MedicAide

An Informational Newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **August 2020**

In This Issue

Information Releases

Duplicate and Overlapping Claims

The Medicaid Program Integrity Unit has found instances in which providers billed and were paid for duplicate claims. There are many types of duplicate claim submissions and not all can be recognized and denied by the DXC claim processing system. Whether denied or paid in error, duplicate claim submissions delay all claim processing and increase system and staff costs for Idaho Medicaid.

Duplicate billing may happen within the same claim or over multiple claim submissions, on the same service date and/or over multiple service dates. Providers can prevent duplicate claim submissions and identify duplicate payments by reviewing their weekly remittance advice. If paid claims require correction, such as addition of a modifier, the provider should adjust the original clam or reverse the incorrect original paid claim and submit a new claim. See the Idaho Medicaid Provider Handbook, General Billing Instructions for more information.

Exact duplicate claim services are the same provider, same client, same day, same service code, same modifier etc. Correct coding rules apply to all providers and require appropriate reporting to the highest level of specificity.

Suspect duplicates are often paid when one element of the claim submission is different than an already paid claim. An example would be adding a previously missing modifier on a new claim could result in two paid claims for the same service. Suspect duplicates are duplicate or overlapping services for the same client, the same or different providers, with closely aligned services, diagnosis, or other claim elements.

Suspect duplicates may be conflicting place of service code, or time of day as recorded in the medical record or service documentation, such as outpatient services billed during an inpatient stay. Other suspect duplicate claims may be for same or similar services such as DMEPOS supplies, kits, and rentals, or medical services like global surgeries, obstetrical services, and diagnostic services.

National Correct Coding Initiative (NCCI) system edits will deny some but not all suspect duplicate claim submissions billed for the same date of service. Providers should be familiar with the NCCI manuals and tables located at Medicaid.gov.

Section 5 of the Idaho Medicaid Provider Agreement addresses accurate billing and states:

> 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 shall 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. The Provider must assure that a duplicate claim under another program or provider type is not submitted.

Medicaid providers are solely responsible for the accuracy of claims submitted and must assure that a duplicate claim under another program or provider type is not submitted. Duplicate services billed to Medicaid will be subject to recoupment and civil monetary penalties.

Back to School, Immunizations and COVID-19

Idaho Medicaid understands the fundamental contribution our providers fulfill in supporting Medicaid enrolled children, adolescents and their families. School districts statewide are preparing plans to resume classes during a turbulent time in our state's history with the COVID-19 public health emergency. Districts are working non-stop to incorporate COVID-19 specific guidelines from the Centers for Disease Control (CDC) to ensure children and school staff members can resume classes as safely as possible. Medicaid providers are key to assisting district policy makers in developing guidelines which ensure healthy outcomes for Idaho's children and families. Idaho Medicaid encourages our providers to participate in this work and we would like to share these new resources with you as you prepare to assist your communities.

- American Academy of Pediatrics: COVID-19 Planning Consideration: Guidance for School Re-entry
- Idaho State Department of Education: Idaho Back to School Framework 2020
- Federal Guidance: CDC's COVID-19 Consideration for Schools -Updated May 19, 2020

We would also like to make providers aware of the most recent guidance from the CDC on immunizations. The CDC has dedicated an entire page to Vaccination Guidance During the Pandemic, which includes such resources as general information on childhood immunizations, additional Considerations for immunizations provided at alternative sites, strategies for catching up immunizations and recommendations specific to the pandemic.

Please take the time to review these resources to ensure you have all the resources you need to ensure Idaho's children receive the full array of ACIP recommended immunizations for their developmental age. Immunizations are exempt from co-pays and Healthy Connections (HC) referral requirements. All immunizations provided to Idaho Medicaid children should be recorded in the Idaho Immunization Reminder Information System (IRIS) or records shared with the participants primary care physician. See the Physician and Non-Physician section of the provider handbook for additional information on immunizations.

If you have questions regarding Medicaid services for children preparing to return to school or for services within schools, please send them to the Medicaid policy team at MCPT@dhw.idaho.gov.

Changes to Healthy Connections Participant Enrollment Processing

Effective August 1, 2020, the following policy is being implemented, and added to the Healthy Connections (HC) section of the General Information and Requirements for Providers section of the provider Handbook.

HC clinics have the option to request enrollment limitations, such as requesting a closed panel , which means to not accept any additional Medicaid enrollees or to request other panel limitations. Participants not meeting the panel limitations set by the clinic will only be enrolled with that clinic, if the clinic contacts HC directly to approve the participant's enrollment.

Limited or closed panel clinics may make prior arrangements with HC to process enrollments without approval when one or more of the following criteria have been met:

- Participant has an established relationship with the clinic, which can be demonstrated through claims for service within the last 12 months.

- Participant has either an upcoming scheduled appointment or had a recent appointment at the clinic.
- Participant has a family member with an established relationship with the clinic .

If the above conditions are not met, or the clinic is closed to enrolling new Medicaid participants, participants will be directed to the clinic to get an approval to enroll from the clinic. The clinic must then submit the approval to HC in one of the following ways:

- HC enrollment form submitted to HC from the clinic and signed by the participant or their authorized representative.
- Phone call from the clinic to HC validating approval of the enrollment request and that the request was received from the participant.Ple

It is the responsibility of the HC organization to communicate changes in panel limits timely to the HC staff. Organizations are also responsible to advise all locations participating with HC of changes to panel limitations.

The Healthy Connections staff will no longer be contacting clinics to get approvals for participants to enroll.

Transparency in Agency Guidance

The Governor's Executive Order 2020-02: Transparency in Agency Guidance Documents requires state agencies to develop an index of all documents the agency uses as guidance. The Department's Rules, Statutes, and Policies webpage provides a quick reference for the public to find these and other documents. A list of documents in affect for Medicaid can be found in the department library under policies. This index includes all documents not already integrated in the Idaho Medicaid Provider Handbook that affect providers. New items, such as Information Releases and MedicAide articles, will be included in the index until they are integrated in the handbook.

Questions about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Attention Ambulatory Surgical Centers: Dental Procedures

Idaho Medicaid is unable to allow continued use of CPT® 41899 for ASC dental procedures. IDAPA 16.03.09.452 limits Idaho Medicaid to covering procedures in ambulatory surgical centers (ASC) based on Medicare's coverage. There is a provision to allow the Department to add procedures that meet the requirements of 42 CFR 416.166. Unfortunately, 42 CFR 416.166(c)(7) prohibits the coverage of unlisted CPT codes for ASC procedures.

Effective October 1, 2020, the Department will require ASCs to bill for dental procedures not represented by a CPT® code with T1015 (Clinic visit/encounter, all-inclusive). The reimbursement for T1015 will be the same as 41899.

Providers must bill the encounter code (T1015) first with one unit, and then list on additional claim lines underneath T1015 all the appropriate codes from the American Dental Association's® Code on Dental Procedures and Nomenclature (CDT) code set that represent the services provided during the encounter. The additional claim lines with CDT codes are priced at $0. Do not

bill T1015 and a CDT code for a procedure that has a CPT® code. Never list more than one unit for T1015. Failure to list CDT codes with T1015 may result in non-payment or recoupment.

For claims with multiple procedures represented by a combination of CPT® codes, the T1015 encounter code and CDT codes, list the CPT codes first, then T1015 and lastly the CDT codes representing the dental services provided.

Example			
DOS	**Code**	**Units**	**Charges**
07/15/2020	24666	1	$8,000
07/15/2020	T1015	1	$634.58
07/15/2020	D7310	2	$0
07/15/2020	D7311	1	$0
07/15/2020	D9971	1	$0

Note: Codes do not represent an actual medical or billing scenario and are only intended to show the order on a claim for types of codes, the billing of one unit for T1015 and billing a $0 amount for CDT codes.

Therapy Modifiers –GP, GO and GN

Effective October 1, 2020, Idaho Medicaid will require all services under a therapy plan of care to include modifiers GP, GO and GN on the appropriate claim line to demonstrate the therapy plan of care in order to align with Medicare. Only one of these modifiers should be reported per claim line.

The modifiers are:

- GN: Outpatient speech-language pathology plan of care.
- GO: Outpatient occupational therapy plan of care.
- GP: Outpatient physical therapy plan of care.

These modifiers always apply to revenue codes:

- 42X: Physical Therapy.
- 43X: Occupational Therapy.
- 44X: Speech-language Pathology.

These modifiers are only for the therapy services in their description. They do not apply to respiratory therapy, nutrition therapy, behavioral health counseling, etc.

Questions about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Therapy Assistant Services

Idaho Medicaid allows services performed by occupational and physical therapy assistants to be reimbursable. Idaho Medicaid will now allow the supervision requirements for those services to match the level determined by the appropriate board of licensing so long as they meet all requirements of the CPT® code billed. In addition to any requirements of the board of licensing and appropriate billing, IDAPA 16.03.09 only allows therapists to provide the following services:

- Evaluations;

- Active Wound Care Management CPT® codes (97597, 97598, 97602, 97605, 97606, 97607, 97608, 97610);
- Tests and Measurements CPT® codes (97750, 97755); and
- Orthotic Management and Prosthetic Management CPT® codes (97760, 97761, 97763).

Providers should be aware that they must follow the most stringent requirements for the involved payors. In order to be eligible for Medicaid payment, providers must also follow the requirements for covered services under primary payors.

Example

A participant has Medicare and Medicaid. Medicare has more stringent supervision requirements such as direct supervision for therapy assistants working under a therapist in private practice. The provider should ensure the therapy assistant is directly supervised to be eligible for Medicare payment. Otherwise the provider wouldn't be eligible for Medicaid payment.

Idaho Code 56-265 requires Idaho Medicaid to align payments to 90% of Medicare rates. Effective October 1, 2020, the Department will require the use of the CO and CQ modifiers on claim lines representing services provided by occupational and physical therapy assistants. Critical access hospitals are exempt from this requirement. Services provided in a single session by a therapist and therapy assistant would be broken into two claim lines. This would not be considered a duplication of service.

The modifiers are:
- CO: Services furnished in whole or in part by an occupational therapy assistant.
- CQ: Services furnished in whole or in part by a physical therapist assistant.

The modifiers apply based on the total minutes for the service the therapy assistant provides. If a single billable unit of a code represents services performed by both the therapist and the assistant, then the code would be billed with the assistant modifier if the assistant provided more than 40% of the service.

Example

John Doe received physical therapy on 07/15/2020. He spent fifty-three minutes doing therapeutic exercises. The therapy assistant provided thirty-four minutes of the service. As 97110 is fifteen-minutes per unit, the claim would be billed with four units due to the eight-minute standard. The therapist's time equals one whole unit. The assistant's time equaled two whole units. Of the remaining unit, four minutes of the service was completed by the assistant. Since that's more than 40% of the service, the unit is billed with the therapy assistant modifier.

Example Claim Lines				
DOS	**CPT®**	**Units**	**Modifier**	**Modifier**
07/15/2020	97110	1	GP	
07/15/2020	97110	3	GP	CQ

Effective January 1, 2022, rates for services provided by assistants will be reduced to 85% of therapists in alignment with the Bipartisan Budget Act of 2018.

As a reminder services provided by speech-language pathology assistants and aides are non-covered services per IDAPA 16.03.09.732.02. Services provided by these professionals must not be billed to Idaho Medicaid.

Questions about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Refills on Disposable Medical Supplies

Disposable medical supplies (DMS) are healthcare related items that are consumable, disposable and cannot withstand repeated use by more than one individual. Effective October 1, 2020, refills on DMS will be allowed to be dispensed within ten days of the participant's current supply running out. No more than a three-months supply of necessary medical supplies can be dispensed per rolling three-month period unless authorized by the Department.

For all items that are provided on a recurring basis and shipped or delivered to the participant, providers are required to have contact with the participant or caregiver/designee prior to dispensing a new supply of items. The provider must contact the participant within 14 calendar days prior to the delivery, and the participant must request a refill of supplies before they are dispensed. DMS cannot be automatically filled or shipped even with authorization of the participant. Documentation of the contact and participant order must be completed at the time of the encounter and kept on file. Retrospective statements will not be permitted as documentation of contact. Contact is required to ensure items remain necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order such as a change of address.

Questions about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Attention Suppliers: Wheelchairs

IDAPA 16.03.09.753.06 requires durable medical equipment to be provided as capped rentals unless otherwise specified by the Department. Effective October 1, 2020, wheelchairs will only be billable with the RR modifier.

Short term rentals of wheel chairs for three months or less will not require a prior authorization or seating evaluation. If the wheel chair is needed beyond three months, then the seating evaluation would be necessary, and a prior authorization may be required.

A new capped rental period is only permissible with a prior authorization and only in the event the equipment meets the requirements for replacement specified in the Repairs and Replacement subsection of the Suppliers, Idaho Medicaid Provider Handbook, the participant voluntarily changes suppliers, or due to a break-in-service. A break-in-service occurs due to a change in medical necessity or if payment for the equipment becomes the responsibility of another Medicaid provider such as a skilled nursing facility. If a break-in-service occurs and medical necessity is later re-established, a prior authorization can be requested for a new capped rental period if it has been more than sixty (60) days since medical necessity ended for the initial rental.

The capped rental period does not reset when the equipment is replaced due to wear and tear, malfunction, repair or maintenance during the required warranty period.

Effective October 1, 2020, Idaho Medicaid is also making the following changes to prior authorization requirements for wheelchairs. Due to the nature of the changes in decreasing the prior authorization requirements and the current public health emergency, comments were not solicited beforehand. Implemented changes will be reviewed periodically for billing trends and reassessment. Please, allow additional time for the system to be updated. Claims will be reprocessed once complete.

Wheelchairs	
Codes	**Description**
K0002	STANDARD HEMI (LOW SEAT) WHEELCHAIR
K0003	LIGHTWEIGHT WHEELCHAIR
K0004	HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR
K0006	HEAVY DUTY WHEELCHAIR
K0007	EXTRA HEAVY DUTY WHEELCHAIR
Prior authorization will be removed for capped rental period. All criteria will remain in place.	

Questions about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Prior Authorization Changes for Durable Medical Equipment

Effective August 1, 2020, Idaho Medicaid is making the following changes to prior authorization requirements for durable medical equipment. Due to the nature of the changes in decreasing the prior authorization requirements and the current public health emergency, comments were not solicited beforehand. Implemented changes will be reviewed periodically for billing trends and reassessment. Please, allow additional time for the system to be updated. Claims will be reprocessed once complete.

Removing the prior authorization includes adding a limitation to the system. Some codes have a shared limitation. Items must have the same limitation for the claims processing system to bundle the codes together. Because two items don't share a limit, doesn't mean it's appropriate to supply those items together.

General DMEPOS		
Codes	**Description**	**Limitation**
A4281	TUBING FOR BREAST PUMP, REPLACEMENT	1 per year.
A4283	CAP FOR BREAST PUMP BOTTLE, REPLACEMENT	1 per year.
A4284	BREAST SHIELD AND SPLASH PROTECTOR FOR USE WITH BREAST PUMP, REPLACEMENT	1 per year.
A4285	POLYCARBONATE BOTTLE FOR USE WITH BREAST PUMP, REPLACEMENT	1 per year.
A4465	NON-ELASTIC BINDER FOR EXTREMITY	2 per month.

General DMEPOS		
Codes	**Description**	**Limitation**
A4606	OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT	2 per month.
A4633	REPLACEMENT BULB/LAMP FOR ULTRAVIOLET LIGHT THERAPY SYSTEM, EACH	1 per year.
A7026	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH	2 per year.
A8000	HELMET, PROTECTIVE, SOFT, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	1 per 3 years.
A8001	HELMET, PROTECTIVE, HARD, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	
A8002	HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	
A8003	HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	
A9276	SENSOR; INVASIVE (E.G., SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY (Non-covered by Medicare. Statute reference: 1861(n)).	1 per day.
A9277	TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM (Non-covered by Medicare. Statute reference: 1861(n)).	2 per year.
A9278	RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM (Non-covered by Medicare. Statute reference: 1861(n)).	1 per 3 years.
K0554	RECEIVER (MONITOR), DEDICATED, FOR USE WITH THERAPEUTIC GLUCOSE CONTINUEOUS MONITOR SYSTEM (Special coverage instructions apply. See CMS-1682-R).	
E0158	LEG EXTENSIONS FOR WALKER, PER SET OF FOUR (4)	1 per 5 years.
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES (Special coverage instructions apply. See MCM: 2100.1).	2 per 3 years.
E0200	HEAT LAMP, WITHOUT STAND (TABLE MODEL), INCLUDES BULB, OR INFRARED ELEMENT (Special coverage instructions apply. See CIM: 60-9 and MCM: 2100.1)	1 per 5 years.
E0605	VAPORIZER, ROOM TYPE (Special coverage instructions apply. See CIM: 60-9)	1 per 5 years.
E0945	EXTREMITY BELT/HARNESS	2 per 5 years.
E0970	NO.2 FOOTPLATES, EXCEPT FOR ELEVATING LEG REST (Not payable by Medicare. See CIM: 60-9)	1 per foot per 3 years.

General DMEPOS		
Codes	**Description**	**Limitation**
E0994	ARM REST, EACH (Special coverage instructions apply. See CIM: 60-9)	1 per foot per 3 years.
E1031	ROLLABOUT CHAIR, ANY AND ALL TYPES WITH CASTERS 5'' OR GREATER (Special coverage instructions apply. See CIM: 60-9)	1 per 5 years.
E1575	TRANSDUCER PROTECTORS/FLUID BARRIERS, FOR HEMODIALYSIS, ANY SIZE, PER 10 (Special Coverage Instructions Apply)	1 per month.
E1701	REPLACEMENT CUSHIONS FOR JAW MOTION REHABILITATION SYSTEM, PKG. OF 6	1 per 6 months.
E1702	REPLACEMENT MEASURING SCALES FOR JAW MOTION REHABILITATION SYSTEM, PKG. OF 200	1 per month.
E1820	REPLACEMENT SOFT INTERFACE MATERIAL, DYNAMIC ADJUSTABLE EXTENSION/FLEXION DEVICE	2 per 5 years.
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	2 per year.
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	4 per year.
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	
E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	
K0072	FRONT CASTER ASSEMBLY, COMPLETE, WITH SEMI-PNEUMATIC TIRE, REPLACEMENT ONLY, EACH	
E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE	1 per 5 years.
E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	2 per year.
E2364	POWER WHEELCHAIR ACCESSORY, U-1 NON-SEALED LEAD ACID BATTERY, EACH	
K0020	FIXED, ADJUSTABLE HEIGHT ARMREST, PAIR	1 per 3 years.
K0039	LEG STRAP, H STYLE, EACH	1 per foot per 3 years.
K0047	ELEVATING LEGREST, UPPER HANGER BRACKET, REPLACEMENT ONLY, EACH	2 per 3 years.
K0050	RATCHET ASSEMBLY, REPLACEMENT ONLY	2 per 3 years.
K0051	CAM RELEASE ASSEMBLY, FOOTREST OR LEGREST, REPLACEMENT ONLY, EACH	2 per 3 years.
K0056	SEAT HEIGHT LESS THAN 17'' OR EQUAL TO OR GREATER THAN 21'' FOR A HIGH STRENGTH, LIGHTWEIGHT, OR ULTRALIGHTWEIGHT WHEELCHAIR	1 per 5 years.

General DMEPOS		
Codes	**Description**	**Limitation**
K0098	DRIVE BELT FOR POWER WHEELCHAIR, REPLACEMENT ONLY	2 per 3 years.
L8032	NIPPLE PROSTHESIS, REUSABLE, ANY TYPE, EACH	2 per 3 years.
Prior authorization will be removed. **Codes must be billed with NU modifier.** All criteria will remain in place.		

Bilevel Positive Airway Pressure Devices	
Codes	**Description**
E0470	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE) (Special coverage instructions apply. See CIM: 60-9).
E0471	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE) (Special coverage instructions apply. See CIM: 60-9).
Prior authorization will not be required to dispense for the initial three-month trial period during a five-year term. Prior authorization will be required for months four through ten. All criteria will remain in place.	

Cochlear Implant Device Accessories		
Codes	**Description**	**Limitation**
L8616	MICROPHONE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT (Special coverage instructions apply. See CIM: 65-14).	1 per 5 years.
L8617	TRANSMITTING COIL FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT (Special coverage instructions apply. See CIM: 65-14).	1 per 5 years.
L8618	TRANSMITTER CABLE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT (Special coverage instructions apply. See CIM: 65-14).	1 per 5 years.
L8623	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, OTHER THAN EAR LEVEL, REPLACEMENT, EACH.	2 per 3 years.
L8624	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, EAR LEVEL, REPLACEMENT, EACH.	
Prior authorization will be removed. **Codes must be billed with NU modifier.** All criteria will remain in place. Only available for participants under the age of twenty-one.		

Comments and questions should be submitted to the Medical Care Unit at MedicalCareUnit@dhw.idaho.gov.

Benzodiazepine Rules Change for New Starts – August 17, 2020

Beginning August 17, 2020, Idaho Medicaid participants who have not received benzodiazepines within the previous 6 months will be limited to a 14 day supply. This recommendation was made by the Idaho Medicaid Pharmacy & Therapeutics Committee because of their risk in the elderly population, tendency for dependence, and potential for substance abuse. Benzodiazepines can be effective for rapidly controlling symptoms associated with anxiety and insomnia. Cognitive behavioral therapy, psychotherapy and medications from the selective serotonin reuptake inhibitor (SSRI) and selective norepinephrine/noradrenalin reuptake inhibitors (SNRI) classes should be used for maintenance and long-term therapy. Exceptions will be made on a case-by-case basis by submitting a prior authorization request to the Pharmacy Unit (fax 800-327-5541 or call 208-364-1829 between 8am to 5pm Monday through Friday).

Solicitation of Comment for Proposed Limitations on Hearing Aid and Cochlear Implant Batteries

Idaho Medicaid is soliciting comments from providers on the following proposed limitations for hearing aid and cochlear implant batteries. All codes with a shared limit must have the same limitation for the claims processing system to bundle the codes together. Because two items don't share a limit, doesn't mean it's appropriate to supply those items together. The descriptions presented here are for the general purpose of reading this article. The official code descriptions still apply.
The claims processing system is unable to determine if a participant has a single hearing aid or binaural hearing aids. Providers supplying batteries for a participant with a single hearing aid are responsible for ensuring they don't dispense over the allowed 8 batteries.

Description	Codes	Shared Limit	Notes
Cochlear Implant Batteries	L8621, L8622	36 per 30-days	Limitation is based off review of other payors.
Hearing Aid Batteries	V5266	8 per month for single hearing aids (per policy). 16 per month for binaural (per system).	Limitation is based off review of other payors.

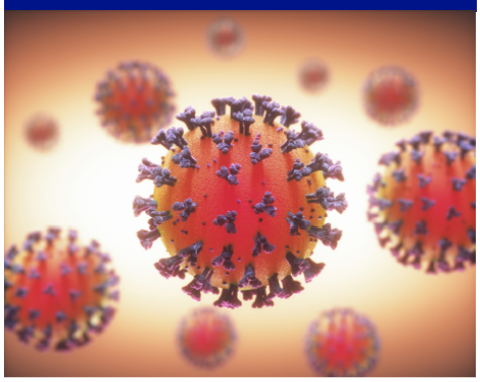
Questions and comments about this article should be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov before October 1, 2020 for consideration.

Coronavirus Counseling Assistance for Frontline Workers

866-536-0239

About

Idaho recognizes that the stress of responding to the COVID-19 outbreak put you — medical professionals, first responders, and other frontline professionals — at an increased risk for experiencing secondary traumatic stress reactions. The stress of the crisis may affect your mental health and your relationships. Support is being offered to you through the Coronavirus Counseling Assistance for Frontline Workers program.



Types of Services

Screening and Benefit Navigation

A toll-free hotline offering access to benefit navigators who will guide you in any behavioral health benefits you may have access to through your current benefits, and provide referrals to behavioral health resources. Screening and navigation services include:

- 24 hour, 7-day-a-week access to telephonic crisis counselors.
- Screening and benefit navigation 8am to 6pm (8am to 5pm Friday) Mountain Time.
- Coaching on how to access benefits and recommendations on available services in any region of the state.

5-Session Professional Assistance Program

For individuals who do not have access to behavioral health services through their current benefits, or who have significant financial or access barriers to those benefits, this program offers up to five sessions of confidential assessment and brief solution-focused problem intervention provided by licensed, professional counselors. Sessions are offered via telehealth services or, when appropriate given social distancing measures, face-to-face. Sessions can be individual, couples, or family counseling. In addition to five counseling sessions, the program offers participants:

- A national, licensed, and credentialed provider network for appropriate access to urgent and non-urgent care.
- Beyond program visits, referral to additional behavioral health services and community resources based on the client's needs, recommended treatment, and financial means.
- Substance use expertise and referrals for treatment of chemical dependency and other addictions.
- Online lifestyle tools and resources including legal, financial and identity theft information, calculators, tip sheets, and webinars.

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF BEHAVIORAL HEALTH

IDAHO DEPARTMENT OF HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 22, 2020
UPDATED: July 13, 2020

MEDICAID INFORMATION RELEASE MA20-30

To: Medicaid Providers

From: Matt Wimmer, Administrator

Subject: COVID-19: Laboratory and Pathology Services

The following are further details for Idaho Medicaid's policy on COVID-19 laboratory and pathology services.

Services must be medically necessary for coverage by Medicaid and reimbursement. Laboratory services should provide information that a clinician can use to initiate or change the management of a participant's care in a way that provides benefit to the tested participant. In the case of the COVID-19 public health emergency this is expanded to include additional considerations for other persons in the same setting (e.g., long-term care facilities) as outlined in this release. Services that are not medically necessary, such as those for employment, are not covered.

Per the Public Readiness and Emergency Preparedness Act (PREP Act) and Health and Human Services March 10 Declaration, pharmacists can order and administer tests for SARS-CoV-2. However, providers are reminded that they cannot bill for services rendered by another. If a pharmacist collects a specimen and sends it to a laboratory or another healthcare professional to test, the testing provider must be enrolled in Idaho Medicaid and bill the service directly.

CMS has granted some temporary flexibilities in their release "Laboratories: CMS Flexibilities to Fight COVID-19" that also apply to Medicaid. Rates paid for the services covered in the release will be at 90% of Medicare. The changes that apply include:

- Medicare COVID-19 Diagnostic Testing:
  - Laboratory Specimen Collection from Patient's Home;
  - Practitioner Payment for Specimen Collection;
  - Hospital Outpatient Payment for Specimen Collection;
  - Home Health Specimen Lab Collection;
  - RHC/FQHC Visiting Nurse Lab Specimen Collection; and
  - COVID-19 Diagnostic Testing.

In order to support recommendations of the State of Idaho Testing Task Force and the Idaho Rebounds plan, Medicaid is covering testing for SARS-CoV-2 based on this information release.

Testing for SARS-CoV-2

COVID-19 is caused by infection with the virus SARS-CoV-2. Testing for SARS-CoV-2 includes molecular and serologic (antibody) tests. Providers should educate participants on symptoms and prevention of COVID-19 when ordering either type of test. At a minimum, prevention education should include discussion of the importance and correct use of masks or face coverings, social distancing, hand washing, self-isolation and environmental cleaning. Recognized symptoms of a possible COVID-19 infection include fever, cough, shortness of breath, sore throat, chills, muscle pain, new loss of taste or smell, vomiting, and/or diarrhea.

Molecular testing demonstrating the presence of viral RNA is the only way to definitively diagnose an active infection with SARS-CoV-2. Molecular testing with reverse transcriptase polymerase chain reaction (RT-PCR) amplifies very small quantities of RNA specific to SARS-CoV-2 to detect the presence of the virus in the body. These tests may detect the virus 1–2 days before symptoms occur and for a short period after symptoms cease. Tests administered outside this window have a higher chance of returning false negative results. Molecular testing cannot determine if a person has recovered from a previous infection with the virus. Molecular tests available on the market include:

- Rapid molecular testing at the point of care for results within minutes (up to 4-5 per hour);
- High-throughput platforms that process large numbers of tests within hours (up to 2,000 per day);
- Out-of-state laboratories with capabilities similar to high-throughput platforms with turnarounds in 2–4-days.

Serologic testing looks for previous infection with the virus by detecting the presence of antibodies that bind to viral proteins. The production of antibodies begins shortly after viral infection as part of the body's immune response. The IgM antibody begins production 5-7 days after the initial viral infection but may not be present in sufficient quantities for detection until days later; serologic tests are therefore not recommended for evaluating symptomatic patients. The immune system begins production of the IgG antibody much later in the infection. The IgG antibody persists in the body for longer periods of time and may provide immunity to the virus. Some serologic tests incorporate both IgM and IgG antibodies while others test only for IgG. It is unclear if antibodies to SARS-CoV2 confer immunity to reinfection and, if they do confer immunity, how long that immunity might persist. Some tests may have cross-reactivity with other coronaviruses and available tests vary significantly in sensitivity and specificity. Serologic tests should never be used for diagnosing acute infection and currently have very limited clinical applicability.

Providers need to consider sensitivity, specificity and prevalence of disease when determining which molecular or serologic test to use. The sensitivity of a test reflects its ability to detect the presence of virus. The specificity of a test reflects its ability to confirm the absence of

virus. It is important to remember that even a highly sensitive and specific test will lead to false positive results when the prevalence of disease is low. False positive results are especially problematic for serologic tests when patients might use those results to make decisions about social distancing. Prevalence of disease has to be very high for a serologic test to reliably confirm prior exposure to COVID-19; serologic testing therefore has very limited clinical applicability for most patients at this time.

Covered Codes for the Collection of Specimens for COVID-19 Tests		
Codes	Description	Effective Date
36415	Collection of venous blood by venipuncture	N/A
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)	N/A
C9803	Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source	03/01/2020
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source	03/01/2020
G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a snf or by a laboratory on behalf of a hha, any specimen source	03/01/2020

Coverage of Molecular Testing for SARS-CoV-2 (Amended 06/19/2020)
Molecular testing is limited to four tests per month without a prior authorization. Only tests with an FDA Emergency Use Authorization are covered. Blanket orders for testing are not permitted.

Participants eligible for testing:

- Symptomatic participants;
- Participants exposed to confirmed or probable cases of COVID-19;
- Participants in group homes, homeless shelters, long-term or residential care facilities;
- Participants in the healthcare industry in contact with patients;
- Participants beginning or modifying treatment that could be affected by the presence of COVID-19;
- Participants discharging from one healthcare facility to another; and
- Participants undergoing the following diagnostic and therapeutic procedures:
    - Surgery;
    - Polysomnography with PAP titration;
    - Bronchoscopies;
    - Laryngoscopies;
    - Cardiovascular procedures that require anesthesia;
    - Gastrointestinal procedures; or
    - Imaging studies that require anesthesia.

Testing of participants outside of these criteria can be requested through a prior authorization from the Medical Care Unit.

Covered Codes for Molecular Testing for SARS-CoV-2		
Codes	Description	Effective Date
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), amplified probe technique	03/13/2020
U0001	2019-Novel Coronavirus Real-Time RT-PCR Diagnostic Panel-CDC	02/04/2020
U0002	2019-Novel Coronavirus Real-Time RT-PCR Diagnostic Panel-NON-CDC	02/04/2020
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.	04/14/2020
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.	04/14/2020

Coverage of Serologic Testing for SARS-CoV-2 (Amended 06/19/2020)
Serologic testing has limited clinical applicability and is at this point not recommended by the CDC or by the State of Idaho's Testing Task Force for use in directing patient care of COVID-19. Serologic testing is limited to twice per year without a prior authorization. Only tests meeting the following criteria are covered:

- Tests with an FDA Emergency Use Authorization;
- 99% or higher sensitivity; and
- 99% or higher specificity.

Participants eligible for testing:

- Evaluation of a recent past episode of symptoms to determine if the infection was from the SARS-CoV-2 virus;
- The participant believes they are immune to the virus and are not following physical distancing guidelines, in order to document continued susceptibility and provide an opportunity for discussion about the importance of physical distancing; or
- Evaluation of a participant under the age of twenty-one for multisystem inflammatory syndrome in children (MIS-C) when the participant is admitted to the hospital with fever, laboratory evidence of inflammation, and clinically severe illness with multisystem organ involvement.

Claims for serologic testing must have a completed Serologic Testing for SARS-CoV-2 Documentation Form attached to be eligible for reimbursement.

Covered Codes for Serologic Testing for SARS-CoV-2		
Codes	Description	Effective Date
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	04/10/2020
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	04/10/2020

COVID-19 Resources (Amended 06/19/2020)
COVID-19 Testing Recommendations by Idaho Testing Task Force

Emergency Use Authorizations

EUA Authorized Serology Test Performance

Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)

FDA STATEMENT: Coronavirus (COVID-19) Update: Serological Test Validation and Education Efforts

Frequently Asked Questions about Laboratory Testing and COVID-19

Infectious Diseases Society of America Guidelines on the Diagnosis of COVID-19

Information for Healthcare Providers about Multisystem Inflammatory Syndrome in Children (MIS-C)

Insight into FDA's Revised Policy on Antibody Tests: Prioritizing Access and Accuracy

Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19

MW/wd

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009

Idaho Medicaid
Serologic Testing for SARS-CoV-2 Documentation Form

Instructions
A physician or non-physician practitioner must complete and sign the Attestation of Meeting Criteria section of this form. The completed document must be provided with an order for testing to the laboratory completing the test. The provider performing the test must attach the completed form to their claim for reimbursement. **Claims for serologic testing of SARS-CoV-2 without a completed form will be denied. Testing for a purpose outside of the covered criteria requires a prior authorization.** Prior authorized claims do not require this form.

Medicaid Participant Information	
Last Name:	First Name:
Medicaid ID Number:	Date of Birth:

Attestation of Meeting Criteria

Serologic testing has limited clinical applicability and is currently not recommended by the CDC or by the State of Idaho's Testing Task Force for use in directing patient care. Idaho Medicaid only covers serologic testing of SARS-CoV-2 without a prior authorization for the following reasons (select one):

- ☐ Test is being used to evaluate a recent past episode of symptoms to determine if the infection was from the SARS-CoV-2 virus.
- ☐ Test is being used for a Medicaid participant who believes they are immune to the virus and is not following physical distancing guidelines and/or other recommended public safety measures. Results will be used to document continued susceptibility and provide an opportunity for discussion about the importance of physical distancing.
- ☐ Test is being used to evaluate a diagnosis of multisystem inflammatory syndrome in children (MIS-C): the participant is under twenty-one and has been admitted with fever, laboratory evidence of inflammation, and clinically severe illness with multisystem organ involvement

I have evaluated the patient above in a face-to-face evaluation or via synchronous telehealth. It is to the best of my knowledge, and in my professional opinion, that the participant meets the criteria selected above for serologic testing.

Signature: _____ Date: _____

Name: _____ NPI: _____

For questions regarding claims, requirements, limitation or status, call DXC Technology Customer Service at 1 (866) 686-4272 or see the DXC portal at www.idmedicaid.com.

Revised: 07/13/2020

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

July 13, 2020

Medicaid Information Release # MA20-34

To: Medicaid Nursing Facility Providers

From: Matt Wimmer, Administrator

Subject: **PDPM Calculations for Omnibus Budget Reconciliation Act (OBRA) Assessments**

The Centers for Medicare and Medicaid Services (CMS) updated the minimum data set (MDS) 3.0 item sets and related technical data specifications on May 15, 2020. These changes will support the calculation of Patient Driven Payment Model (PDPM) case mix groups for the federally required OBRA assessment schedule. CMS is allowing states the option to start collecting this data for OBRA assessments beginning October 1, 2020 or after. The Department of Health and Welfare has elected to exercise this option and will begin requiring and collecting the additional OBRA PDPM data fields effective October 1, 2020.

The current nursing facility reimbursement system utilizes the Resource Utilization Group Version III (RUG-III) information to calculate the case-mix adjustment factors. It is estimated that by collecting the additional PDPM fields on OBRA assessments, the Department will have the ability to start modeling the viability and impact of the PDPM classification system on case mix rates during calendar year 2022.

By the Department electing to collect this information, providers will be required to complete 28 additional MDS items for each OBRA assessment. These items are elements of Sections GG, I, and J of the MDS form. While we understand this may cause a slight increase in the administrative burden placed upon providers for MDS submission, the Department feels this information is meaningful and essential in evaluating the future of nursing facility rate setting.

It should be noted that the elements necessary for PDPM and RUG resident classification will be maintained on a single assessment, and providers will **NOT** need to file the Optional State Assessment (OSA) at this time.

If you have any questions or comments please contact the Office of Reimbursement, Idaho Division of Medicaid, at (208) 287-1180 or email MedicaidReimTeam@dhw.idaho.gov.

MW/ab

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

July 14, 2020

MEDICAID INFORMATION RELEASE MA20-36

To: Developmental Disability Agencies
Community Supported Employment Agencies
Adult Day Health Agencies

From: Matt Wimmer, Administrator

Subject: COVID-19 Rescindment of Select Home and Community-Based Services (HCBS) Rate Adjustments

On April 17, 2020, the Idaho Department of Health and Welfare (Department) issued Information Release MA20-24 implementing temporary rate adjustments for select home and community-based services to help maintain a stable workforce and preserve HCBS provider networks significantly-impacted during the COVID-19 public health emergency.

The Department has been closely monitoring claims data and has determined that utilization of some services is returning to levels that existed prior to the public health emergency. As a result, effective July 25, 2020, the Department intends to rescind the temporary rate adjustments for the impacted children's developmental disability services as specified in the details below. Except for supported employment services, the temporary rate adjustments for the impacted adult developmental disability waiver services and the impacted aged and disabled waiver services will remain in effect. Supported employment services provided on or after July 1, 2020 will continue to be reimbursed at the rate approved by the 2020 Legislature. (Please see Information Release MA20-33 for more details regarding the supported employment service reimbursement increase).

The Department is aware of recent increases of COVID-19 cases in Idaho and understands that rapidly changing circumstances may warrant adjustments to this decision and Medicaid's on-going response to this public health emergency. The Department continues to monitor the situation and will provide updated information as it becomes available.

As a reminder, telehealth flexibilities (established in Information Releases MA20-07, MA20-13, and MA20-15) remain in effect, and the Department encourages providers to continue to utilize telehealth services when appropriate. Given the positive impacts of telehealth services on healthcare in Idaho, the Department is currently evaluating the extent to which these flexibilities may be made permanent.

Rescindment of Rate Adjustments to Children's Developmental Disability (DD) Fee Schedule for Developmental Disability Agencies (DDA's)

For each service listed in Table T-1 below, the reimbursement rate for claims submitted by Developmental Disability Agencies with dates of service on or after July 25, 2020 will be automatically adjusted to the lesser of the claimed amount or the standard rate specified in Table T-1. No further action will be required by the impacted providers.

Table T-1: Impacted Children's Developmental Disability Services Provided by DDA's			
Code	Service Title	Temporary Rate per 15-min Unit	Standard Rate per 15-min Unit
H0004 HN	Behavioral Intervention – Individual – Intervention Specialist	$14.50	$12.91
H0004 HO	Behavioral Intervention – Individual – Intervention Professional	$19.31	$17.80
H0004 TG	Behavioral Intervention – Individual – EBM Intervention Professional	$25.97	$20.59
H2015 HA	Community Based Supports – Individual	$9.58	$7.26
H2015 HQ	Community Based Supports – Group	$3.21	$2.90

Rate Adjustments to Adult Developmental Disability Waiver Fee Schedule

For each service listed in Table T-2 below, the reimbursement rate for claims submitted by Developmental Disability Agencies, Community Supported Employment Agencies, and Adult Day Health Agencies will continue to be paid at the temporary rate specified in Table T-2. For supported employment services, the temporary rate has been adjusted to align with the rate approved by the 2020 Legislature. No further action will be required by the impacted providers.

Table T-2: Impacted Adult Developmental Disability Waiver Services			
Code	Service Title	Temporary Rate per 15-min Unit	Standard Rate per 15-min Unit
97537	Home/Community Individual and/or Group Developmental Therapy for Adults	$4.67	$3.34
H2032	Center Based Individual and/or Group Developmental Therapy for Adults	$4.12	$3.02
H2023	Supported Employment	[$8.61]	$8.61
S5100	Adult Day Health	$2.12	$1.50

Rate Adjustments to Aged and Disabled Waiver Fee Schedule

For each service listed in Table T-3 below, the reimbursement rate for claims submitted by Developmental Disability Agencies, Community Supported Employment Agencies, and Adult Day Health Agencies will continue to be paid at the temporary rate specified in Table T-3. For supported employment services, the temporary rate has been adjusted to align with the rate approved by the 2020 Legislature. No further action will be required by the impacted providers.

Table T-3: Impacted Aged and Disabled Waiver Services			
Code	Service Title	Temporary Rate per 15-min Unit	Standard Rate per 15-min Unit
H2023	Supported Employment	[$8.61]	$8.61
S5100	Adult Day Health	$2.12	$1.50

MW/krw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

July 22, 2020

MEDICAID INFORMATION RELEASE MA20-37

To: Medicaid Providers

From: Matt Wimmer, Administrator

Subject: Safety guidelines for drivers and passengers who use Non-Emergency Medical Transportation (NEMT) during the COVID 19 Pandemic

The Idaho Department of Health and Welfare continues to monitor impacts resulting from the transmission of 2019 Novel Coronavirus (COVID-19). The Non-Emergency Medical Transportation (NEMT) program continues to provide an essential service for Medicaid participants who depend on it for transportation to and from healthcare appointments. People are usually not able to practice social distancing when riding in a vehicle, so it is important to take safety precautions to protect participants and drivers from the risk of contracting coronavirus. The information below explains safety precautions DHW expects everyone to take to help keep people safe and clarifies rights and responsibilities of participants, NEMT drivers and providers who support participants at pick up and destination locations.

Department Expectations for NEMT Providers and Drivers

During the COVID pandemic, DHW expects all NEMT providers and drivers to follow the safety protocols outlined below.

- Wear a mask when participants are in your vehicle.
- Wear a mask when helping a participant to or from your vehicle.
- Thoroughly clean and wipe down the vehicle with a disinfectant after each transport.
- Avoid using the recirculated air for the car's ventilation during passenger transport; use the car's vents to bring in fresh air.
- Require all passengers to wear a mask while using the service. Included with this Information Release is a flyer NEMT providers may print to post in vehicles to communicate expectations for face coverings.
- Drivers have the right to refuse to provide transportation to protect yourself and other passengers if a participant refuses to wear a mask.

  - Notify MTM immediately if you refuse to provide transportation to a member due to safety concerns, so MTM can try to make other transportation arrangements for the participant.
- Drivers are not responsible for providing masks to participants, helping participants with their masks, or reminding them to keep masks in place during transportation, as this could be a distraction for the driver causing a safety risk. Participants who need assistance may have an attendant support them during a transport.
- Whenever possible, call ahead to facilities when you are 5-10 minutes from the site and let them know you are an NEMT provider dropping off a patient who will need to wait inside the building.
- Transport single participants or reduce the number of participants per vehicle whenever possible.
- Consider installing a partition between driver and passengers.
- Continue providing driver education aligned with Idaho Public Health and Center for Disease Control and Prevention (CDC) guidelines.

Member's rights and responsibilities during the COVID-19 Pandemic:

- DHW expects all participants to wear masks or a face covering while using Medicaid transportation services for the safety of everyone in the vehicle.
- Participants have the right to refuse transportation if the driver is not taking safety precautions and to request future transportation is scheduled with a different provider.
- Participants should contact MTM at (877) 503-1261 prior to their scheduled pick up in any of the following situations:
  - They are experiencing symptoms or have tested positive for COVID-19.
  - Their medical appointment has been rescheduled or cancelled due to COVID.
  - They have refused transportation because the driver is not taking safety precautions to prevent the spread of coronavirus.
  - They are at high risk of medical complications from coronavirus and will need special accommodations.
- Participants who are at high risk for contracting coronavirus are encouraged to use the gas mileage reimbursement program instead of riding with a transportation provider to reduce the risk of exposure.
- Participants who need support to travel safely may ride with an attendant. Information about transportation attendant processes can be found at www.mtm-inc.net. Questions should be directed to MTM at (877) 503-1261.

Department Expectations for Providers Who Support Participants at Pick up and Destination Locations

- Please support participants in wearing a face covering to and from healthcare appointments. NEMT drivers are not responsible for providing masks to participants, helping participants with their masks, or reminding them to keep masks in place during transportation, as this could be a distraction for the driver causing a safety risk. Participants who need assistance may have an attendant support them during a

transport. To find out more about the NEMT attendant program, contact MTM at (877)503-1261.

- If your facility is limiting the number of patients and non-patients who enter, please understand that NEMT drivers are not expected to wait outside the facility with the participant This would prevent them from providing scheduled transportation to other participants.

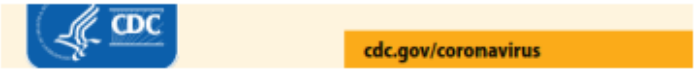
MW/va

The Department of Health and Welfare expects drivers and passengers to wear face coverings.

Thank you for doing your part to promote health and safety!

El Departamento de Salud y Bienestar espera que los conductores y pasajeros usen cubre bocas.

¡Gracias por hacer su parte en promover salud y seguridad!



Provider Training Opportunities in 2020

You are invited to attend the following webinars offered by DXC Technology Regional Provider Relations Consultants.

August: Long Term Care
This training will walk Long Term Care providers through the process of signing up for a trading partner account, viewing prior authorizations, creating patient rosters, verifying eligibility, accessing remittance advice reports, and submitting and reviewing claims.

Training is delivered at the times shown in the table below. Each session is open to any region, but space is limited to 25 participants per session, so please choose the session that works best with your schedule. To register for training, or to learn how to register, visit www.idmedicaid.com.

	August	September	October
	Long Term Care	Certified Family Home	PEA Presentation
10-11:00 AM MT	08/18/2020	09/15/2020	10/15/2020
	08/19/2020	09/16/2020	10/20/2020
	08/20/2020	09/17/2020	10/21/2020
2-3:00 PM MT	08/18/2020	09/09/2020	10/08/2020
	08/20/2020	09/10/2020	10/14/2020
	-	09/15/2020	10/15/2020
	-	09/17/2020	10/20/2020

If you would prefer one-on-one training in your office with your Regional Provider Relations Consultant, please feel free to contact them directly. Provider Relations Consultant contact information can be found on page 32 of this newsletter.

Medical Care Unit Contact and Prior Authorization Information

Prior Authorizations, Forms, and References
To learn about prior authorization (PA) requirements, QIO review, or print request forms, go to the medical service area webpage at www.medunit.dhw.idaho.gov. Prior authorization request forms containing the "fax to" number can be found at www.idmedicaid.com. Select **Forms** under the References section and you will see the PA request forms under the DHW Forms heading. If you prefer to mail in your form, the mailing address is:

Medicaid Medical Care Unit
P.O. Box 83720
Boise, ID 83720-0009

Note: The Medical Care Unit (MCU) does not give authorizations for services over the telephone or for services which do not require a prior authorization.

To Check Prior Authorizations Status
Log on to your Trading Partner Account on www.idmedicaid.com. Choose **Form Entry**, then choose **View Authorizations**. If you are unable to identify the reason for a denied service, a DXC Technology representative can provide the medical reviewer's reason captured in the participant's non-clinical notes. If you are unable to view the authorization status, please review the Trading Partner Account (TPA) User Guide located under **User Guides** on www.idmedicaid.com. To speak to a DXC Technology representative, call 1 (866) 686-4272, option 3.

MCU Medical Review Decisions
If you have any questions about medical review decisions, please refer to the following contact numbers or e-mail MedicalCareUnit@dhw.idaho.gov.

For DMEPOS PA policy, please see the DMEPOS PA Policy and Medical Criteria under the **Resources** tab on the DME page. Please review the DMEPOS PA Policy and Medical Criteria to obtain important information, policy, and guidance relating to requesting PAs for DMEPOS items. This document also includes the medical criteria used by the department in most circumstances related to DMEPOS requests.

	Fax Number	Phone Number
Administratively Necessary Days	1 (877) 314-8779	1 (866) 205-7403
Ambulance*	1 (877) 314-8781	1 (800) 362-7648
Breast & Cervical Cancer	1 (877) 314-8779	1 (866) 205-7403
Durable Medical Equipment	1 (877) 314-8782	1 (866) 205-7403
Hospice	1 (877) 314-8779	1 (866) 205-7403
Preventive Health Assistance	1 (877) 845-3956	1 (866) 205-7403
Service Coordination	1 (877) 314-8779	1 (866) 205-7403
Surgery-Procedure-Lab	1 (877) 314-8779	1 (866) 205-7403
Therapy: OT, PT, SLP	1 (877) 314-8779	1 (866) 205-7403
Vision	1 (877) 314-8779	1 (866) 205-7403

***Idaho Medicaid contracts with Medical Transportation Management (MTM) for all non-emergency medical transportation (NEMT) services. Please go to http://www.mtm-inc.net/idaho/ or call 1 (877) 503-1261 for more information.

DHW Resource and Contact Information

DHW Website	www.healthandwelfare.idaho.gov
Idaho CareLine	2-1-1 1 (800) 926-2588
Medicaid Program Integrity Unit	P.O. Box 83720 Boise, ID 83720-0036 prvfraud@dhw.idaho.gov Fax: 1 (208) 334-2026
Telligen	1 (866) 538-9510 Fax: 1 (866) 539-0365 http://IDMedicaid.Telligen.com
Healthy Connections Regional Health Resource Coordinators	
Region I **Coeur d'Alene**	1 (208) 666-6766 1 (800) 299-6766
Region II **Lewiston**	1 (208) 799-5088 1 (800) 799-5088
Region III **Caldwell**	1 (208) 455-7244 1 (208) 642-7006 1 (800) 494-4133
Region IV **Boise**	1 (208) 334-0717 1 (208) 334-0718 1 (800) 354-2574
Region V **Twin Falls**	1 (208) 736-4793 1 (800) 897-4929
Region VI **Pocatello**	1 (208) 235-2927 1 (800) 284-7857
Region VII **Idaho Falls**	1 (208) 528-5786 1 (800) 919-9945
In Spanish **(en Español)**	1 (800) 378-3385

Insurance Verification

HMS PO Box 2894 Boise, ID 83701	1 (800) 873-5875 1 (208) 375-1132 Fax: 1 (208) 375-1134

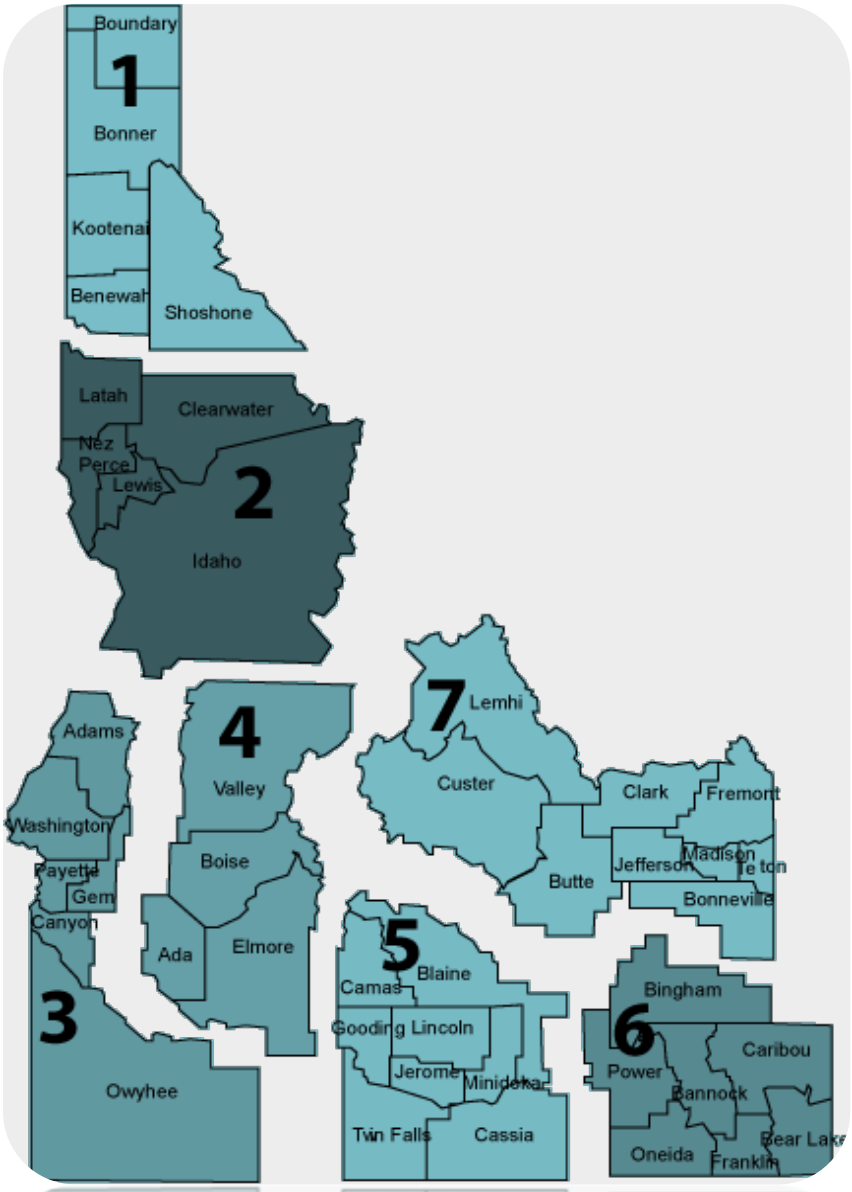
DXC Technology Provider and Participant Services Contact Information

Provider Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4272 1 (208) 373-1424
Provider Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4272 1 (208) 373-1424
E-mail	idproviderservices@molinahealthcare.com idproviderenrollment@molinahealthcare.com
Mail	P.O. Box 70082 Boise, ID 83707
Participant Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4752 1 (208) 373-1432
Participant Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4752 1 (208) 373-1424
E-mail	idparticipantservices@molinahealthcare.com
Mail – Participant Correspondence	P.O. Box 70081 Boise, ID 83707
Medicaid Claims	
Utilization Management/Case Management	P.O. Box 70084 Boise, ID 83707
CMS 1500 Professional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional Crossover/CMS 1500/Third-Party Recovery (TPR)	P.O. Box 70084 Boise, ID 83707
Financial/ADA 2006 Dental	P.O. Box 70087 Boise, ID 83707

DXC Technology Provider Services Fax Numbers

Provider Enrollment	1 (877) 517-2041
Provider and Participant Services	1 (877) 661-0974

Provider Relations Consultant (PRC) Information



Region 1 and the state of Washington
1 (208) 559-4793
Region.1@MolinaHealthCare.com

Region 2 and the state of Montana
1 (208) 991-7138
Region.2@MolinaHealthCare.com

Region 3 and the state of Oregon
1 (208) 860-4682
Region.3@MolinaHealthCare.com

Region 4 and all other states
1 (208) 912-3970
Region.4@MolinaHealthCare.com

Region 5 and the state of Nevada
1 (208) 484-6323
Region.5@MolinaHealthCare.com

Region 6 and the state of Utah
1 (208) 870-3997
Region.6@MolinaHealthCare.com

Region 7 and the state of Wyoming
1 (208) 991-7149
Region.7@MolinaHealthCare.com

DXC Technology
PO Box 70082
Boise, Idaho 83707

IDAHO DEPARTMENT OF HEALTH & WELFARE

Digital Edition

MedicAide is available online by the fifth of each month at www.idmedicaid.com. There may be occasional exceptions to the availability date as a result of special circumstances. The electronic edition reduces costs and provides links to important forms and websites. To request a paper copy, please call 1 (866) 686-4272.

MedicAide **is the monthly informational newsletter for Idaho Medicaid providers.**
Editor: Shannon Tolman

If you have any comments or suggestions, please send them to:
Shannon Tolman,
MedicaidCommunications@dhw.idaho.gov
Medicaid – Communications Team
P.O. Box 83720
Boise, ID 83720-0009
Fax: 1 (208) 364-1811