereby incorporated by reference; and any instructions contained in provider information releases or other program notices.

1.1. To comply with the Health Insurance Portability and Accountability Act (HIPAA), §§ 262 and 264 of Public Law 104-191, 42 USC § 1320d, and federal regulations at 45 CFR Parts 160 and 164. The Provider shall comply with all amendments of HIPAA and federal regulations made during the term of the Contract. The Provider specifically acknowledges its obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations.

1.2. To protect the confidentiality of identifying participant information that is collected, used, or maintained according to IDAPA 16.05.01, “Use and Disclosure of Department Records,” and 42 CFR § 431.300.

1.3. To comply with the False Claims Act (31 USC 3729-3733). Any Provider who either receives or makes annual Medicaid payments of at least five million dollars (\$5,000,000) shall comply with 42 USC § 1396(a)(68). The Provider specifically acknowledges the responsibility regarding employee education about the False Claims Act and State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws.

1.4. To comply with Titles VI and VII of the 1964 Civil Rights Act and Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.

1.5. To comply with the disclosure of ownership requirements in 42 CFR § Part 455, Subpart B, and 42 CFR § 411.361, when applicable, and to notify the Department thirty (30) days prior to any change of ownership. This Provider Agreement is not transferable.

1.6. To comply with the advance directives requirements of 42 CFR Part 489, Subpart I, and 42 CFR § 417.436(d), when applicable.

2. Provider Information.

To provide true and accurate information on the Enrollment Request form, Enrollment Attachment (if applicable), Disclosure Statement and all supporting documentation. The provider further agrees:

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2.1 To furnish to the Department or to the U.S. Health and Human Services, within thirty-five (35) days of the request, full and complete information related to certain business transactions, specifically about:

- (a) The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- (b) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

2.2 To notify the Department of any changes to the information contained in the Enrollment Application, including but not limited to its mailing address and service locations, within 30 days of the date of the change. All correspondence sent to the mailing address on file with the State's fiscal agent shall be deemed to have been received by the Provider.

3. Professionalism.

To be licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with statute, rules, and professionally recognized standards by qualified staff or professionally supervised paraprofessionals where their use is authorized. The Provider shall respect the Medicaid participant's right to privacy, dignity, and free choice of provider.

4. Recordkeeping.

To document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of Idaho Code, § 56-209h(3), as amended, applicable rules, and this Agreement. Such records shall be maintained for at least five years after the date of services or as required by rule. In compliance with 42 CFR § 1001.1301, IDHW, the Medicaid Fraud Control Unit of the Office of the Idaho Attorney General, the U.S. Department of Health and Human Services, or their agents, shall be given immediate access to, and permitted to review and copy any and all records relied on by the Provider in support of services billed to Medicaid.

5. Accurate Billing.

To certify by the signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the items or services claimed were actually provided and medically necessary, were documented at the time they were provided, and were provided in accordance with professionally recognized standards of health care, applicable Department rules, and this Agreement. The provider further agrees:

- 5.1 To be solely responsible for the accuracy of claims submitted, and shall immediately repay the Department for any items or services the Department or the Provider determines were not properly provided, documented, or claimed.
- 5.2 To assure that a duplicate claim under another program or provider type is not submitted.
- 5.3 To bill only for services delivered by individuals who are not on any state or federal exclusion or disbarment list and have the qualifications required for the type of service that is being delivered.

6. Secondary Payer.

To acknowledge that Medicaid is a secondary payer and to seek payment first from other all sources as required by rule, regulation, or statute, before billing Medicaid. The Provider shall not refuse to furnish services on account of a third party's potential liability for the services. (42 CFR § 447.20)

7. Payment.

To accept Medicaid payment for any item or service as payment in full and to make no additional charge except that specifically allowed by Medicaid. The Provider further agrees:

- 7.1. To submit requests for prior authorization, if required, before the item or service is provided. The Provider agrees not to bill Medicaid if a required request for prior authorization is not timely submitted.
- 7.2. Not to bill the participant unless the item or service is not covered by Medicaid, and the participant has agreed to be responsible for payment prior to receiving the item or service.
- 7.3. That if a third party pays the participant, the participant may be billed for that amount, and Medicaid will not be billed.

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7.4. Not to bill Medicaid or the participant if a third party payment is made to the Provider unless the third party payment is less than the amount Medicaid would pay.

8. Service Providers.

To be responsible for the recruiting, hiring, firing, training, supervision, scheduling, and payroll for its employees, subcontractors, or agents. The Provider shall maintain general liability insurance coverage, worker's compensation, and unemployment insurance, and shall pay all FICA taxes and state and federal tax withholding for its employees. The Provider agrees to bill only for service providers who have the qualifications required for the type of service that is being delivered.

9. Officers and Employees Not Liable.

No official, employee, or agent of the State of Idaho shall be in any way personally liable or responsible for any term of this Agreement, whether express or implied, nor for any statement, representation, or warranty made in connection with this Agreement.

10. Duration and Termination of Agreement.

This Agreement shall remain in effect until terminated in writing. In the event of termination, the Department's sole obligation shall be to pay for services provided prior to the effective date of termination. The Department shall not be responsible for any costs or expenditures of the Provider in reliance upon the terms of this Agreement.

10.1. This Agreement may be terminated by either party without cause by giving thirty (30) days' notice in writing to the other party.

10.2. This Agreement shall be terminated if judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of the Agreement infeasible or impossible.

10.3. This Agreement shall be terminated immediately if the Provider's license or certification required by law is suspended, not renewed, or is otherwise not in effect at the time service is provided.

10.4. The Department may, in its discretion, terminate this Agreement in writing when the Provider fails to comply with any applicable rule, term, or provision of this Agreement, either immediately or upon such notice as the Department deems appropriate. The Provider also understands and agrees that its conduct may be subject to additional penalties or sanctions under Idaho Code §§ 56-209h, 56-227, 56-227A, 56-227B, and 56-227E, and IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse and Misconduct", as amended. The Provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this Agreement. Notice of these sections shall in no way imply that they represent an exclusive or exhaustive list of available actions to deal with fraud and abuse.

11. Provider Liability. If the Provider is any type of partnership, corporation or nonprofit entity, the Provider agrees that the entity and the partners, directors, officers, members, or individuals with an ownership interest of 5% or greater, are jointly and severally liable for any breach of this Provider Agreement, and that action by the Department against the Provider may result in action against all such individuals in the entity.

12. Additional Terms, if any, are attached.

Information disclosed by Provider is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in the Enrollment Request form, Enrollment Attachment (if applicable), and Disclosure Statement, or contained in any communication supplying information to the Department may be punished by law, including but not limited to revocation of the provider number and recovery of payments made.

I have read the foregoing Provider Agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this agreement constitute sufficient grounds for termination of this Agreement and may be grounds for other action as provided by state rule, federal regulation, or statute.

Printed name of individual practitioner or individual authorized to sign on behalf of the Provider:

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Position: _____

By my signature, I declare, under penalty of perjury, that I have the legal authority to enter into this Agreement and hereby bind all entities and individuals that comprise the Provider.

Signature

Date

Appendix B. General Information and Requirements for Providers, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date.

General Information and Requirements for Providers, Provider Handbook Modifications				
Version	Section	Update	Publish Date	SME
78.0	All	Published version	9/18/2020	TQD
77.1	4.6 Provider Relations Consultants (PRC)	Updated PRC Contact information	9/18/2020	M Payne E Garibovic
77.0	All	Published version	7/23/2020	TQD
76.4	1.3. Ordering, Referring and Prescribing Providers	Approval for changes related to CCF 10857B1 provided	7/23/2020	T Humpherys M Payne
76.3	7.3.1 Enrollment in Healthy Connections	Added information for clinics in Healthy Connections to restrict participant enrollment.	7/22/2020	W Deseron E Garibovic
76.2	7.2.4 Primary Care Provider Listing	Renamed section to Provider Network Lists. Clarified where changes should be submitted.	7/22/2020	W Deseron E Garibovic
76.1	1.3. Ordering, Referring and Prescribing Providers	Added Pharmacist specialty per CCF 10857B1.	5/28/2020	M Payne
76.0	All	Published version	4/01/2020	TQD
77.25	6.13.3. References: Otherwise Ineligible Non-Citizens	Added reference.	3/30/2020	W Deseron E Garibovic
77.24	6.9.2.b. References: Incarcerated Persons	Added reference.	3/30/2020	W Deseron E Garibovic
77.23	Appendix B. General Provider and Participant Information, Provider Handbook Modifications	Renamed General Information and Requirements for Providers, Provider Handbook Modifications. Clarified that table only contains three years of changes.	3/25/2020	W Deseron E Garibovic M Hurst
77.22	8.10.3. Covered Services and Limitations: Weight Management	Added National Diabetes Prevention Program as eligible service.	3/25/2020	W Deseron E Garibovic M Hurst
77.21	8.10.2. Provider Qualifications: Weight Management	Updated information on eligible providers and enrollment.	3/25/2020	W Deseron E Garibovic M Hurst
77.20	8.10. Weight Management Services	Clarified how to read a provider handbook.	3/25/2020	W Deseron E Garibovic M Hurst
77.19	8.9. Telehealth Services	Added direction to Medicaid Information Release 18-07.	3/25/2020	W Deseron E Garibovic M Hurst
77.18	8.5. Dental	Added direction to Physician and Non-Physician Practitioner Handbook.	3/25/2020	W Deseron E Garibovic M Hurst
77.17	8.4. Non-Covered and Excluded Services	Subsection moved under Covered Services and Limitations: General.	3/25/2020	W Deseron E Garibovic M Hurst
77.16	8.3. Service Limitations	Subsection moved under Covered Services and Limitations: General.	3/25/2020	W Deseron E Garibovic M Hurst
77.15	8.2. Experimental/Investigational Services	New section	3/25/2020	W Deseron E Garibovic M Hurst
77.14	8.1. Medical Necessity	Subsection moved under Covered Services and Limitations: General.	3/25/2020	W Deseron E Garibovic M Hurst

General Information and Requirements for Providers, Provider Handbook Modifications				
Version	Section	Update	Publish Date	SME
77.13	8. General Participant Eligibility Information	Header deleted. Contents moved to other sections.	3/25/2020	W Deseron E Garibovic M Hurst
77.12	6.13.2. Prior Authorizations: Otherwise Ineligible Non-Citizens	New subsection.	3/25/2020	W Deseron E Garibovic M Hurst
77.11	6.13. Otherwise Ineligible Non-citizens (OINC)	Added instructions on prior authorizations.	3/25/2020	W Deseron E Garibovic M Hurst
77.10	6.3. Participant Program Abuse/Lock-In Program	Subsection moved under Participant Eligibility and Benefit Plan Coverage.	3/25/2020	W Deseron E Garibovic M Hurst
77.9	6.2. Verifying Participant Eligibility	Subsection moved under Participant Eligibility and Benefit Plan Coverage.	3/25/2020	W Deseron E Garibovic M Hurst
77.8	6.1. Medicaid Identification Card	Subsection moved under Participant Eligibility and Benefit Plan Coverage.	3/25/2020	W Deseron E Garibovic M Hurst
77.7	6. Benefit Plan Eligibility and Coverage	Renamed Participant Eligibility and Benefit Plan Coverage.	3/25/2020	W Deseron E Garibovic M Hurst
77.6	5. Provider Enrollment	Updated to reflect latest Code of Federal Regulations.	3/25/2020	W Deseron E Garibovic M Hurst
77.5	4.4. Provider Handbooks	Clarified the purpose of the provider handbook.	3/25/2020	W Deseron E Garibovic M Hurst
77.4	4.3. MedicAide Newsletter	New section.	3/25/2020	W Deseron E Garibovic M Hurst
77.3	4.2. Information Releases	New section.	3/25/2020	W Deseron E Garibovic M Hurst
77.2	1. Provider Responsibilities	Incorporated that MedicAide Newsletter and Information Releases must be followed per the provider contract	3/25/2020	W Deseron E Garibovic M Hurst
77.1	General Information and Requirements for Providers	Clarified how to read a provider handbook.	3/25/2020	W Deseron E Garibovic M Hurst
77.0	All	Published version	02/04/2020	TQD
76.12	1.9.7. CHIP Wellness Incentive	Updated to align with IDAPA 16.03.09.	01/26/2020	W Deseron E Garibovic
76.11	1.9.6.4. Reimbursement: Weight Management Services	New section. Provides information on billing and details billing code guidance.	01/26/2020	W Deseron E Garibovic
76.10	1.9.6.3. Covered Services and Limitations: Weight Management Services	New section. Details process and available services.	01/26/2020	W Deseron E Garibovic
76.9	1.9.6.2. Enrolling and Billing for Services	Renamed Provider Qualifications: Weight Management Services. Clarified enrollment requirements.	01/26/2020	W Deseron E Garibovic
76.8	1.9.6.1 Weight Management Eligibility b) Participants Over 21	New section. Clarifies eligibility for participants over 21.	01/26/2020	W Deseron E Garibovic

General Information and Requirements for Providers, Provider Handbook Modifications				
Version	Section	Update	Publish Date	SME
76.7	1.9.6.1 Weight Management Eligibility a) Participants Under 21	New section. Clarifies eligibility for participants under 21.	01/26/2020	W Deseron E Garibovic
76.6	1.9.6.1 Weight Management Eligibility	Renamed Eligible Participants: Weight Management Services. Updated to align with IDAPA 16.03.09.	01/26/2020	W Deseron E Garibovic
76.5	1.9.6 Weight Management	Renamed Weight Management Services. Updated to align with IDAPA 16.03.09.	01/26/2020	W Deseron E Garibovic
76.4	1.8.4.5 Services Not Requiring an HC PCP Referral	Removed CPT ranges. Returned previous language about coordination with PCP.	01/26/2020	W Deseron E Garibovic
76.3	1.8.4.4.Follow-up Communication Requirements for Referrals	New section. Provides information about the requirement for follow-up with PCP.	01/26/2020	W Deseron E Garibovic
76.2	1.8.3.3. Changing Enrollment in Healthy Connections	Deleted outdated paragraph about enrollment outside of business hours.	01/26/2020	W Deseron E Garibovic
76.1	1.7.5 Incarcerated Persons	Clarified eligibility, applying and coverage.	01/26/2020	W Deseron E Garibovic
76.0	All	Published version	01/01/2020	TQD
75.85	Appendix B. Section Modifications.	Renamed General Provider and Participant Information, Provider Handbook Modifications.	12/20/2019	W Deseron E Garibovic
75.84	1.5.3.1. Individual Provider Numbers	Moved information on atypical providers from General Billing Instructions here.	12/20/2019	W Deseron E Garibovic
75.83	1.3.2. Retrospective Review	New Section. Moved from General Billing Instructions to.	12/20/2019	W Deseron E Garibovic
75.82	1.2. Participant Financial Responsibility	New Section. Clarifies guidance on when participants can be charged. Moved co-payments and share of cost from General Billing Instructions to subsections here.	12/20/2019	W Deseron E Garibovic
75.81	1.1.9. Self-Reporting Overpayments	Incorporated information about overpayments.	12/20/2019	W Deseron E Garibovic
75.80	1.7.4.4. Urgent Care Services	New section on referrals and urgent care services.	12/20/2019	W Deseron E Garibovic
75.79	1.6.4. Service Limitations	New section. Moved here from General Billing Instructions.	12/20/2019	W Deseron E Garibovic
75.78	1.5.4. Provider Licensing	New section. Moved here from General Billing Instructions.	12/20/2019	W Deseron E Garibovic
75.77	1.8.4.1. Important Referral Policy Reminders	New section.	12/20/2019	W Deseron E Garibovic
75.76	1.9.1. Dental	New section. Moved here from General Billing Instructions.	12/20/2019	W Deseron E Garibovic
75.75	1.8.6. Wellness	Renamed CHIP Wellness Incentive. Consolidated subsection.	12/20/2019	W Deseron E Garibovic

General Information and Requirements for Providers, Provider Handbook Modifications						
Version	Section	Update	Publish Date	SME		
75.74	1.8.5.1. Weight Management Eligibility	Renamed Weight Management Eligibility.	12/20/2019	W Deseron E Garibovic		
75.73	1.22.9 Preventive Health Assistance (PHA)	Clarified this is under the Preventive Health Assistance program.	12/20/2019	W Deseron E Garibovic		
75.72	1.8.3.1. Telehealth Eligible Services	Added Board of Nursing licensure as a qualification.	12/20/2019	W Deseron E Garibovic		
75.71	1.8.2.3. Interpretive Services – Reimbursement	Clarified that for reimbursement interpreters must be eighteen years of age.	12/20/2019	W Deseron E Garibovic		
75.70	1.8.1.4. Record Keeping	Renamed Documentation.	12/20/2019	W Deseron E Garibovic		
75.69	1.8. Covered Services and Limitations: General	New Section.	12/20/2019	W Deseron E Garibovic		
75.68	1.7.4.7. Reimbursement for Services Requiring Referral	Clarified reimbursement requirements and billing participants.	12/20/2019	W Deseron E Garibovic		
75.67	1.7.4.6. Services Not Requiring an HC PCP Referral	Updated and clarified list of services.	12/20/2019	W Deseron E Garibovic		
75.66	a) Advantages of Electronic Online Referrals	Renamed Advantages of Electronic Referrals.	12/20/2019	W Deseron E Garibovic		
75.65	1.7.4.4. Referral Requirements	Renamed Referral Elements.	12/20/2019	W Deseron E Garibovic		
75.64	1.7.4.3 School Based Health Centers	New Section header with existing text.	12/20/2019	W Deseron E Garibovic		
75.63	1.7.4.2. Medicaid Providers Receiving Referrals	New Section header with existing text. Clarified how to check if participant is exempt from HC.	12/20/2019	W Deseron E Garibovic		
75.62	1.7.4.1. Primary Care Providers.	New Section header with existing text. Incorporated delegation of referral authority.	12/20/2019	W Deseron E Garibovic		
75.61	1.5.4.1 General Guidelines	Deleted header. New section headers added to existing text.	12/20/2019	W Deseron E Garibovic		
75.60	1.7.4. Referrals	Added details of referral process.	12/20/2019	W Deseron E Garibovic		
75.59	1.7.3.4. Exceptions & Exemptions to HC Enrollment	Added verifying HC enrollment. Updated list of exemptions.	12/20/2019	W Deseron E Garibovic		
75.58	1.7.3.3. Changing Enrollment in Healthy Connections	Updated reasons to change PCP.	12/20/2019	W Deseron E Garibovic		
75.57	1.7.2. Provider Enrollment	Renamed Healthy Connections Provider Enrollment. Added reminder to maintain record.	12/20/2019	W Deseron E Garibovic		
75.56	1.6.13. Youth Empowerment Services (YES)	New Section. Provides an overview and coverage for YES.	12/20/2019	W Deseron E Garibovic		

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75.55	1.6.12. Refugee Medical Assistance Program	New Section. Provides an overview and coverage for Refugee Medical Assistance.	12/20/2019	W Deseron E Garibovic
75.54	1.6.11.1. Presumptive Eligibility for Pregnant Women (PW)	New Section. Consolidates information from previous Presumptive Eligibility subsections.	12/20/2019	W Deseron E Garibovic
75.53	1.6.11. The Pregnant Women (PW) Program	New Section. Provides an overview and coverage for the Pregnant Women Program.	12/20/2019	W Deseron E Garibovic
75.52	1.6.10.1 Applying for Eligibility	New Section. Documents process for requesting eligibility for otherwise ineligible non-citizen.	12/20/2019	W Deseron E Garibovic
75.51	1.6.10. Otherwise Ineligible Non-citizens (OINC)	Consolidated subsections Eligibility and Covered Services.	12/20/2019	W Deseron E Garibovic
75.50	1.6.9. Managed Care Programs for Dual Eligible Participants	Clarified Medicaid Id Number. Consolidated Participant Identification Number subsection.	12/20/2019	W Deseron E Garibovic
75.49	1.6.8.1. Part A Medicare Savings Programs	New section header for existing text. Consolidated Qualified Disabled Working Individual (QDWI) Part A Medicare Savings Program section.	12/20/2019	W Deseron E Garibovic
75.48	1.6.8. Medicare Savings Program	Consolidated Program Policy. Changed in-text references to reference citations.	12/20/2019	W Deseron E Garibovic
75.47	1.6.7. The Katie Beckett Program	New Section.	12/20/2019	W Deseron E Garibovic
75.46	1.6.6.2. EPSDT Request Procedure	New Section and subsections. Incorporated published EPSDT policy.	12/20/2019	W Deseron E Garibovic
75.45	1.6.6.1. EPSDT and Waiver Services	New Section. Incorporated published EPSDT policy.	12/20/2019	W Deseron E Garibovic
75.44	1.6.6. Early & Periodic Screening, Diagnostic & Treatment	Incorporated published EPSDT policy.	12/20/2019	W Deseron E Garibovic
75.43	1.6.5. Medicaid Exception for Inmates	Renamed Incarcerated Persons. Added policy coverage for inmates.	12/20/2019	W Deseron E Garibovic
75.42	1.6.4. Breast and Cervical Cancer (BCC)	Renamed Breast and Cervical Cancer (BCC) Program. Updated FPL. Consolidated subsections.	12/20/2019	W Deseron E Garibovic
75.41	1.21.14 Pregnant Women (PW)	Deleted section and all subsection to remove restrictions on Pregnant Women program.	12/20/2019	W Deseron E Garibovic
75.40	1.6.3 Presumptive Eligibility (PE)	Consolidated general requirements and list of potentially eligible applicants from subsections. Moved content for Pregnant Women Program to Presumptive Eligibility for Pregnant Women (PW).	12/20/2019	W Deseron E Garibovic
75.39	1.21.13.4 Third Party Recovery Requirements (TPR)	Deleted section. Redundancy.	12/20/2019	W Deseron E Garibovic
75.38	1.21.13.3 Restricted Services	Deleted section. Redundancy.	12/20/2019	W Deseron E Garibovic

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75.37	1.21.13.2 Excluded Services		Deleted section.	12/20/2019	W Deseron E Garibovic
75.36	1.21.13.1 Covered Services		Deleted section. No information provided.	12/20/2019	W Deseron E Garibovic
75.35	1.6.1 Medicaid Basic Plan		Moved information here about changing to Enhanced Plan.	12/20/2019	W Deseron E Garibovic
75.34	1.6 Benefit Plan Coverage		Renamed Benefit Plan Eligibility and Coverage. Moved information here about qualifying for Medicaid. Added reference to handouts for participants.	12/20/2019	W Deseron E Garibovic
75.33	1.5.5.1 Primary Care Physician (PCP)		Changed referral information to reference to Healthy Connections section.	12/20/2019	W Deseron E Garibovic
75.32	1.5.5 Participant Program Abuse/Lock-In Program		Clarified process, participant selection of providers and appeal rights.	12/20/2019	W Deseron E Garibovic
75.31	1.5.4.2 Exceptions to Non-Covered and Excluded Service		Added information about focused case reviews.	12/20/2019	W Deseron E Garibovic
75.30	1.5.4.1 List of Excluded Services		Added exception for biofeedback. Added screening services and exceptions.	12/20/2019	W Deseron E Garibovic
75.29	1.5.4 Non-Covered and Excluded Services		Added list of circumstances not considered to result in non-covered or excluded services. Moved information about billing participant to Billing Participant section.	12/20/2019	W Deseron E Garibovic
75.28	1.5.3 Medical Necessity		Clarified state plan limitations primarily affect adults. Added EPSDT definition of medical necessity for children under 21.	12/20/2019	W Deseron E Garibovic
75.27	1.5.2.4 Medicaid Participants with Medicare		New Section. Incorporates guidance on eligibility screens.	12/20/2019	W Deseron E Garibovic
75.26	1.5.2.3 Vendor Supplied Software		New section header for existing text.	12/20/2019	W Deseron E Garibovic
75.25	1.5.2.2 Online Billing and Eligibility Verification		Renamed Trading Partner Account (TPA)	12/20/2019	W Deseron E Garibovic
75.24	1.5.2.1 Medicaid Automated Customer Service (MACS)		New section header for existing text. Removed restrictions for Pregnant Women Program.	12/20/2019	W Deseron E Garibovic
75.23	1.5.2 Verifying Participant Eligibility		Incorporated information from other sections.	12/20/2019	W Deseron E Garibovic
75.22	1.21.3.1 Medicaid Identification Card for Dual Eligible Participants		Section deleted. Moved text to Medicaid Identification Card.	12/20/2019	W Deseron E Garibovic
75.21	1.21.2 Period of Eligibility		Section deleted. Moved text to Verifying Participant Eligibility.	12/20/2019	W Deseron E Garibovic
75.20	1.21.1 Eligibility Requirements		Section deleted. Moved text to Benefit Plan Eligibility and Coverage.	12/20/2019	W Deseron E Garibovic

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75.19	1.5 Participant Eligibility	Renamed General Participant Eligibility Information.	12/20/2019	W Deseron E Garibovic
75.18	1.4.7 Maintenance of Contact Information	New Section. Incorporates requirement to maintain contact information.	12/20/2019	W Deseron E Garibovic
75.17	1.4.6 Provider Enrollment Moratoria	Incorporated information previously published and CFR.	12/20/2019	W Deseron E Garibovic
75.16	1.4.5.3 High Risk Providers	Incorporated high risk criteria.	12/20/2019	W Deseron E Garibovic
75.15	1.4.4 Ownership and Controlling Interests	New Section. Incorporates disclosure requirements referenced in other sections.	12/20/2019	W Deseron E Garibovic
75.14	1.4.2 Crossover Only Providers	New Section. Provides information for enrolling as a crossover only provider.	12/20/2019	W Deseron E Garibovic
75.13	1.2.2.2 Billing Providers	Section deleted.	12/20/2019	W Deseron E Garibovic
75.12	1.4 Provider Enrollment	Added enrollment requirements on disclosures and maintaining information.	12/20/2019	W Deseron E Garibovic
75.11	1.3.4. Provider Relations Consultants (PRC)	Added map with regional contact information.	12/20/2019	W Deseron E Garibovic
75.10	1.1.8 Prevention of Waste, Fraud and Abuse	New section. Incorporates previous guidance on Deficit Reduction Act of 2005.	12/20/2019	W Deseron E Garibovic
75.9	1.1.7 Payment Error Rate Measurement (PERM) Audits	Incorporated previously referenced document.	12/20/2019	W Deseron E Garibovic
75.8	1.1.6 Services for Immediate Family or Household Member	New Section. Incorporates previous guidance, Federal standards and professional ethics.	12/20/2019	W Deseron E Garibovic
75.7	1.1.5 Prohibition on Gifts to Participants	New section to align with Federal law	12/20/2019	W Deseron E Garibovic
75.6	1.1.4 Billing Participants	New section	12/20/2019	W Deseron E Garibovic
75.5	1.1.3 Ordering, Referring and Prescribing Providers	Incorporated published policy into handbook.	12/20/2019	W Deseron E Garibovic
75.4	1.1.2 Documentation	Incorporated previous guidance that documentation cannot be made after it is requested by the Department.	12/20/2019	W Deseron E Garibovic
75.3	1.1.1 Employees and Contractors	New section. Incorporates prior guidance and requirements.	12/20/2019	W Deseron E Garibovic
75.2	1.1 Provider Responsibilities	Clarified list. Clarified no-shows and missed appointments criteria. Added list of Federal regulations.	12/20/2019	W Deseron E Garibovic
75.1	1.0 General Provider and Participant Information	Added Summary for handbook and reference to other applicable sections.	12/20/2019	W Deseron E Garibovic
75.0	All	Published version	7/01/2019	TQD

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74.6	1.8.1 Telehealth Eligible Services	Updated with codes from Information Release MA18-07. Clarified place of service.	6/26/2019	W Deseron K Duke
74.5	1.5.3.2 Mandatory Assignment	New section. Added to incorporate 2019 changes to IDAPA 16.03.09.	6/26/2019	W Deseron K Duke
74.4	1.5 Healthy Connections	Updated provider and participant initial and changing enrollment, and disenrollment.	6/26/2019	W Deseron K Duke
74.3	1.3.2 Period of Eligibility	Clarified that deceased participants are no longer eligible for Idaho Medicaid.	6/26/2019	W Deseron K Duke
74.2	1.1.3.1 Electronic Signatures	New section. Incorporates Idaho Medicaid's Electronic Signature policy into the handbook.	6/26/2019	W Deseron K Duke
74.1	1.1.3 Record Requirements	Renamed Documentation. Updated to include CMS guidance on documentation and signatures.	6/26/2019	W Deseron K Duke
74.0	All	Published version	6/13/2019	TQD
73.5	1.9 Non-Emergent Medical Transportation	Corrected section name.	6/13/2019	W Deseron E Garibovic
73.4	1.6 Early & Periodic Screening, Diagnostic & Treatment (EPSDT)	Added "Non Emergent" clarification to Medical Transportation Services. Added EP modifier requirement	6/13/2019	W Deseron E Garibovic
73.3	1.5.4.5 Services Not Requiring an HC PCP Referral	<ul style="list-style-type: none"> Updated Outpatient Mental Health Services to include a reference to referral information. Updated Substance Abuse Services to Substance Use Disorder (SUD) Services and updated description. 	6/13/2019	W Deseron E Garibovic
73.2	1.4.2.3 Restricted Services	Added coverage for over 65 in an IMD to match IDAPA 16.03.10.	6/13/2019	W Deseron E Garibovic
73.1	1.1.2.1 Record Requirements	Updated subheader title.	6/13/2019	W Deseron E Garibovic
73.0	All	Published version	1/17/2019	TQD
72.5	2.10.1.1 Eligibility	Update verbiage to include all dual plans collectively instead of just MMCP.	1/17/2019	E Garibovic J Pinkerton
72.4	2.5.4.5 Services Not Requiring an HC PCP Referral	Change verbiage in Speech Language Pathology from "midlevel" to "non-physician".	1/17/2019	E Garibovic J Pinkerton
72.3	2.4.7.3 Billing Procedures for Managed Care Participants	<ol style="list-style-type: none"> Remove DD TSC and note, and ICF/ID services as they are no longer billable as of 1/1/19 per provider contract. Add Transition Management and Transition Services to the appropriate billing lists. 	1/17/2019	E Garibovic J Pinkerton
72.2	2.4.2.2 Excluded Services	Transition Management is an Enhanced Plan benefit only.	1/17/2019	E Garibovic J Pinkerton
72.1	2.2.2.2 Billing Providers	<ol style="list-style-type: none"> Correct the acronym for BDDS (DD is actually captured below). Remove the redundant entry of BLTC. 	1/17/2019	E Garibovic J Pinkerton
72.0	All	Published version	12/21/2018	TQD
71.1	2.3.2 Medicaid Identification Card	Added section 2.3.2.1 to include Medicaid Identification Card for Dual Eligible Participants	12/21/2018	J Pinkerton C Loveless
71.0	All	Published version	11/16/2018	TQD

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70.1	2.2.4 Provider Relations Consultants 2.3.4 Covered Benefits	Added a disclaimer language	11/16/2018	E Garibovic
70.0	All	Published version	11/1/2018	TQD
69.1	All	Removed Molina references	11/1/2018	D Baker E Garibovic
69.0	All	Published version	10/24/2018	TQD
68.6	2.5.3.2 Exceptions & Exemptions to HC Enrollment	Update MMCP exemption to broadly cover all managed care plans for dual eligible participants.	10/24/2018	W Deseron D Baker E Garibovic
68.5	2.4.7.3 Billing Procedures for MMCP Plan Participants	Update header name. Add IMPlus information.	10/24/2018	W Deseron D Baker E Garibovic
68.4	2.4.7.2 Participant Identification Number	Updated using "managed care program" to cover both dual plans.	10/24/2018	W Deseron D Baker E Garibovic
68.3	2.4.7.1 Programs	Update to include a definition of the IMPlus plan and separately define MMCP.	10/24/2018	W Deseron D Baker E Garibovic
68.2	2.4.7 Medicare Medicaid Coordinated Plan (MMCP)	Rename this section to encompass both managed care programs for Dual Eligible participants.	10/24/2018	W Deseron D Baker E Garibovic
68.1	2.2.2.2 Billing Providers	Replace RMS with BLTC.	10/24/2018	W Deseron D Baker E Garibovic
68.0	All	Published version	9/4/2018	TQD
67.6	Appendix A.- Provider Agreement Example	New section.	9/4/2018	W Deseron D Baker E Garibovic
67.5	2.10.- Preventive Health Assistance (PHA)	Added billable codes from CMS-1500 handbook.	9/4/2018	W Deseron D Baker E Garibovic
67.4	2.5.4.- Referrals	Added reminder that referrals are not physician orders.	9/4/2018	W Deseron D Baker E Garibovic
67.3	2.3.6- Non-Covered and Excluded Services	Expanded Non-Covered Services to include Excluded Services, and defined both.	9/4/2018	W Deseron D Baker E Garibovic
67.2	2.3.4.- Medical Necessity	New section about medical necessity requirements.	9/4/2018	W Deseron D Baker E Garibovic
67.1	2.1.- Provider Participation	Add reference to Appendix A Provider Agreement Example and Non-Covered and Excluded Services.	9/4/2018	W Deseron D Baker E Garibovic
67.0	All	Published version	7/26/2018	TQD
66.2	2.10. Preventive Health Assistance (PHA)	Removed reference to CMS-1500 Instructions, and added table of codes.	7/26/2018	W Deseron E Garibovic
66.1	2.8. Telehealth Services	Corrected Health Connections to Healthy Connections. Updated eligible services/references.	7/26/2018	W Deseron E Garibovic
66.0	All	Published version	7/2/2018	TQD
65.6	2.4.6.4. Part B Medicare Savings Program	Cleaned up formatting	7/2/2018	W Deseron E Garibovic
65.5	2.9 Physicals and Wellness Exams	Moved to Physician and Non-Physician Practitioner handbook	7/2/2018	W Deseron E Garibovic

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65.4	2.7-2.7.4.2 Interpretive Services 2.8-2.8.5.3 Telehealth Services	Expanded section to include policy	7/2/2018	W Deseron E Garibovic
65.3	2.4.3-2.4.3.2 Presumptive Eligibility (PE) 2.5.-2.5.1.10 Early & Periodic Screening, Diagnostic & Treatment (EPSDT)	New section	7/2/2018	W Deseron E Garibovic
65.2	2.4.1-2.4.2.1 Benefit Plan Coverage 2.4.4.1-2.4.4.2 Pregnant Women (PW) 2.4.7.1 Otherwise Ineligible Non-citizens (OINC) 2.6.1-2.6.4.6 Healthy Connections (HC) 2.10.1.1-2.10.2.1 Weight Management	Cleaned up language and removed Overview header	7/2/2018	W Deseron E Garibovic
65.1	2.3.7., 2.3.8.1 Participant Eligibility 2.4.5.2 Breast and Cervical Cancer	Cleaned up language	7/2/2018	W Deseron E Garibovic
65.0	All	Published version	3/8/2018	TQD
64.1	2.5.4.1 Enrollment in Healthy Connections	Changed "member" to "participant"	3/8/2018	W Deseron D Baker E Garibovic
64.0	All	Published version	2/20/2018	TQD
63.2	2.8 Non-Emergent Non-Medical Transportation	Updated with new transportation vendor information	2/20/2018	D Baker E Garibovic
63.1	2.4.2.3 Excluded Services 2.4.7.3 Billing Procedures for MMCP Participants 2.5.4.2 Exceptions & Exemptions to HC Enrollment 2.5.5.5 Services Not Requiring an HC PCP Referral	Updated ICF/ID acronym	2/20/2018	D Baker E Garibovic
63.0	All	Published version	1/11/2018	TQD
62.4	2.9.1.9 Billing	Added information for postpartum depression screening	1/11/2018	W Deseron D Baker E Garibovic
62.3	2.4.4.2 Covered Services	Added information for postpartum depression	1/11/2018	W Deseron D Baker E Garibovic
62.2	2.3.6.1 Exceptions to Excluded Services	New section; moved from Hospital handbook	1/11/2018	W Deseron D Baker E Garibovic
62.1	2.3.6 Excluded Services	Updated to reflect current policy	1/11/2018	W Deseron D Baker E Garibovic
62.0	All	Published version	1/6/2018	TQD

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61.1	2.1.1 Provider Participation Requirements 2.2.3.4 Provider File Updates 2.2.4.2 Online Billing and Eligibility Verification 2.3.5.1 Eligibility Verification 2.3.7.1 Primary Care Physician (PCP) 2.5.5.4 Advantages of Electronic Online Referrals	Updated for TPA upgrade	1/6/2018	T Humpherys D Baker E Garibovic
61.0	All	Published version	12/29/2017	TQD
60.1	2.4.7 Medicare-Medicaid Coordinated Plan (MMCP) 2.4.7.1 Program Overview 2.4.7.3 Billing Procedures for MMCP Participants	Updated for MMCP expansion	12/29/2017	F Clarke L Windham E Garibovic
60.0	All	Published version	12/14/2017	TQD
59.1	2.5.5.6 Reimbursement for Services Requiring Referral	Updates for clarity	12/14/2017	W Deseron D Baker E Garibovic
59.0	All	Published version	12/5/2017	TQD
58.12	2.10.1.1 Eligibility 2.10.2.1 Premium Statements	Changed "PHA unit" to "Medical Care Unit"	12/5/2017	W Deseron C Loveless
58.11	2.9.2 Adult Wellness Exams	Removed references to other handbook documents	12/5/2017	W Deseron C Loveless
58.10	2.9.1.10 Diagnosis Codes 2.10.1.2 Enrolling and Billing for Services	Removed ICD-9 information	12/5/2017	W Deseron C Loveless
58.9	2.9 Physicals and Wellness Exams	New section	12/5/2017	W Deseron C Loveless
58.8	2.4.4.5 Excluded Services	Removed section	12/5/2017	W Deseron C Loveless
58.7	2.4.4.5 Billing Procedures	Clarified primary diagnosis information	12/5/2017	W Deseron C Loveless
58.6	2.4.4.4 Medical Necessity	Removed information about Medical Necessity form; updated Department review detail	12/5/2017	W Deseron C Loveless
58.5	2.4.4.1 Overview	Clarified postpartum coverage period	12/5/2017	W Deseron C Loveless
58.4	2.4.2.4 Restricted Services	Removed limitation information	12/5/2017	W Deseron C Loveless
58.3	2.3.5.1 Eligibility Verification	Minor clarifications	12/5/2017	W Deseron C Loveless
58.2	2.3.4.1 Medicaid Non-Covered Services	Clarified participant responsibility information	12/5/2017	W Deseron C Loveless
58.1	2.1.2 Provider Responsibilities	Added detail re: participant responsibility; removed limitation information	12/5/2017	W Deseron C Loveless
58.0	All	Published version	7/13/17	TQD
57.1	2.1.8.1 Provider Program Abuse	Added missing word	7/13/17	D Baker E Garibovic
57.0	All	Published version	6/27/17	TQD
56.17	2.10.1.1 Eligibility	Minor verbiage update for clarity; added statement about Medicare beneficiaries/MMCP	6/27/17	C Brock D Baker E Garibovic

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56.16	2.10 Preventive Health Assistance	Added CHIP information	6/27/17	C Brock D Baker E Garibovic
56.15	2.9.4 Early & Periodic Screening, Diagnostic, and Treatment	Updated list of services	6/27/17	C Brock D Baker E Garibovic
56.14	2.9.3.5 Notes from the Recommendations for Preventive Pediatrics Health Care, the American Academy of Pediatrics (AAP) and the American Association of Pediatric Dentistry (AAPD)	Updated all notes	6/27/17	C Brock D Baker E Garibovic
56.13	2.9.3.1 Infancy Screening 2.9.3.2 Early Childhood Screenings 2.9.3.3 Middle Childhood Screening 2.9.3.4 Adolescence Screening	Updated charts	6/27/17	C Brock D Baker E Garibovic
56.12	2.7 Telehealth	Added reference to Telehealth policy	6/27/17	C Brock D Baker E Garibovic
56.11	2.5.5.5 Services Not Requiring an HC PCP Referral	Updated "Hospital Admissions Subsequent to ER Visit" and "Urgent Care Clinic Services"	6/27/17	C Brock D Baker E Garibovic
56.10	2.5.5.2 Referral Requirements	Modified diagnose and treat bullet	6/27/17	C Brock D Baker E Garibovic
56.9	2.5.5.1 General Guidelines	Added delegation within and outside organization	6/27/17	C Brock D Baker E Garibovic
56.8	2.5.3.2 Healthy Connections Participant Rosters	Added ability to verify eligibility and issue referrals	6/27/17	C Brock D Baker E Garibovic
56.7	2.5.3 Provider Enrollment	Updated requirements for Tier II, III, and IV	6/27/17	C Brock D Baker E Garibovic
56.6	2.3.5.1 Eligibility Verification	Moved section; minor updates to make current	6/27/17	C Brock D Baker E Garibovic
56.5	2.3.5 Verifying Participant Eligibility	Moved section; minor updates to make current	6/27/17	C Brock D Baker E Garibovic
56.4	2.3.1.2 Period of Eligibility	Changed "recommended" to "required" for verifying participant eligibility	6/27/17	C Brock D Baker E Garibovic
56.3	2.2.4.1 Provider Handbooks	Added reference to Molina Medicaid website	6/27/17	C Brock D Baker E Garibovic
56.2	2.2.3.2 Billing Providers	Changed "MSST" to "BoMS"	6/27/17	C Brock D Baker E Garibovic
56.1	2.2.3.1 Non-billing Ordering and Referring Providers	Updated reference to ORP policy document	6/27/17	C Brock D Baker E Garibovic