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<td>72.5</td>
<td>2.10.1.1 Eligibility</td>
<td>Update verbiage to include all dual plans collectively instead of just MMCP.</td>
<td>1/17/2019</td>
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<td>72.4</td>
<td>2.5.4.5 Services Not Requiring an HC PCP Referral</td>
<td>Change verbiage in Speech Language Pathology from &quot;midlevel&quot; to &quot;non-physician&quot;.</td>
<td>1/17/2019</td>
<td>E Garibovic J Pinkerton</td>
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<td>72.3</td>
<td>2.4.7.3 Billing Procedures for Managed Care Participants</td>
<td>1. Remove DD TSC and note, and ICF/ID services as they are no longer billable as of 1/1/19 per provider contract. 2. Add Transition Management and Transition Services to the appropriate billing lists.</td>
<td>1/17/2019</td>
<td>E Garibovic J Pinkerton</td>
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<td>72.2</td>
<td>2.4.2.2 Excluded Services</td>
<td>Transition Management is an Enhanced Plan benefit only.</td>
<td>1/17/2019</td>
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<td>72.1</td>
<td>2.2.2.2 Billing Providers</td>
<td>1. Correct the acronym for BDDS (DD is actually captured below). 2. Remove the redundant entry of BLTC.</td>
<td>1/17/2019</td>
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<td>71.1</td>
<td>2.3.2 Medicaid Identification Card</td>
<td>Added section 2.3.2.1 to include Medicaid Identification Card for Dual Eligible Participants</td>
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<td>Removed Molina references</td>
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<td>68.6</td>
<td>2.5.3.2 Exceptions &amp; Exemptions to HC Enrollment</td>
<td>Update MMCP exemption to broadly cover all managed care plans for dual eligible participants.</td>
<td>10/24/2018</td>
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<td>68.5</td>
<td>2.4.7.3 Billing Procedures for MMCP Plan Participants</td>
<td>Update header name. Add IMPlus information.</td>
<td>10/24/2018</td>
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<td>68.4</td>
<td>2.4.7.2 Participant Identification Number</td>
<td>Updated using &quot;managed care program&quot; to cover both dual plans.</td>
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<td>68.3</td>
<td>2.4.7.1 Programs</td>
<td>Update to include a definition of the IMPlus plan and separately define MMCP.</td>
<td>10/24/2018</td>
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<td>68.2</td>
<td>2.4.7 Medicare Medicaid Coordinated Plan (MMCP)</td>
<td>Rename this section to encompass both managed care programs for Dual Eligible participants.</td>
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<td>Replace RMS with BLTC.</td>
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<td>2.10.- Preventive Health Assistance (PHA)</td>
<td>Added billable codes from CMS-1500 handbook.</td>
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<td>2.5.4. - Referrals</td>
<td>Added reminder that referrals are not physician orders.</td>
<td>9/4/2018</td>
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<td>67.3</td>
<td>2.3.6- Non-Covered and Excluded Services</td>
<td>Expanded Non-covered Services to include Excluded Services, and defined both.</td>
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<td>New section about medical necessity requirements.</td>
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<td>Add reference to Appendix A Provider Agreement Example and Non-Covered and Excluded Services.</td>
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<td>Removed reference to CMS-1500 Instructions, and added table of codes.</td>
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<td>2.8. Telehealth Services</td>
<td>Corrected Health Connections to Healthy Connections. Updated eligible services/references.</td>
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<td>7/2/2018</td>
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<td>Cleaned up language and removed Overview header</td>
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<td>Changed “member” to “participant”</td>
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<td>2.10.1.1 Eligibility 2.10.2.1 Premium Statements</td>
<td>Changed &quot;PHA unit“ to &quot;Medical Care Unit“</td>
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<td>2.9.2 Adult Wellness Exams</td>
<td>Removed references to other handbook documents</td>
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<td>Modified diagnose and treat bullet</td>
<td>6/27/17</td>
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<td>Added delegation within and outside organization</td>
<td>6/27/17</td>
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<td>56.8</td>
<td>2.5.3.2 Healthy Connections Participant Rosters</td>
<td>Added ability to verify eligibility and issue referrals</td>
<td>6/27/17</td>
<td>C Brock D Baker E Garibovic</td>
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<td>56.7</td>
<td>2.5.3 Provider Enrollment</td>
<td>Updated requirements for Tier II, III, and IV</td>
<td>6/27/17</td>
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<td>Moved section; minor updates to make current</td>
<td>6/27/17</td>
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<td>Changed &quot;recommended&quot; to &quot;required&quot; for verifying participant eligibility</td>
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<td>Content rewrite to bring up to date</td>
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<td>J Kennedy-King E Garibovic</td>
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<td>Minor PHA form verbiage updates</td>
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<td>Changed &quot;Behavioral&quot; to &quot;Weight Management&quot;; changed &quot;opportunities&quot; to &quot;assistance&quot;</td>
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<td>5/5/16</td>
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<td>Insert verbiage difference between PA and referral</td>
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<td>Rephrasing “exception or exemption”</td>
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<td>Add sentence to first paragraph, updates bullets under Tier IV, and HC Clinic</td>
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<td>2.5.2. Importance of Verifying Medicaid Eligibility and Healthy Connections Enrollment</td>
<td>Insert Network of HC clinic - bulleted trier list Insert &quot;Demographics of the HC Clinic&quot;</td>
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<td>Updates necessary to provide clarity to providers on the removal of the referral requirement for occupational therapy and service coordination</td>
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<td>2.4.6.5 Dually Eligible Medicare Beneficiaries</td>
<td>Rewrote/clarified section</td>
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<td>Removed to align with 2/1/2016 HC/PCCM changes</td>
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<td>Changed &quot;Adult DD State Plan” to &quot;Adult DD 1915(i) State Plan Option Services”</td>
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<td>Added link to Request for Additional Services Form</td>
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<td>Merged with information previously contained in Suppliers handbook</td>
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<td>Figure 2-2: Provider File Updates</td>
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<td>10/11/12</td>
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<td>Replaced member with participant</td>
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2. General Provider and Participant Information

2.1. Provider Participation

2.1.1. Provider Participation Requirements

All providers wishing to participate in the Idaho Medicaid Program must first register for a Trading Partner Account (TPA) at 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 W9, which must be signed by the provider and submitted with the enrollment application along with other attachments to DXC Technology through the website.

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 the 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.

2.1.2. Provider Responsibilities

Providers have the following ongoing responsibilities.

- To offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended.
- To review and abide by the contents of all Idaho Medicaid rules governing the reimbursement of items and services under Medicaid.
- To review periodic provider information releases and other program notification issued by Medicaid.
- To be licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with professionally recognized standards.
- To keep Medicaid and DXC Technology advised of the provider's current address and telephone number.
- To sign every claim form submitted for payment, or complete a signature-on-file form (including electronic signatures).
- To acknowledge when Medicaid is a secondary payer and agree to seek payment from other sources.
- To accept Medicaid payment for any item or service as payment in full and to make no additional charge for the difference.
- To comply with the disclosure of ownership requirements.
- To comply with the advanced directives requirement.
- To make records available to Medicaid upon request.
- To not bill a Medicaid participant unless:
The item or service is not covered or excluded by Medicaid, and the provider complies with the Non-Covered and Excluded Services section, which includes a list of excluded services.

- A third-party payment was made to the participant instead of the provider, in which case the participant may be billed for an amount equal to that payment.
- Medicaid participants cannot be billed for “no-show” or missed appointments

2.1.2.1. **Medical Record Requirements**

Idaho Code Section 56-209h requires that providers 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. The provider delivering services must sign the documentation to attest that the records are a true and accurate account of the services delivered. Electronic signatures are acceptable.

Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years after the date of service.

2.1.3. **Payment Error Rate Measurement (PERM)**

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). PERM is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law No. 107-300). For PERM, CMS is using contractors to perform statistical calculations, medical records collection, and medical data processing review of Medicaid and SCHIP fee-for-service (FFS) claims.

Medical records are needed to support medical reviews that the CMS review contractor will conduct on the Medicaid and SCHIP FFS claims to determine whether the claims were correctly paid. It is important that providers cooperate by submitting all requested documentation within the designated timeframe. Failure to provide the requested documentation is in violation of Idaho Code Section 56-209h and the Idaho Medicaid Provider Agreement.

**NOTE:** Providers are required to notify the Department of any changes, including but not limited to mailing addresses, service locations, and phone numbers, within 30 days of the date of the change. All providers should check the system to ensure their phone numbers and addresses are correct in the Idaho Medicaid provider file. If not, please request a change immediately to ensure the PERM medical record request can be delivered to the correct address. See Section 2.2.2.4 Provider File Updates for more information.

Detailed information regarding the PERM program requirements is available online under the Payment Error Rate Measurement heading.

2.1.4. **Medicaid Provider Identification Numbers**

2.1.4.1. **Individual Provider Numbers**

The National Provider Identifier (NPI) is part of HIPAA. The NPI number or numbers 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. Providers without an NPI will use the ‘M’ or ‘A’ number assigned to them during the registration/application process.

Providers with an NPI will be paid through the pay-to address associated to the NPI.

Providers who are not eligible for, or do not have, an NPI will have a unique eight-digit Idaho Medicaid provider number assigned when the provider is approved to service Medicaid participants. Claims will be paid through the pay-to address associated with the Medicaid provider number.

2.1.4.2.  **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 was identified on your approval letter when you became a Medicaid provider. You can also obtain this number by logging into your 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
- Electronic claims refer to 837 Professional/Institutional/Dental companion guide

2.1.4.3.  **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.

2.1.5.  **Signature-On-File Form**

A provider or authorized agent must sign in the claimant’s certification field on all claims. This is an agreement the provider makes to accept payment from Medicaid as payment in full for services rendered. The provider cannot bill the participant for an unpaid balance.

Providers must sign every claim form or complete a Signature-On-File form. This form is used to submit paper claims without a signature and/or to submit electronic claims. This form allows submission of claims without a handwritten signature. It is used for computer-generated, signature stamp, or typewritten signatures.

The Signature-On-File form remains on file at DXC Technology and must exactly match the information in the claimant’s certification field on the claim form. Never submit paper claims with the claimant’s certification field blank. Enter Signature-on-File or have the provider sign in field 31 of the CMS-1500 claim form or field 62 on the ADA claim form. Contact DXC Technology Provider Enrollment for more information as indicated in Section 2.2 Services for Providers. To bill electronically, it is necessary to complete a Trading Partner Agreement.

The Trading Partner Agreement and a Signature-On-File form are available online at the DXC Technology Medicaid website or as paper copy by request from Provider Services.
2.1.6. 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.

2.1.7. 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.

2.1.8. 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.

2.1.8.1. 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 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

2.2. 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.

2.2.1. Idaho Medicaid Automated Customer Service (Idaho 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.

Figure 2-1: Information Available Through MACS

<table>
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<th>Claims Information</th>
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<th>Security Code</th>
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<td>Amount and date of payment</td>
<td>Paper claims</td>
<td>Copay/Deductible</td>
<td>Create a new code</td>
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<td>Procedure code coverage</td>
<td>Number of claims paid</td>
<td>ResHab/PCS PA</td>
<td>Eligibility</td>
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<tr>
<td>PA required for procedure code</td>
<td>Warrant/EFT number</td>
<td>Medical or Surgical PA</td>
<td>HC enrollment and referrals</td>
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<td>Units remaining</td>
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<td>Dental PA</td>
<td>Lock-In</td>
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<tr>
<td>Revenue code coverage</td>
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<td>DME PA</td>
<td>Other Insurance/TPLs</td>
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<td>PA required for revenue code</td>
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<td>Inpatient or Outpatient PA</td>
<td>Prior Authorizations</td>
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<td>Diagnosis code coverage</td>
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<td>Transportation PA</td>
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2.2.2. Provider Enrollment

Idaho Medicaid enrolls two types of providers, billing and non-billing. All providers wishing to participate in the Idaho Medicaid Program must first register for a Trading Partner Account (TPA) at 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 W9, which must be signed by the provider and submitted with the enrollment application along with other attachments to DXC Technology through the website.
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 the 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.

See Provider Responsibilities for additional details.

2.2.2.1. **Non-billing Ordering and Referring Providers**

Providers who enroll as non-billing entities are enrolling for the sole purpose of ordering services/items for use by Medicaid participants or referring participants to another provider.

Federal Regulations (42 CFR 455.410) require the enrollment of all non-billing physicians and practitioners. The regulation also requires the inclusion of the ordering/referring provider on the billing provider’s claim for reimbursement.

Medicaid 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 method is not for individuals who want to submit claims to Idaho Medicaid for reimbursement for their services.

For more information refer to the Idaho Medicaid Ordering, Rendering, Prescribing Provider policy located on the Department of Health and Welfare Medicaid Providers website.

2.2.2.2. **Billing Providers**

Medicaid works with DXC Technology Provider Enrollment to promptly and accurately enroll new providers in the Idaho Medicaid Program. This team effort ensures efficient Medicaid provider enrollment and claims processing for services rendered to Medicaid participants.

The entities that participate in provider enrollment are:

- Medical Care Unit
- Bureau of Developmental Disability Services (BDDS)
- Bureau of Facility Standards
- Licensure and Certification
- Bureau of Long Term Care (BLTC) (all regions)
- Mental Health and Substance Abuse
- Pharmacy Unit
- Family and Community Services (all regions)
- Developmental Disabilities (DD) Program (all regions)
- Healthy Connections (HC)
- DXC Technology
• Bureau of MMIS Support (BoMS)

To become an approved Medicaid provider, a credentials investigation is conducted using the enrollment information.

After the provider is approved for participation in the Idaho Medicaid Program, a unique provider number is assigned to providers without an NPI. For providers that enroll with an NPI, the NPI becomes the provider number.

2.2.2.3. **Provider Risk Levels**

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.

<table>
<thead>
<tr>
<th>Type of Screening Required by the ACA</th>
<th>Limited</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification of any provider/supplier-specific requirements established by Medicare</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Conduct license verifications (may include licensure checks across States)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>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)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pre and post enrollment Site Visits (Unscheduled/Unannounced)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Criminal Background Check</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Fingerprinting</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

The following tables include the risk level by provider type.

**Limited Risk Providers**

<table>
<thead>
<tr>
<th>IDAHO Provider Types</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Care</td>
<td>L</td>
</tr>
<tr>
<td>Ambulatory Surgical Center (ASC)</td>
<td>L</td>
</tr>
<tr>
<td>Assistive Tech Supplier</td>
<td>L</td>
</tr>
<tr>
<td>Audiologist</td>
<td>L</td>
</tr>
<tr>
<td>Behavior Consultation/Crisis Management</td>
<td>L</td>
</tr>
<tr>
<td>Certified Family Home (CFH)</td>
<td>L</td>
</tr>
<tr>
<td>Children's Service Coordination (CSC)</td>
<td>L</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>L</td>
</tr>
<tr>
<td>Chore Services</td>
<td>L</td>
</tr>
<tr>
<td>Classic Optical</td>
<td>L</td>
</tr>
<tr>
<td>IDAHO Provider Types</td>
<td>Risk Level</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Clinic/Center - Hearing &amp; Speech</td>
<td>L</td>
</tr>
<tr>
<td>Clinic/Center - Rehab, SA – Division of Behavioral Health</td>
<td>L</td>
</tr>
<tr>
<td>Critical Access Hospital (CAH)</td>
<td>L</td>
</tr>
<tr>
<td>Developmental Disability (DD) Case Management</td>
<td>L</td>
</tr>
<tr>
<td>Developmental Disability (DD) Child Independent Crisis Intervention/Professional</td>
<td>L</td>
</tr>
<tr>
<td>Developmental Disability (DD) Independent Therapeutic Consultation</td>
<td>L</td>
</tr>
<tr>
<td>Developmental Disability Agency (DDA)</td>
<td>L</td>
</tr>
<tr>
<td>Developmental Disability Agency (DDA) – Support Only Child Services</td>
<td>L</td>
</tr>
<tr>
<td>Diabetes Educator</td>
<td>L</td>
</tr>
<tr>
<td>Diagnostic Services (Elks-only)</td>
<td>L</td>
</tr>
<tr>
<td>Dialysis Unit</td>
<td>L</td>
</tr>
<tr>
<td>Dietician</td>
<td>L</td>
</tr>
<tr>
<td>Federally Qualified Health Clinic (FQHC)</td>
<td>L</td>
</tr>
<tr>
<td>Groups (Idaho has groups of physicians, non-physician practitioners, and therapists)</td>
<td>L</td>
</tr>
<tr>
<td>Home Modifications</td>
<td>L</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>L</td>
</tr>
<tr>
<td>Hospital</td>
<td>L</td>
</tr>
<tr>
<td>Indian Health Services (IHS)</td>
<td>L</td>
</tr>
<tr>
<td>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) - private</td>
<td>L</td>
</tr>
<tr>
<td>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) - state</td>
<td>L</td>
</tr>
<tr>
<td>Mental Health Case Management</td>
<td>L</td>
</tr>
<tr>
<td>Mental Health Clinic</td>
<td>L</td>
</tr>
<tr>
<td>Nurse Non-physician Practitioner</td>
<td>L</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>L</td>
</tr>
<tr>
<td>Optician</td>
<td>L</td>
</tr>
<tr>
<td>Optometrist</td>
<td>L</td>
</tr>
<tr>
<td>Personal Care Services (PCS) Aged and Disabled (A&amp;D) Agency</td>
<td>L</td>
</tr>
<tr>
<td>Personal Care Services (PCS) Family Alternate Care Home</td>
<td>L</td>
</tr>
<tr>
<td>Personal Care Services (PCS) Homes - DD children</td>
<td>L</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>L</td>
</tr>
<tr>
<td>PHA – Weight Management Dietician</td>
<td>L</td>
</tr>
<tr>
<td>PHA – Weight Management</td>
<td>L</td>
</tr>
<tr>
<td>Pharmacy (clinic, retail, institution, specialty, mail, unit dose)</td>
<td>L</td>
</tr>
<tr>
<td>Pharmacy Infusion Therapy</td>
<td>L</td>
</tr>
<tr>
<td>Physician</td>
<td>L</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>L</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>L</td>
</tr>
<tr>
<td>Pregnant Women Clinic (PWC) – CLIA</td>
<td>L</td>
</tr>
<tr>
<td>Private Duty Nursing (PDN) Agency</td>
<td>L</td>
</tr>
<tr>
<td>Public Health</td>
<td>L</td>
</tr>
<tr>
<td>Radiology/Other Techs</td>
<td>L</td>
</tr>
</tbody>
</table>
### IDAHO Provider Types

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Mental Health</td>
<td>L</td>
</tr>
<tr>
<td>Residential Assisted Living Facility (RALF)</td>
<td>L</td>
</tr>
<tr>
<td>Residential Habilitation Agency</td>
<td>L</td>
</tr>
<tr>
<td>Respite Care</td>
<td>L</td>
</tr>
<tr>
<td>Rural Health Clinic (RHC)</td>
<td>L</td>
</tr>
<tr>
<td>School Based Services (SBS)</td>
<td>L</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>L</td>
</tr>
<tr>
<td>Social Worker</td>
<td>L</td>
</tr>
<tr>
<td>Speech Language Pathologist (SLP)</td>
<td>L</td>
</tr>
<tr>
<td>Supported Employment Services</td>
<td>L</td>
</tr>
<tr>
<td>Supports Brokerage-Fiscal Employer Agent (FEA)</td>
<td>L</td>
</tr>
<tr>
<td>Swing Bed Units</td>
<td>L</td>
</tr>
<tr>
<td>Transportation</td>
<td>L</td>
</tr>
</tbody>
</table>

### Moderate Risk Providers

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab CLIA</td>
<td>M</td>
</tr>
<tr>
<td>Ambulance</td>
<td>M</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>M</td>
</tr>
<tr>
<td>Hearing Aid Vendor</td>
<td>M</td>
</tr>
<tr>
<td>Clinic/Center – Physical Therapy (PT)</td>
<td>M</td>
</tr>
<tr>
<td>Clinic/Center – Mobile Radiology</td>
<td>M</td>
</tr>
<tr>
<td>Home Health (Existing Idaho Providers)</td>
<td>M</td>
</tr>
<tr>
<td>Hospice</td>
<td>M</td>
</tr>
<tr>
<td>Pharmacy Durable Medical Equipment (DME)</td>
<td>M</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) (Existing Idaho Providers)</td>
<td>M</td>
</tr>
<tr>
<td>Prosthetics &amp; Orthotics – existing</td>
<td>M</td>
</tr>
<tr>
<td>Portable X-ray</td>
<td>M</td>
</tr>
</tbody>
</table>

### High Risk Providers

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health (New to Idaho Medicaid)</td>
<td>H</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) (New to Idaho Medicaid)</td>
<td>H</td>
</tr>
</tbody>
</table>

### 2.2.2.4. 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
- Add/update/end date of service locations

**Figure 2-2: Provider File Updates**

<table>
<thead>
<tr>
<th>Provider Maintenance</th>
<th>Provider Maintenance–Demographic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screen: Business Information</strong> Update the FEIN Update the Name Check the box to update the provider name</td>
<td><strong>Screen: Business Information</strong> Update Office Contact Information Phone Numbers Fax Number Gender (Individual only)</td>
</tr>
<tr>
<td><strong>Screen: Pay-To Address</strong> 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)</td>
<td><strong>Screen: Pay-To Address</strong> No updates available</td>
</tr>
<tr>
<td><strong>Screen: Ownership</strong> Update and Add Owners &amp; Board Members Update the Owner/Board Member Type Update the Owner/Board Member Address Info Update Sanctions</td>
<td><strong>Screen: Ownership</strong> No updates available</td>
</tr>
<tr>
<td><strong>Screen: Owner Relationship</strong> Update Relationship to Owner/Board Members Add Owner/Board Relationships Add Ownership or Control Interest Information</td>
<td><strong>Screen: Owner Relationship</strong> No updates available</td>
</tr>
<tr>
<td><strong>Screen: Service Location Summary</strong> Add Service Location Terminate a Service Location Change Site Name</td>
<td><strong>Screen: Service Location Summary</strong> Edit Site Information</td>
</tr>
<tr>
<td><strong>Screen: Service Location Address</strong> No updates available</td>
<td><strong>Screen: Service Location Address</strong> Update physical address phone number Update additional Languages Spoken Update Office Hours Update other Office Information</td>
</tr>
<tr>
<td><strong>Screen: Service Location Provider Type and Specialty (PTSP)</strong> Add/Update Specialties Add/Update Specialty Details</td>
<td><strong>Screen: Service Location Provider Type and Specialty (PTSP)</strong> No updates available</td>
</tr>
<tr>
<td><strong>Screen: PCCM Information</strong> Update Service Location Details</td>
<td><strong>Screen: PCCM Information</strong> No updates available</td>
</tr>
</tbody>
</table>
Table: Provider Maintenance

<table>
<thead>
<tr>
<th>Provider Maintenance</th>
<th>Provider Maintenance–Demographic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Other Restrictions</td>
<td></td>
</tr>
<tr>
<td>Update Special Accommodations</td>
<td></td>
</tr>
<tr>
<td>Update After Hours Coverage</td>
<td></td>
</tr>
<tr>
<td>Update After Hours Phone Number</td>
<td></td>
</tr>
<tr>
<td>Update NPI/Medicaid IDs of covering Medicaid Providers</td>
<td></td>
</tr>
<tr>
<td>Screen: <strong>Financial Agreement</strong></td>
<td>Screen: <strong>Financial Agreement</strong></td>
</tr>
<tr>
<td>Update routing of payments automatically</td>
<td>No updates available</td>
</tr>
<tr>
<td>Update the Account Details</td>
<td></td>
</tr>
<tr>
<td>Terminate current banking information</td>
<td></td>
</tr>
<tr>
<td>Screen: <strong>Documentation</strong></td>
<td>Screen: <strong>Documentation</strong></td>
</tr>
<tr>
<td>Provider Agreement</td>
<td>No updates available</td>
</tr>
<tr>
<td>Enrollment Application Acknowledgement</td>
<td></td>
</tr>
<tr>
<td>W9</td>
<td></td>
</tr>
<tr>
<td>Ownership &amp; Conviction</td>
<td></td>
</tr>
<tr>
<td>Signature on File</td>
<td></td>
</tr>
<tr>
<td>Authorization for Electronic Funds Transfer (if necessary)</td>
<td></td>
</tr>
<tr>
<td>Staff Affiliation Roster (if necessary)</td>
<td></td>
</tr>
<tr>
<td>Group Affiliation Roster (if necessary)</td>
<td></td>
</tr>
<tr>
<td>Driver Roster (if necessary)</td>
<td></td>
</tr>
<tr>
<td>Vehicle Roster (if necessary)</td>
<td></td>
</tr>
</tbody>
</table>

**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.

2.2.3. **Provider Service Representatives (PSRs)**

DXC Technology provider service representatives are trained to promptly and accurately respond to requests for information on:

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

**Provider Service Representatives**

To contact a DXC Technology Provider Service Representative, call MACS at 1 (208) 373-1424 or 1 (866) 686-4272, and say representative or rep.

Provider service representatives are available Monday through Friday from 7 A.M. to 7 P.M. Mountain Time.
When calling a Provider Service Representative for questions about claims status, please have the following information ready.

- Billing provider’s Idaho Medicaid provider number
- Participant’s Medicaid identification number
- Date(s) of service

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

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

### Provider Handbooks

Providers can access an electronic copy of the *Idaho Medicaid Provider Handbook* from the [DXC Technology Medicaid](#) website.

The *Idaho Medicaid Provider Handbook* is updated periodically. These updates are designed to keep providers informed of program changes and provide billing instructions. Printed and CD copies of the provider handbook are always considered out of date. *The most current version of the handbook is always available on the DXC Technology Medicaid website.*

The provider handbook is intended to provide basic program guidelines, however, in any case where the guidelines appear to contradict relevant provisions of the Idaho Code or rules, the code or rules prevail.

### Online Billing and Eligibility Verification

For information regarding online billing and eligibility verification, refer to Trading Partner Account (TPA) User Guides found at the [User Guides](#) link under the *Reference Material* menu at [www.idmedicaid.com](http://www.idmedicaid.com).

### 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.
- Assisting providers with electronic claims submission.

See the [Directory](#), Idaho Medicaid Provider Handbook for telephone, fax, and addresses of the Provider Relations Consultants.

### Participant Eligibility

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 meeting eligibility requirements. Income, resources, and assets are taken into consideration when determining Medicaid eligibility.
2.3.1.1. **Eligibility Requirements**

Applicants for Medicaid must meet each of the financial and non-financial requirements of the program in which they will participate. The Medicaid field offices determine Medicaid eligibility and enroll eligible applicants in the appropriate benefit package. See **Covered Benefits**, for more information.

2.3.1.2. **Period of Eligibility**

Participant eligibility is determined on a month-to-month basis. For example, a participant may be eligible during the months of April and June, but ineligible during May. Providers are required to verify participant eligibility (prior to rendering services) to qualify for reimbursement, in accordance with **IDAPA 16.03.09.210**. Participant eligibility can be verified by using MACS or the **DXC Technology Medicaid** website. Medicaid only reimburses for services rendered while the participant is eligible for Medicaid benefits. Confirmation of eligibility is not available for dates in the future.

See **Verifying Participant Eligibility** for more information.

2.3.2. **Medicaid Identification Card**

**Figure 2-3: Health 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.

2.3.2.1 **Medicaid Identification Card for Dual Eligible Participants**

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

Medicaid benefits are not available for inmates of government jail or prison facilities, unless the inmate becomes an inpatient in a medical institution. In that case, Medicaid coverage begins the day the inmate is admitted and ends the day of discharge from the medical institution. The inmate must also meet all other Medicaid eligibility requirements during the inpatient period.

2.3.3. **Covered Benefits**

General information 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.

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.

2.3.4. **Medical Necessity**

State Medicaid programs are mandated to pay for only medically necessary services and items for state plan services. 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.

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 examined in peer-reviewed literature before being considered medically necessary. 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 those 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. Screening is generally not medically necessary, but may be considered so for wellness examinations. Idaho Medicaid covers screening services as mandated by the 2016 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 about services that may exceed those under state plan for participants under the age of 21.

2.3.4.1. References: Medical Necessity

Department of Administration, State of Idaho,

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature,


Department of Administration, State of Idaho,


2.3.5. Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If the prescription cannot be faxed, phoned, or electronically sent to the pharmacy, then providers must ensure that the prescription form meets all three of the following requirements:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

**Note:** The intent of this requirement is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

2.3.6. Non-Covered and Excluded Services

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; or
- The participant has exhausted their allowed amount; or
- 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.

Specific non-covered services and circumstances are detailed throughout the provider handbook.

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.

Prior to rendering services that are non-covered or excluded, providers must inform participants that services are 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. 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.

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 an unlisted code may be subject to recoupment and penalties. See Idaho Medicaid Claim Standards in the General Billing Instructions, Idaho Medicaid Provider Handbook for more information.
2.3.6.1. **List of Excluded Services**

Services excluded from coverage by statute or rule include:

**Acupuncture**

**Biofeedback Therapy**

**Complications**
The treatment of complications, consequences, or repair of any excluded medical procedure is not covered, although Medicaid may authorize treatment if the resultant condition is determined by Medicaid to be life threatening. A physician must document that the situation was life threatening.

**Cosmetic Surgery**
All surgery which 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**

**Investigational/Unproven/Experimental Procedures**
New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and which are excluded by the Medicare Program and/or the Federal Drug Administration (FDA) are excluded from payment by Medicaid.

**Laetrile Therapy**

**Naturopathic Services**

**Surgical Procedures on the Cornea for Myopia**

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

2.3.6.2. **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 EPSDT. Coverage under EPSDT must be prior authorized by Medicaid.

Some examples of the services for which payment may be made are private duty nursing in the participant’s home and outpatient substance abuse treatment. Any service recognized under the provisions of the Social Security Act can be made available if the above conditions are met. See the Early & Periodic Screening, Diagnostic & Treatment (EPSDT) section for more information.

2.3.6.3. References: Non-Covered and Excluded Services


2.3.7. Verifying Participant Eligibility

Providers should verify eligibility on the actual date of service, prior to providing the service. Eligibility information can be accessed three different ways.

- DXC Technology Medicaid website
- MACS 1 (866) 686-4272
- 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
- Date of birth

Participant eligibility information available 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.
2.3.7.1. **Eligibility Verification**

Providers can verify eligibility by logging into their Trading Partner Accounts (TPA) on the Idaho [DXC Technology Medicaid](#) website, or by using the MACS system.

See the following paragraphs for additional information regarding eligibility verification using MACS.

**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
- 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. For example, if the participant is eligible for the Medicaid Basic Plan, their eligibility is communicated as eligible for basic Medicaid benefits, and only benefits restricted to the basic plan are communicated.

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

**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 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.

2.3.8. **Participant Program Abuse/Lock-In Program**

Medicaid reviews participant utilization to determine if services are being used at a frequency or amount that may result in 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. This prevents these participants from going from doctor to doctor, or from pharmacy to pharmacy, to obtain excessive services.

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 if the participant is a candidate for the lock-in program.

2.3.8.1. **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. Referrals can be done electronically through your secure Trading Partner Account (TPA). More information on the referral process can be found in the *Referrals* section of the Trading Partner Account (TPA) User Guide. This also applies to physicians covering for the PCP and emergency rooms for non-emergency care. The referred physician must contact the PCP for the Idaho Medicaid provider number and enter it on all claims.

**Note**: 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 Health Resources Coordinator in your region.

2.3.8.2. **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.

**Note**: All referrals must be confirmed with the PCP before prescriptions are dispensed.

2.4. **Benefit Plan Coverage**

2.4.1. **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.

2.4.2. **Medicaid Basic Plan**

The Medicaid Basic Plan has been designed to achieve and maintain wellness by emphasizing prevention and proactively managing health.
2.4.2.1. **Covered Services**

Medical coverage under the Medicaid Basic Plan is limited with some notable differences between the Medicaid Enhanced Plan and Medicaid Basic Plan.

2.4.2.2. **Excluded Services**

- Drugs not covered under Medicaid
- Rehabilitative services provided by a developmental disability (DD) facility
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services
- Skilled nursing facility services
- Nursing facility services
- Hospice care services
- Case management services
- Personal care services
- Home and community based services
- Transition Management

2.4.2.3. **Restricted Services**

Institutions for mental disease are limited to individuals under the age of 21.

2.4.2.4. **Third Party Recovery (TPR) Requirements**

All services must be billed to the participant’s other insurance before billing Medicaid. See *General Billing Instructions*, Idaho Medicaid Provider Handbook Third Party Recovery (TPR), for billing details.

2.4.2.5. **Medical Necessity**

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 appropriate units in the Welfare (Self Reliance) and Medicaid Divisions.

2.4.3. **Presumptive Eligibility (PE)**

2.4.3.1. **Billing Presumptive Eligibility (PE) Determinations**

Use HCPCS code T1023 to bill for PE determination. Include the participant’s full name, MID number, and date of birth.

2.4.3.2. **Billing for Presumptive Eligibility (PE) or Pregnant Women (PW) Services**

PE prenatal clinics can bill only the special services procedure codes and laboratory services under the prenatal clinic provider number.

2.4.3.3. **Pregnant Women (PW)**

The Pregnant Women (PW) program was developed to provide medical assistance to pregnant participants in response to the Federal Catastrophic Health Bill of 1988. The program is designed to encourage women to seek prenatal care early in a pregnancy and preserve the health of both mother and infant. The program assists pregnant Idaho residents not currently
receiving medical assistance from the state or county, and without sufficient resources for private medical coverage. Presumptive Eligibility (PE) provides immediate, presumed coverage for qualified candidates for a maximum of 45 days. PE allows the participant time to formally apply for another program offered under Medicaid, such as the Pregnant Women program.

2.4.3.4. **Breast and Cervical Cancer**

Presumptive eligibility is also available for women who have been initially screened and diagnosed through the Centers for Disease Control and Prevention’s (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

This program allows the state to provide Medicaid benefits to uninsured women between the ages of 21 and 65 when they are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. Certain criteria must be met in order to qualify.

2.4.3.5. **Program Procedures**

The candidate seeking medical assistance for pregnancy must see an approved provider trained and certified by Medicaid, such as a health district or hospital. Additionally, providers qualified to perform PW PE determination must meet the eligibility criteria listed in Section 1920 of the Social Security Act.

Potential PE candidates answer preliminary program questions from the provider to determine if they are eligible for the program. These qualifications are determined by federal guidelines.

The PE candidate for the PW Program must have a medically verified pregnancy and have financial resources that fall within specific income levels. Eligibility for pregnancy services under the PE Program is determined as follows.

- Participant and provider complete program questions and determine if the participant is eligible for the PE Program.
- Participant’s local field office receives the application for services from the provider, processes it, and issues a Medicaid number for participant’s PE eligibility period.
- Participant’s PE period ends after a maximum coverage period of 45 days or sooner if the candidate is eligible for PW or another Medicaid program.

Follow these steps to submit your claims.

1. Verify the participant’s eligibility using Medicaid Automated Customer Service (MACS) or electronic software. See Section 2.3.7 Verifying Participant Eligibility, for instructions.
2. Submit your claim with the participant’s Medicaid identification (MID) number.

The PE candidate for the Breast and Cervical Cancer Program must be screened through a local Women’s Health Check Office (usually the district health department) and test positive for a breast or cervical cancerous or pre-cancerous condition that requires treatment.

2.4.3.6. **Covered Services**

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.

Women having PE for the Breast and Cervical Cancer Program, at the time of service, are eligible for Medicaid benefits during the PE period.

2.4.3.7. **Medical Necessity**

To bill PE services for the PW Program that are not clearly pregnancy-related, attach medical necessity documentation to a paper claim form explaining how the service is pregnancy-related. Services not clearly pregnancy-related will be denied, if documentation of medical necessity is not provided.

If the PE participant is referred to the hospital for lab testing or x-rays and the services are not clearly pregnancy-related, give the participant a completed PW Medical Necessity form. The participant takes this form to the next provider to establish the service as pregnancy-related. See Medical Necessity Form (pregnancy related). Forms are available online or as paper copies by request from Provider Services.

2.4.3.8. **Excluded Services**

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.

No specific services are excluded for Breast and Cervical Cancer program participants.

2.4.4. **Pregnant Women (PW)**

Medicaid offers extended eligibility and additional services to all women covered by Medicaid during their prenatal, pregnancy and postpartum period. The Pregnant Women (PW) Program is available to pregnant women who meet the eligibility requirements. Per 42 CFR 440.210, postpartum coverage is provided after delivery for sixty days, and extends until the last day of the month in which the 60th day occurs.

2.4.4.1. **Covered Services**

Medical coverage under PW covers services that are necessary for the health of the pregnant woman and the fetus, or services that have become necessary because of the pregnancy or for conditions that might complicate the pregnancy. Covered services include: normal prenatal care, delivery, post-partum including treatment for depression, family planning (including sterilization), nutrition counseling, risk reduction follow-up, and social service counseling.

Women who are eligible under the PW program are covered by a dental insurance program called Idaho Smiles.

Contact Idaho Smiles Customer Service at 1 (855) 233-6262, or at http://www.mcna.net/en/plans/medicaid, and click on the Idaho Smiles link, for Idaho Smiles eligibility, benefits, and claims processing information.
All family planning services normally covered under Medicaid, including sterilization, are covered under the PW Program. When billing for sterilization, all appropriate consent forms must be attached, along with documentation/justification that the service was performed during the two-month post-partum period. Family planning services are only covered during the postpartum period.

The following table shows some examples.

**Figure 2-6: Example of PW Coverage**

<table>
<thead>
<tr>
<th>Delivery Date</th>
<th>30 Days Postpartum</th>
<th>60 Days Postpartum</th>
<th>PW Coverage Ends</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/02/2010</td>
<td>01/01/2011</td>
<td>01/31/2011</td>
<td>01/31/2011</td>
</tr>
</tbody>
</table>

**Note:** A Healthy Connections referral is not required for pregnancy related services or for family planning services, but such services are to be coordinated with the PCP, see Section 2.5.4.5.

### 2.4.4.2. Non-Covered Services

Optical benefits are not normally covered as a part of the PW Program. An ophthalmologist or other physician must provide medical necessity documentation if billing for optical services that directly affect the pregnancy, or if the symptoms being treated are a direct result of the pregnancy.

### 2.4.4.3. Medical Necessity

If the services are not clearly pregnancy-related, you must provide documentation of medical necessity and attach it to the paper or electronic claim to explain how the service is:

- Necessary for the health of the fetus;
- Necessary for the health of the mother;
- A condition that might complicate the pregnancy;
- Necessary as a result of the pregnancy; or
- Family planning services.

The Department reviews each claim on a case-by-case basis. Services not clearly meeting the above requirements, will be denied. A claim review request (see the Claim Review Request section of the General Billing Instructions, Idaho Medicaid Provider Handbook may be made if the provider disagrees with the decision.

### 2.4.4.4. Billing Procedures

Follow the same billing practices for a PW participant as for any other pregnant Medicaid participant. Until delivery, the primary diagnosis for PW claims should be the weeks of gestation. All services must be pregnancy-related.

### 2.4.5. Breast and Cervical Cancer (BCC)

#### 2.4.5.1. Program Policy

A woman not otherwise eligible for Medicaid who meets certain conditions may be eligible for Medicaid benefits for the duration of her cancer treatment.
2.4.5.2. **Eligibility**

In order to be eligible, the participant must be initially screened and diagnosed through a local Women’s Health Check Office (usually the district health department) as a representative of the Centers for Disease Control and Prevention.

The participant can be presumed eligible before a formal Medicaid determination under PE as described in Section 2.4.3 Presumptive Eligibility (PE). Although Medicaid resource limits do not apply, the participant must:

- Meet the designated income limit.
- Be diagnosed with breast or cervical cancer through the Women’s Health Check Program.
- Be at least 21 years old and under the age of 65.
- Have no creditable insurance (if insured, the plan does not cover the same type of cancer).
- Be an Idaho resident.
- Provide a valid Social Security number.
- Be a U.S. citizen or meet requirement for legal noncitizen.
- Not reside in an ineligible institution.
- Not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole.
- Be willing to cooperate with Medicaid to secure medical or child support services, unless the participant has good cause.

2.4.5.3. **Covered Services**

Women who qualify for this program are eligible for Medicaid benefits during the treatment phase of their cancer care.

2.4.5.4. **Stages of Treatment**

Coverage for primary cancer treatment may include:

- Medical and surgical services
- Pre-cancerous conditions
- Early stage cancer

Adjuvant cancer treatment involving radiation or systemic chemotherapy included in the treatment plan, are also covered.

2.4.5.5. **End of Treatment**

Cancer treatment ends when a participant’s plan of care reflects a status of surveillance, follow-up, or maintenance. Additionally, benefits will end if a participant’s treatment relies on an unproven procedure in lieu of primary or adjuvant treatment methods.

2.4.6. **Medicare Savings Program**

2.4.6.1. **Program Policy**

The state has agreements with the Social Security Administration (SSA) 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 the 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. The statutory authority for the Medicare Savings Program is §1843 of the Social Security Act and Medicare Catastrophic Act of 1988.

The purpose of these arrangements is to permit the state to provide Medicare protection to certain groups of low income and disabled individuals as part of its total assistance plan. The arrangements transfer the partially state-funded medical costs for this population from Title XIX Medicaid Program to the Title XVIII Medicare Program, which is funded by the federal government and by payment of individual premiums. Federal Financial Participation (FFP) is available through the Medicaid Program to assist the states with the premium payment for certain groups of low income and disabled individuals.

There are two types of Part A Medicare Savings Program participation.
- Regular Type Part A
- Qualified Disabled Working Individual (QDWI) Part A

See the General Billing Instructions, Idaho Medicaid Provider Handbook Qualified Medicare Beneficiaries (QMB) Medicare/ Medicaid Billing Information, for more information.

2.4.6.2. Part A Medicare Savings Program
This 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.

2.4.6.3. Qualified Disabled Working Individual (QDWI) Part A Medicare Savings Program
Qualified Disabled Working Individual Program does not include state payment of Part B Medicare premiums.

Individuals on the QDWI Program 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.

2.4.6.4. Part B Medicare Savings Program
There are several types of participation in the Part B Medicare Savings Program in Idaho.
Figure 2-7: Part B Medicare Savings Program

<table>
<thead>
<tr>
<th>Part B Medicare Savings Program</th>
<th>Individual is entitled to Medicare</th>
<th>Medicaid Pays the Medicare Premium</th>
<th>Individual is entitled to Medicaid</th>
<th>Medicaid Prior Authorization Rules Apply for Medicare Covered Services</th>
<th>Medicaid Claim Editing Applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB-Only)</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary with Medicaid QMB + (QMB Plus)</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary (SLMB)</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary with Medicaid eligibility SLMB + (SLMB Plus)</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Medicaid (with deemed Cash Assistance Recipient)</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Medicaid – Non-Cash (also known as Medical Assistance Only) (MAO)</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Qualified Individual 1 (QI1)</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

2.4.6.5. **Dually Eligible Medicare Beneficiaries**

Individuals that are enrolled in Medicare, and eligible for Medicaid, are considered dually eligible participants. Dually eligible participants are eligible for Medicare benefits and Medicaid benefits.

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.

2.4.6.6. **Medicare Part D**

Under the Medicare Modernization Act, dually eligible individuals will no longer receive their drug coverage from Medicaid and instead will select or be auto 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.
2.4.7. 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.

2.4.7.1. Programs

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.

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.

2.4.7.2. Participant Identification Number

Participants enrolled in a managed care program will continue to use their Medicaid ID (MID) numbers as established under Section 2.3 Participant Eligibility. Participating Medicare Advantage Plans offering MMCP programs will also issue a plan identification number specific to their company.

2.4.7.3. Billing Procedures for Managed Care Participants

The following 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
- Transition Management and Transition Services

The following 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
- 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
- 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)
- Interpretive Services sign language (to assist Enrollees to receive DD services)

**Consumer Directed Services**

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

**2.4.8. Otherwise Ineligible Noncitizens (OINC)**

Individuals who do not meet the citizenship or qualified noncitizen 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.

2.4.8.1. **Eligibility**

Medicaid eligibility for OINC begins no earlier than the date the participant experiences the medical emergency and ends the date the emergency condition stops. The Division of Medicaid, Medical Care Unit determines the beginning and ending dates of eligibility.

2.4.8.2. **Covered Services**

Obstetrical deliveries are considered emergencies. However, ante partum and postpartum care are not considered to be emergencies. The Division of Medicaid, Medical Care Unit reviews each request for payment for OINC and determines if a medical condition is an emergency.

2.5. **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 patients with the goal of improving health outcomes. Our mission is to ensure Medicaid participants receive the care they need, when they need it, and at the appropriate place.

The Healthy Connections program is structured to incentivize HC providers to transform to the Patient Centered Medical Home (PCMH) model of care. PCMH is a care delivery model whereby patient’s treatment is coordinated through their primary care provider or team to ensure patients receive the necessary care in a manner they can understand, with the goal of improving health outcomes.

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 patients to be involved in their healthcare decisions.
- 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.

2.5.1. **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 Section Provider Responsibilities. When verifying eligibility on HealthPAS on [www.idmedicaid.com](http://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
If an HC clinic is not indicated or the participant is exempt from HC, a referral for services rendered is not required.

**2.5.2. Provider Enrollment**

Idaho Medicaid primary care providers participate in Healthy Connections by signing a Coordinated Care Provider Agreement. This is in addition to the Idaho Medicaid Provider Agreement. Coordinated Care Provider Agreements are available from the Regional Health Resources Coordinators (HRC). Addresses and telephone numbers for the regional HC offices are listed in the Directory of this provider handbook, as well as contact information available on our HC website at [www.healthyconnections.idaho.gov](http://www.healthyconnections.idaho.gov).

In this program, HC providers are incentivized to transform to the Patient Centered Medical Home (PCMH) model of care. Each HC clinic location will qualify for one of the four HC tiers, depending on the PCMH capabilities. Once tier placement is approved for a clinic, they will receive an HC clinic Addendum B, to include the tier requirements and reimbursement. The HC tier names and requirements are as follows:

1. Tier I - Healthy Connections
2. Tier II - Healthy Connections Access Plus
3. Tier III - Healthy Connections Care Management
4. Tier IV - Healthy Connections Medical Home

**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 [www.healthyconnections.idaho.gov](http://www.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.
o Ability to request appointments.
o Ability to request medication refills.
o 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.
  o If you have achieved National Committee for Quality Assurance (NCQA) PCMH recognition, or another nationally recognized PCMH accreditation, you have met this criterion.
  o 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.
  o At six months the finalized tracker is to be submitted which must include assignment of work and projected deadlines for completion.
  o 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 http://www.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.
  o 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.
  o 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:
  o 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.
  o Population health management capabilities - registry reminder system or other proactive patient management approach.
  o 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).
  o 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 members records are outbound into clinics 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 www.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 mailed to this unit at HCR7@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 clinics 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:
  o 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.
  o At six months the finalized tracker is to be submitted which must include assignment of work and projected deadlines for completion.
  o Every six months thereafter a newly updated HC PCMH Tracker or equivalent must be submitted until clinic achieves recognition within the three-year deadline.
  o These reports can be found at www.healthyconnections.idaho.gov.
  o Tier III clinics that do not achieve national PCMH recognition within three years will be restored to the Tier in which they are eligible.

• Tier III & IV nationally recognized PCMH clinics must demonstrate a well-established quality improvement process:
  o 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:
    o Template worksheets can be found at www.healthyconnections.idaho.gov and must be submitted to HC QI staff every six months and demonstrate progress in selected competency area.

2.5.2.1. 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:

<table>
<thead>
<tr>
<th>Medicaid Plan</th>
<th>Tier I</th>
<th>Tier II</th>
<th>Tier III</th>
<th>Tier IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Plan participants</td>
<td>$2.50</td>
<td>$3.00</td>
<td>$7.00</td>
<td>$9.50</td>
</tr>
<tr>
<td>Enhanced Plan participants</td>
<td>$3.00</td>
<td>$3.50</td>
<td>$7.50</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

2.5.2.2. **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](https://www.dxctechnology.com) 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.
- 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. 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.

2.5.2.3. **Primary Care Provider Listing**

A listing of HC PCPs, sorted by Region and County, is made available on the [HC website](https://www.hc.idaho.gov) to participants and providers. Any time there is a change to a provider’s record or the clinic’s record, the provider is required to submit those updates to DXC Technology Provider Enrollment. Failure to keep the provider records up to date could result in inaccurate information on the HC PCP listing and eligibility verification, and non-payment of claims.

Some common changes or updates could include:

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

Please refer to the Provider File Updates section for more provider enrollment information.
2.5.3. **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. Medicaid eligible participants not enrolled in HC are mailed an enrollment form and given up to 30 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.

### 2.5.3.1. **Enrollment in Healthy Connections**

If a participant is not enrolled with your clinic, 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. Enrolling participants at 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.

Enrollment in Healthy Connections:

- For participants currently eligible for the Idaho Medicaid Benefit Plan, enrollment with their chosen HC clinics will be effective the first business day the request is received.
- 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.
- A list of HC clinics can be found at [www.healthyconnections.idaho.gov](http://www.healthyconnections.idaho.gov).
- Participants not submitting a choice of provider will be assigned to an HC clinic 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.

### Changing Enrollment in Healthy Connections

- The request to change a participant’s PCP can be made by the following:
  - Participant or a family member
  - The participant’s provider sending an enrollment form or calling on behalf of the patient
- The request to change a PCP **must** be received via fax, secure e-mail, or phone call **prior** to rendering services.
- When a change in PCP is requested during the Department’s non-business hours, such as weekends or holidays, the current enrollment will be termed one day prior to the
date the request was received and the new enrollment will be effective the next business day.

- A request to change a participant’s PCP must be mutually agreed upon by the provider and participant. The request indicates the provider accepts responsibility as the PCP and the change is not intended to facilitate access to urgent care.

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

### 2.5.3.2. **Exceptions & Exemptions to HC Enrollment**

Participants meeting the following exception or exemption criteria are not required to enroll in the Healthy Connections Program. An HC referral is not required for services rendered to non-enrolled participants.

**Exceptions to Healthy Connections Enrollment:**
- Participant has an eligibility period that is less than three (3) months.
- Participant has an eligibility period that is only retroactive.
- Participant is eligible only as a Qualified Medicare Beneficiary.
- Participant is enrolled in one of the managed care programs for Dual eligible participants.
- Participant resides in long-term care or ICF/IID facility.
- Participant resides in a non-mandatory county where there are not an adequate number of providers to deliver primary care case management services.

**Exemption criteria for participants to opt out of the Healthy Connections program:**
- 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 Medicare as their primary healthcare plan.
- Participant is enrolled in the State of Idaho foster care program.
- Participant is a member of a federally recognized tribe.
- Participant has an existing relationship with a primary care provider or clinic who is not participating in Healthy Connections; or a participant chooses a non-participating OB provider.

**Note:** A participant can request to be exempted from the Healthy Connections program based on the criteria listed above. If the participant meets the above criteria, an exemption can be granted by Healthy Connections. When verifying eligibility, participants meeting this criteria will appear as “Exempt from Healthy Connections”. If the participant establishes care with a Healthy Connections provider and is listed as having an exemption, the clinic can contact Healthy Connections and request the participant be enrolled.

### 2.5.3.3. **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 an enrollee because:
- The enrollee fails to follow treatment plan.
- The enrollee missed appointments without notifying provider.
The enrollee/PCP relationship is not mutually acceptable.
The enrollee’s condition would be better treated by another provider.
The PCP has moved and/or is no longer in business.

A PCP may not request disenrollment because:
- There is a change in the enrollee’s health status.
- The enrollee’s over/under utilization of medical services.
- Diminished mental capacity.
- Uncooperative or disruptive behavior resulting from his/her special needs, except where his/her continued enrollment with the PCP seriously impairs the PCP’s ability to furnish services either to the enrollee or other enrollees (patients).

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.

2.5.4. **Referrals**

A referral is a documented communication from a participant’s PCP of record to another Medicaid provider for specific covered services outside of the PCP’s expertise. Referrals may not be accepted in lieu of a physician or non-physician practitioner’s order for services or items.

To effectively provide comprehensive coordinated patient care, the primary care provider and team will track and support patients when they obtain services outside of the practice. The PCP also plays a key role in linking patients with community resources to facilitate referrals and respond to the patient’s medical and social needs.

2.5.4.1. **General Guidelines**

**Primary Care Providers:**
The participant’s HC clinic is responsible for providing primary care, managing the participant’s care, and **making referrals for medically necessary services**.

**General Referral Guidelines:**
For services requiring a HC referral, the referral is required prior to delivery of care to be considered valid.

Backdated or retroactive referrals are not acceptable and considered non-covered services subject to review or recoupment, and/or subject to assessment of civil monetary penalties.

- For services not requiring a referral and accessed directly by the participant, the PCPs shall contact the health care providers to obtain the findings.
- Referral requirements apply for participants enrolled in the Healthy Connections Program with Medicare or other primary/secondary insurance coverage.
- The PCP will have a system in place to track the status of a referral until the results are returned for evaluation and care coordination,
- When verifying eligibility for a specific date of service, if enrollment with an HC clinic is not indicated, an HC referral is not required prior to services rendered.

**Referral Delegation within Same Organization:**
- The referral requirement for primary care services accessed between HC clinics within the same organization (affiliated either by the same NPI or Tax ID) is at the discretion of the HC clinic/organization of record.

**Referral Delegation to an HC Service Location outside the Organization:**
• An HC service location may delegate referral authority to an “outside organization” for the purposes of care coverage. Referral authority must be included in the referral documentation of the covering HC service location for the specific visit.

**Medicaid Providers Receiving 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. Failure to communicate findings with the PCP may result in services considered non-covered and subject to recoupment.

For services referred on an ongoing basis, the specialist shall provide the PCP with an annual report, or more frequently if significant changes in the patient’s overall health condition occur.

**School Based Health Center (SBHC)** is defined as a health center located at an elementary, middle, or high school and does not include college health services. **Acute services** provided to a student at an SBHC may qualify for referral exemption if the following conditions are met:

- Timely coordination of services with the participant’s PCP is to occur within three business days. Care coordination, either in written or electronic format, shall include:
  - Visit summary
  - Prescriptions or DME ordered
  - Other pertinent information

If secondary or specialty care is medically necessary, the SBHC provider will refer the student back to their HC PCP.

The SBHC medical provider agrees to communicate the following with the student’s parent/guardian:

- Visit outcome and any follow-up care recommendations
- Inform visit summary will be provided to student’s PCP
- Advise a Healthy Connections referral is not required for acute services delivered at an SBHC

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

2.5.4.2. **Referral Requirements**

Following are the required core referral elements (Effective 2/1/2016):

- 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
- Referral reason:
  - Consultation/diagnosis only
  - Diagnose, treat, and/or forward to specialty provider
  - One time visit until seen by PCP
  - Other (to include additional referral limits or restrictions)
Note:
- Referrals remain active and do not expire if a participant changes their enrollment with an HC clinic.
- To be considered valid, a referral must be documented in both the refer-from and refer-to provider records.
  - This requirement is met for both the refer-from and refer-to provider for referrals entered online in the HealthPAS portal.
- A referral may be passed on to another Medicaid provider to treat the condition indicated in the original referral.

2.5.4.3. **Method of Referral**
A referral is a PCP’s authorization for services from another Medicaid Provider and may be communicated by any of the following methods:
- Electronic referral
  - Online DXC Technology HealthPAS portal
  - HC clinic electronic Medical Record (EMR)
- Paper referral
  - HC Referral Form
  - Prescription Pad
  - Other paper forms
- Verbal Referral
  - (e.g., calling order to specialist)
- Admit Order
  - Verbal or written (e.g., hospital direct admit by participant’s HC clinic PCP)

2.5.4.4. **Advantages of Electronic Online Referrals**
There are many advantages to submitting an online electronic referral, including:
- **Improved Accessibility & 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.
- **Timesaver** - No handling 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 Idaho DXC Technology Medicaid website, for instructions to enter or retrieve online referrals.

2.5.4.5. **Services Not Requiring an HC PCP Referral**
The following services do not require a referral by the PCP. Services must be a covered service under the participant’s benefit plan. If the service is not on this list, it must have a referral. A referral is not the same as a Prior Authorization (PA). Some services may require a referral, (e.g., to see a cardiologist), but not require a PA. Prior authorizations are for certain services that require review and approval prior to being provided. (see General Billing, section 2.9)
- **Acute Medical Services**
  - Delivered in a School Based Health Center (SBHC) and coordinated with the participant’s PCP within three business days.
- **Anesthesiology Services**
  - To include all anesthesiology services.
• **Audiology Services**
  o Performed in the office of a certified audiologist.

• **Children’s Developmental Disabilities Services**
  o Managed by the Department or the Department’s designee (effective 9/1/13).

• **Chiropractic Services**
  o Performed in the office of the chiropractor.

• **Dental Services**
  o All dental services are exempt from referral. Pre-operative examinations for procedures performed in an inpatient-outpatient hospital setting or ambulatory surgical center setting should be performed by the PCP when possible. Otherwise, the exam requires a referral. Dental procedures may require PA.

• **Durable Medical Equipment**
  o This service requires a physician or a midlevel practitioner’s order and should be coordinated with the PCP of record (effective 2/1/16).

• **Emergency Services**
  o Treatment for emergency medical condition when the definition is met as outlined in *IDAPA 16.03.09.10.24* (effective 1/1/13).
    ▪ Emergency Medical Definition – A medical 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 women or unborn child in serious jeopardy
      • Serious impairment to bodily functions
      • Serious dysfunction of any bodily organ or part

• **Family Planning Services**
  o Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling and restricted sterilization for pregnancy prevention.

• **Hospice Services**
  o This service requires a physician or a midlevel practitioner’s order and should be coordinated with the PCP of record (effective 2/1/16).

• **Hospital Admissions Subsequent to ER Visit**
  o Hospital admission resulting in direct admit from the same facility emergency room. Patient discharge planning from hospital admit is to be coordinated with the HC PCP. (Effective 5/23/2017.)

• **Immunizations**
  o Immunizations do not require a referral or an office visit.
  o 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) (Developmentally Disabled) Services**
  o This includes all services delivered to participants residing in an ICF/IID, regardless of place of service.

• **Indian Health Clinic Services**

• **Infant Toddler Program Services**
  o Managed by the Department or the Department’s designee (effective 9/1/13).

• **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** (includes pathology)
  - All services related to laboratory services.

- **Occupational Therapy Services**
  - This service requires a physician or a midlevel practitioner order, and should be coordinated with the PCP of record (effective 2/1/16).

- **Outpatient Mental Health Services**
  - Outpatient services managed by the Department or the Department’s designee (effective 9/1/13).
  
  **Note:** Mental Health Services not coordinated by the Department’s Behavioral Health Managed Care Contractor, Optum Idaho, and billed directly to DXC Technology do 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 a behavioral health diagnosis.

- **Nursing Facility Services**
  - This includes all services delivered to participants residing in a nursing facility, regardless of place of service.

- **Personal Care Services (PCS)**
  - These services are only covered for Medicaid Enhanced Plan participants.

- **PCS Case Management**
  - These services are only covered for Medicaid Enhanced Plan participants.

- **Pharmacy Services**
  - For prescription drugs only.

- **Physical Therapy**
  - This service requires a physician or midlevel practitioner’s order and should be coordinated with the PCP of record (effective 2/1/16).

- **Podiatry Services**
  - Performed in the office.

- **Pregnancy Related Services**
  - Pregnancy related services, provided to HC participants, are to be coordinated with their primary care providers (effective 1/1/13).

- **Radiology Services**
  - To include all radiology services.

- **Respiratory Services**
  - This includes services such as ventilator care and breathing treatments. This does not include sleep studies. (effective 2/1/16).

- **School District Services**
  - Includes all health-related services provided by a school district under an Individual Education Plan (IEP).

- **Screening Mammography**
  - Limited to one per calendar year, for women age 40 or older.

- **Services managed directly by the Department, as defined in the Provider Handbook, Provider Guidelines**

- **Speech Language Pathology**
  - This service requires a physician or a non-physician practitioner order and should be coordinated with the PCP of record (effective 2/1/16).

- **Sexually Transmitted Disease Testing**

- **Substance Abuse Services**
  - Outpatient services managed by the Department or the Department’s designee (effective 9/1/13).
• **Transportation Services**
• **Urgent Care Clinic Services**
  o Services provided by an Urgent Care Clinic when the participant’s PCP office they are enrolled with is closed. Participants should be referred to their PCPs for follow up care.
• **Vision Services**
  o Performed in the offices of ophthalmologists and optometrists, including eyeglasses.
• **Waiver Services for the Aged and Disabled**
  o These services are only covered for those Medicaid participants who qualify for both the Medicaid Enhanced plan and the Aged and Disabled Waiver.

2.5.4.6. **Reimbursement for Services Requiring Referral**
• It is the responsibility of the billing provider to ensure a referral is documented prior to rendering services.
• Backdated or retro referrals are not valid.
• A service requiring a referral, without a documented referral in place, may be billed to a participant. See Section 2.1.2 Provider Responsibilities for more information about billing participants.
• Billing Medicaid for services without a documented referral is not allowed. All Medicaid payments are subject to review or recoupment, and/or subject to assessment of civil monetary penalties by the Idaho Department of Health and Welfare, as stipulated in the provider agreement.
• A referral number is not required on a claim and claims will process regardless of referral status. **Entering a referral number on a claim will cause it to fail.**
• A referral is not required if during a procedure that did not require a referral, to one that now requires a referral.

2.5.4.7. **Program Liaison**
The HC Program provides staff to help you resolve program related problems you may encounter. Please contact your local PRC to obtain information, training, or to answer questions. Refer to the Directory, Idaho Medicaid Provider Handbook for specific contact information.

2.6. **Early & Periodic Screening, Diagnostic & Treatment (EPSDT)**
Children up to the age of 21 may request medically necessary services under the EPSDT prior authorization process.

The services may include, but are not limited to the following:
• Annual physicals
• Counseling and behavioral health services
• Dental services, including a referral to a dentist by age one
• Doctor visits
• Durable Medical Equipment
• Emergency Medical Transportation
• Health Education
• Hearing services, including hearing aids
• Home health care (doctor prescribed)
• Hospice Care
• Immunizations
• Inpatient and outpatient hospital care
• Laboratory tests (including blood level assessments appropriate for age and risk factors)
• Medical equipment and supplies
• Medical Transportation services
The EPSDT benefit was designed to help ensure that all Medicaid-eligible children receive preventive health care and early intervention services needed to maximize each child’s potential for healthy growth and development.

The benefits also allow children to receive some additional services that are not covered for adults. If services not covered under the State Plan are needed, a Request for Additional Services (RAS) form must be submitted to the Department for review. If services are approved, a prior authorization will be issued. All services under EPSDT must be considered safe, effective, and meet acceptable standards of medical practice.

2.6.1. 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
- Assistive Technology

2.6.1.1. Early Intervention Services Eligibility

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
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.

2.6.1.2. **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.

Evaluations must include the following information:
- Summary of Findings
- Recommendations for treatment
- Dated signature of professional completing the evaluation

2.6.1.3. **Assessments**

Assessments must support services billed to Medicaid, 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
- Dated signature of professional completing the assessment

2.6.1.4. **Record Keeping**

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)
- Other child specific documentation listed in the Department Intra-Agency Agreement

2.6.1.5. **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.

2.6.1.6. **Medicaid Reimbursable IDEA Part C Services**

IDEA Part C services reimbursed based on the [early intervention fee schedule](https://example.com) include:

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

IDEA Part C services reimbursed in ways other than the [early intervention fee schedule](https://example.com) include:

- Service Coordination
- Transportation
- 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.

2.6.1.7. **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
- Provide [Telehealth Services](https://example.com) in accordance with the *General Provider and Participant*, Idaho Medicaid Provider Handbook

Reimbursement is subject to pre-payment and post-payment review in accordance with [Section 56-209(h)(j)(3)](https://example.com), Idaho Code and recoupment in accordance with [IDAPA 16.05.07](https://example.com), “The Investigation and Enforcement of Fraud, Abuse and Misconduct.”

2.6.1.8. **Prior Authorization**

Prior authorization is not required for services on the [early intervention fee schedule](https://example.com). 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.

2.6.1.9. 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.

2.6.1.10. Place of Service Codes
Early Intervention services can only be provided in the following POS:
- 12 Home
- 99 Other (Community)

2.7. 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.

2.7.1. 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. 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 canceling appointments;
  - Making reminder calls;
  - The interpreter’s travel time; or
  - No show appointments.
- Services in conjunction with a noncovered, 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.
- The interpreter or translator’s waiting time, except when the participant is in surgery or receiving other covered services such as radiology.

Interpretive Services may be billed under T1013 (Language Interpretive – Oral Services, per 15 minutes) and T1013-CG (Sign Language Interpretive Services, per 15 minutes).
2.7.2. Interpretive Services Documentation

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

- The name and Medicaid ID# of the Participant;
- If services are for a child’s family member, the name and relationship of the person to the child;
- 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.

2.7.3. 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.

2.7.4. References: Interpretive Services

2.7.4.1. Idaho Medicaid Publications


2.7.4.2. **Regulations**


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 C.F.R. Sec. 92 (2016). Government Printing Office, https://www.ecfr.gov/cgi-bin/text idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=pt45.1.92&rgn=div5.


2.8. **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 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, and any other pertinent information from the visit.

2.8.1. **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. 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. 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 (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 are 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.

### 2.8.2. 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.

### 2.8.3. 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).

### 2.8.4. 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 distant sites. Reimbursement is also not available for services that are interrupted and/or terminated early due to equipment difficulties.

All normal Place of Service codes are acceptable for telehealth. 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.

### 2.8.5. References: Telehealth Services

#### 2.8.5.1. CMS Guidance


#### 2.8.5.2. Idaho Medicaid Publications


2.8.5.3. **Regulations**


2.9. **Non-Emergent Non-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 go to www.mtm-inc.net/idaho or call (877) 503-1261 for more information.
2.10. Preventive Health Assistance (PHA)

Preventive Health Assistance (PHA) is a benefit for Medicaid participants. Weight Management PHA is a program that provides Medicaid participants with weight management assistance to help them live a healthy lifestyle.

Wellness PHA, for the participants of the Children’s Health Insurance Program (CHIP), rewards parents for keeping their children up to date on well child exams and immunizations. If participants are current on these preventive services, then their CHIP premiums are reduced by $10/month.

2.10.1. Weight Management

Medicaid will reimburse a qualified, enrolled provider up to $200 per participant per year for providing weight management services to eligible participants.

2.10.1.1. Eligibility

Adults with a body mass index (BMI) of 30 or higher, or 18 ½ or lower, may qualify for assistance with paying for an approved weight management program. Children aged five years and older, with a BMI that falls into either the overweight, obese, or underweight category, may qualify for assistance with paying for an approved weight management program.

The eligibility process is initiated by a visit with the participant’s primary care provider. If the PCP determines their patient would benefit from a weight management program, the provider recommends the participant for the PHA WM benefit by filling out the section for the Health Care Provider on the Weight Management Agreement Form (Step 1). Once the participant receives their agreement form from the provider, they must complete and return the form to the Medical Care Unit. The initiating height and weight information must be charted within the two months prior to the Medical Care Unit receiving the agreement form for processing. The Medical Care Unit will determine eligibility and send the participant a Notice of Decision (NOD). The NOD will contain a voucher that specifies the approved weight management provider. The participant must then take the NOD to their weight management program to receive services.

Initiating PHA Weight Management Benefits – HC Provider

The primary care provider:

- Confirms participant meets the BMI criteria.
- Confirms the participant is enrolled in either the Basic or Enhanced plan.
- Discusses weight management programs with patient and help to identify obtainable goals.
- Prints the PHA Agreement form and the list of credentialed PHA WM organizations from the PHA website.
- Completes and signs Healthcare Provider Section (Step 1) of PHA Agreement form.
- Gives the PHA Agreement form and list of PHA WM organizations to the participant or their guardian for completion and submission.

Medicaid participants enrolled in one of the managed care programs for dual eligible participants are not eligible for PHA benefits.
2.10.1.2. **Enrolling and Billing for Services**

Weight management programs must meet the enrollment requirements listed in *IDAPA 16.03.09.622.02*.

Weight management providers must follow the steps below to determine eligibility for weight management services and to bill.

1. The provider verifies eligibility by calling DXC Technology customer service at 1 (866) 686-4272, to verify both Medicaid and PHA weight management eligibility.
2. The provider accepts the participant’s voucher.
3. The participant is enrolled in an approved weight management program. Their benefit is limited to the dollar amount listed on their voucher and will never exceed $200 per year.
4. A claim is submitted through the DXC Technology provider portal for the weight management services.

**Payment of Services**

All services must be prior authorized by the Department. Providers must bill on an original CMS-1500 form and submit it to DXC Technology for reimbursement via mail or the provider portal.

**Diagnosis Codes**

All claims for PHA Weight Management must have a primary diagnosis code. Refer to the list below for the appropriate code.

- E66.09 Other obesity due to excess calories
- E66.1 Drug-induced obesity
- E66.8 Other obesity
- E66.01 Morbid (severe) obesity due to excess calories
- R63.6 Underweight

**Procedure Codes**

These procedure codes are available for billing PHA Weight Management services.

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Physician Weight Management</td>
<td>S9449</td>
<td>Weight Management counseling</td>
</tr>
<tr>
<td>Non-Physician Weight Management</td>
<td>S9451</td>
<td>Weight Management exercise</td>
</tr>
<tr>
<td>Nutrition classes, nonphysician provider, per session</td>
<td>S9452</td>
<td>Nutrition classes, nonphysician and nondietician provider, per session</td>
</tr>
<tr>
<td>Non-Physician Weight Management</td>
<td>S9970</td>
<td>Weight Management health club membership annual</td>
</tr>
</tbody>
</table>

2.10.2. **Wellness**

Children enrolled in the Children’s Health Insurance Program (CHIP) are subject to a monthly premium of $10 or $15 per month. If parents keep their children up-to-date on their well child exams AND immunizations (see the Wellness Examinations section of the *Physician and Non-Physician Practitioner*, Idaho Medicaid Provider Handbook the child will receive a $10 discount every month on their premium.
2.10.2.1. **Premium Statements**

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 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.
Appendix A. Provider Agreement Example

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 §
       1395ff(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 §
       417.430(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:

Medicaid Provider Agreement (06/11)
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.

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.
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:

Medicaid Provider Agreement (08/11)
Provider Agreement

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 ____________________________