MedicAide

An Informational Newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **January 2019**

In This Issue

Information Releases

2019 CPT® Coverage Added

The following codes are being added for coverage. Please allow additional time for the system to be updated. Coverage is expected to be active in February.

The appearance of a CPT® on this table or any Medicaid fee schedule are informational only. Because many factors influence payment, inclusion of a CPT® does not guarantee payment. The following CPT® may or may not require prior authorization. Corrections or changes to this list below may still occur based on pending national guidance and NCCI edits, etc. Corrections or changes would be announced at idmedicaid.com.

CPT Code	Long Description	Effective Date
10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)	1/1/2019
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	1/1/2019
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)	1/1/2019
10007	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion	1/1/2019
10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)	1/1/2019
10009	Fine needle aspiration biopsy, including CT guidance; first lesion	1/1/2019
10010	Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)	1/1/2019
10011	Fine needle aspiration biopsy, including MR guidance; first lesion	1/1/2019
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)	1/1/2019
11102	Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion	1/1/2019
11103	Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)	1/1/2019

11104	Punch biopsy of skin (including simple closure, when performed); single lesion	1/1/2019
11105	Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	1/1/2019
11106	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion	1/1/2019
11107	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	1/1/2019
20932	Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)	1/1/2019
20933	Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)	1/1/2019
20934	Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)	1/1/2019
27369	Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography	1/1/2019
33440	Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)	1/1/2019
33866	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)	1/1/2019
36572	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age	1/1/2019
36573	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older	1/1/2019

38531	Biopsy or excision of lymph node(s); open, inguinofemoral node(s)	1/1/2019
43762	Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract	1/1/2019
43763	Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract	1/1/2019
50436	Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed	1/1/2019
50437	Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed; including new access into the renal collecting system	1/1/2019
76391	Magnetic resonance (eg, vibration) elastography	1/1/2019
76981	Ultrasound, elastography; parenchyma (eg, organ)	1/1/2019
76982	Ultrasound, elastography; first target lesion	1/1/2019
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	1/1/2019
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	1/1/2019
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	1/1/2019
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	1/1/2019
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	1/1/2019
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	1/1/2019
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	1/1/2019

81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	1/1/2019
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	1/1/2019
81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	1/1/2019
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation status)	1/1/2019
81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence	1/1/2019
81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant	1/1/2019
81177	ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81178	ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81179	ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81180	ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81181	ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	1/1/2019

81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	1/1/2019
81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (eg, myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81188	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	1/1/2019
81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)	1/1/2019
81204	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status)	1/1/2019
81233	BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, C481S, C481R, C481F)	1/1/2019
81234	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles	1/1/2019
81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence	1/1/2019
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell lymphoma) gene analysis, common variant(s) (eg, codon 646)	1/1/2019
81239	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)	1/1/2019
81271	HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81274	HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)	1/1/2019
81284	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles	1/1/2019
81285	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	1/1/2019
81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence	1/1/2019
81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)	1/1/2019
81305	MYD88 (myeloid differentiation primary response 88) (eg, Waldenstrom's macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant	1/1/2019

81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)	1/1/2019
81312	PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81320	PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, R665W, S707F, L845F)	1/1/2019
81329	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; dosage/deletion analysis (eg, carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed	1/1/2019
81333	TGFBI (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)	1/1/2019
81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence	1/1/2019
81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)	1/1/2019
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81344	TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	1/1/2019
81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver	1/1/2019
82642	Dihydrotestosterone (DHT)	1/1/2019
90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use	1/1/2019
92273	Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)	1/1/2019
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)	1/1/2019
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days	1/1/2019

95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	1/1/2019
95977	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	1/1/2019
95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	1/1/2019
95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2019
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	1/1/2019
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)	1/1/2019

96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	1/1/2019
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	1/1/2019
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	1/1/2019
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	1/1/2019
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	1/1/2019
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	1/1/2019
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	1/1/2019
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	1/1/2019
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	1/1/2019

2019 HCPCS Coverage Added

The following codes are being added for coverage. Please allow additional time for the system to be updated. Coverage is expected to be active in February.

The appearance of a HCPC on this table or any Medicaid fee schedule are informational only. Because many factors influence payment, inclusion of a HCPC does not guarantee payment. The following HCPC may or may not require prior authorization. Corrections or changes to this list below may still occur based on pending national guidance and NCCI edits, etc. Corrections or changes would be announced at idmedicaid.com.

HCPCS Code	Long Description	Effective Date
A4563	Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each	1/1/2019
A5514	For diabetics only, multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each	1/1/2019
A6460	Synthetic resorbable wound dressing, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	1/1/2019
A6461	Synthetic resorbable wound dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	1/1/2019
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	1/1/2019
C9035	Injection, aripiprazole lauroxil (aristada initio), 1 mg	1/1/2019
C9036	Injection, patisiran, 0.1 mg	1/1/2019
C9037	Injection, risperidone (perseris), 0.5 mg	1/1/2019
C9038	Injection, mogamulizumab-kpkc, 1 mg	1/1/2019
C9039	Injection, plazomicin, 5 mg	1/1/2019
C9407	Iodine i-131 iobenguane, diagnostic, 1 millicurie	1/1/2019
C9408	Iodine i-131 iobenguane, therapeutic, 1 millicurie	1/1/2019
E0447	Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (lpm)	1/1/2019
E0467	Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions	1/1/2019
J0185	Injection, aprepitant, 1 mg	1/1/2019
J0517	Injection, benralizumab, 1 mg	1/1/2019
J0567	Injection, cerliponase alfa, 1 mg	1/1/2019
J0584	Injection, burosumab-twza 1 mg	1/1/2019
J0599	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	1/1/2019

J0841	Injection, crotalidae immune f(ab')2 (equine), 120 mg	1/1/2019
J1301	Injection, edaravone, 1 mg	1/1/2019
J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	1/1/2019
J1628	Injection, guselkumab, 1 mg	1/1/2019
J1746	Injection, ibalizumab-uiyk, 10 mg	1/1/2019
J2062	Loxapine for inhalation, 1 mg	1/1/2019
J2797	Injection, rolapitant, 0.5 mg	1/1/2019
J3245	Injection, tildrakizumab, 1 mg	1/1/2019
J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	1/1/2019
J3316	Injection, triptorelin, extended-release, 3.75 mg	1/1/2019
J3397	Injection, vestronidase alfa-vjbk, 1 mg	1/1/2019
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	1/1/2019
J3591	Unclassified drug or biological used for esrd on dialysis	1/1/2019
J7170	Injection, emicizumab-kxwh, 0.5 mg	1/1/2019
J7177	Injection, human fibrinogen concentrate (fibryga), 1 mg	1/1/2019
J7203	Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu	1/1/2019
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	1/1/2019
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	1/1/2019
J9044	Injection, bortezomib, not otherwise specified, 0.1 mg	1/1/2019
J9057	Injection, copanlisib, 1 mg	1/1/2019
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	1/1/2019
J9173	Injection, durvalumab, 10 mg	1/1/2019
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	1/1/2019
J9311	Injection, rituximab 10 mg and hyaluronidase	1/1/2019
J9312	Injection, rituximab, 10 mg	1/1/2019
L8608	Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system	1/1/2019
L8698	Miscellaneous component, supply or accessory for use with total artificial heart system	1/1/2019
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	1/1/2019
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	1/1/2019
Q5107	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg	1/1/2019
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	1/1/2019
V5171	Hearing aid, contralateral routing device, monaural, in the ear (ite)	1/1/2019
V5172	Hearing aid, contralateral routing device, monaural, in the canal (itc)	1/1/2019

V5181	Hearing aid, contralateral routing device, monaural, behind the ear (bte)	1/1/2019
V5211	Hearing aid, contralateral routing system, binaural, ite/ite	1/1/2019
V5212	Hearing aid, contralateral routing system, binaural, ite/itc	1/1/2019
V5213	Hearing aid, contralateral routing system, binaural, ite/bte	1/1/2019
V5214	Hearing aid, contralateral routing system, binaural, itc/itc	1/1/2019
V5215	Hearing aid, contralateral routing system, binaural, itc/bte	1/1/2019
V5221	Hearing aid, contralateral routing system, binaural, bte/bte	1/1/2019

2019 Evaluation and Management (E&M) Documentation Updates

Most Idaho Medicaid Providers of medical/surgical services also participate in Medicare, and all Medicaid providers submitting claims for **Evaluation and Management (E&M) services must conform to CMS 1995 or 1997 E&M documentation guidelines.** New documentation guidance for 2019 has been issued in the CMS Final Rule, Physician Fee Schedule for calendar year 2019.

Idaho Medicaid has unique payment methodologies and not all changes in the Medicare Physician Fee Schedule final rule affect Medicaid. Idaho Medicaid also has unique programs such as preventive care, telehealth, coordinated care and diabetes education programs which do not match Medicare and are not changed with the 2019 final rule.

However, providers who render services for an Idaho Medicaid benefit which is a benefit shared by Medicare, should be familiar with CMS and Medicare policy, regulation, diagnostic and clinical criteria for services which include, but are not limited to, visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. This includes the variety of medical/surgical practitioners and entities, such as nurse practitioners, physician assistants, certified nurse midwives, and therapy providers, as well as radiation therapy centers and independent diagnostic testing facilities.

Following are excerpts from a few recent CMS educational publications regarding 2019 updates to E&M documentation requirements. Additionally, below is a link to the current CMS Medicare Learning Network (MLN) guidance for E&M services.

CMS Finalizes Changes to Advance Innovation, Restore Focus on Patients, Press Release
https://www.cms.gov/newsroom/press-releases/cms-finalizes-changes-advance-innovation-restore-focus-patients

> Nov 01, 2018
> ...Coding requirements for physician services known as “evaluation and management” (E&M) visits have not been updated in 20 years. This final rule addresses longstanding issues and also responds to concerns raised by commenters on the proposed rule. CMS is finalizing several burden-reduction proposals immediately (effective January 1, 2019),

where commenters provided overwhelming support. In response to concerns raised on the proposal, the final rule includes revisions that preserve access to care for complex patients, equalize certain payments for primary and specialty care, and allow for continued stakeholder engagement by delaying implementation of E&M coding reforms until 2021…

Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019, Fact Sheet
https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year

Nov 01, 2018

… **Streamlining Evaluation and Management Payment and Reducing Clinician Burden**

CMS is finalizing a number of documentation, coding, and payment changes to reduce administrative burden and improve payment accuracy for office/outpatient evaluation and management (E/M) visits over several years. For CYs 2019 and 2020, we are implementing several documentation policies to provide immediate burden reduction, while other changes to documentation, coding, and payment would be implemented in CY 2021.

For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. For CY 2019 and beyond, CMS is finalizing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;
- Additionally, we are clarifying that for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information; and
- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

Beginning in CY 2021, CMS will further reduce burden with the implementation of payment, coding, and other documentation changes. Payment for E/M office/outpatient

visits will be simplified and payment would vary primarily based on attributes that do not require separate, complex documentation…

CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary. CMS intends to engage in further discussions with the public to potentially further refine the policies for CY 2021.

After consideration of concerns raised by commenters in response to the proposed rule, CMS is not finalizing aspects of the proposal that would have: (1) reduced payment when E/M office/outpatient visits are furnished on the same day as procedures, (2) established separate coding and payment for podiatric E/M visits, or (3) standardized the allocation of practice expense RVUs for the codes that describe these services…

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/E-M-Visit-FAQs-PFS.pdf
Released, November 26, 2018

Evaluation and Management (E/M) Visit Frequently Asked Questions (FAQs) Physician Fee Schedule (PFS)

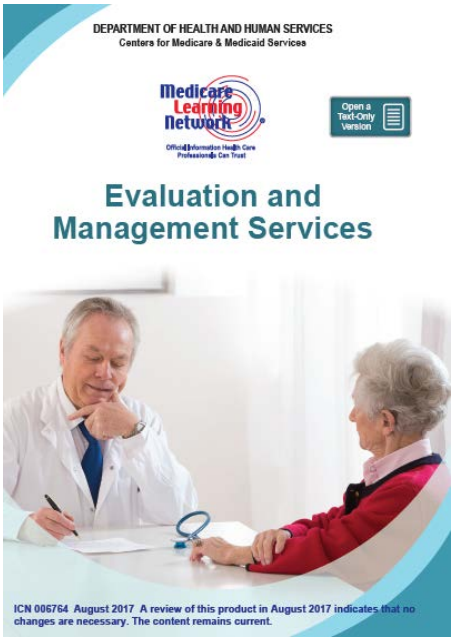
This document addresses Frequently Asked Questions (FAQs) regarding documentation and payment for evaluation and management (E/M) visits under the Medicare Physician Fee Schedule (PFS).

1. What parts of the history can be documented by ancillary staff or the beneficiary starting in CY 2019?

The CY 2019 PFS final rule expanded current policy for office/outpatient E/M visits starting January 1, 2019 to provide that any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the beneficiary does not need to be re-documented by the billing practitioner. Instead, when the information is already documented, the billing practitioner can review the information, update or supplement it as necessary, and indicate in the medical record that she or she has done so. This is an optional approach for the billing practitioner, and applies to the chief complaint (CC) and any other part of the history (History of Present Illness (HPI), Past Family Social History (PFSH), or Review of Systems (ROS)) for new and established office/outpatient E/M visits. To clarify terminology, we are using the term “history” broadly in the same way that the 1995 and 1997 E/M documentation guidelines use this term in describing the CC, ROS and PFSH as “components of history that can be listed separately or included in the description of HPI.” This policy does not address (and we believe never has addressed) who can independently take/perform histories or what part(s) of history they can take, but rather addresses who can document information included in a history and what supplemental documentation should be provided by the billing practitioner if someone else has already recorded the information in the medical record.

MLN Evaluation and Management Services

ICN 006764 August 2017 A review of this product in August 2017 indicates that no changes are necessary. The content remains current.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf



PREFACE
This guide is offered as a reference tool and does not replace content found in the 1995 Documentation Guidelines for Evaluation and Management Services and the 1997 Documentation Guidelines for Evaluation and Management Services. These publications are available in the Reference Section and at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

Note: For billing Medicare, you may use either version of the documentation guidelines for a patient encounter, not a combination of the two. For reporting services furnished on and after September 10, 2013, to Medicare, you may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 documentation guidelines to document an evaluation and management service.

TABLE OF CONTENTS

MEDICAL RECORD DOCUMENTATION
Learn about the general principles of evaluation and management (E/M) documentation, common sets of codes used to bill for E/M services, and E/M services providers.

GENERAL PRINCIPLES OF E/M DOCUMENTATION
If it is not documented, it has not been done…

Attention Therapy Providers – Group Therapy

IDAPA 16.03.09.732.03.g, "Idaho Medicaid Basic Plan Benefits" excludes group therapy except for school-based services and the infant toddler program (ITP). ITP no longer provides this service due to changes in their contract effective 7/01/18. Therefore, only school-based services are currently allowed to provide group therapy. Providers outside of school-based services will not be reimbursed for these services. Providers submitting claims for group therapy services under general therapy codes to circumvent system edits are committing fraud. If ineligible providers have previously billed Medicaid they are subject to recoupment. See your therapy provider handbook for additional information on allowed services.

Attention DME Suppliers: Oxygen Claim Reprocessing

In the March 2018 edition of the MedicAide newsletter Idaho Medicaid announced changes to coverage beginning July 1, 2018 for oxygen services to align more with Medicare. The DXC Technology claim processing system has been updated to enforce some of these requirements. Claims will be reprocessed in the following months. Providers may reprocess their own claims if they have a concern about an overpayment.

As a reminder Idaho Medicaid pays for medically necessary liquid or gas oxygen, or an oxygen concentrator with an all-inclusive monthly rate found on the Medicaid Fee Schedule. This rate includes the rental of the delivery system, its contents, maintenance, repair, and any necessary supplies. Separate payments may be made for both stationary and portable systems when medically necessary. Suppliers may bill equipment for the first 36 months, and then the contents afterwards. The CMN and laboratory evidence must be kept on file and will remain in effect for one year from the date the test was taken, unless a lifetime need is indicated. Oxygen services, requirements and documentation are the same as DME MAC local coverage determination (LCD) except:

- Clinical trials are not covered.
- Oxygen services for cluster headaches require a prior authorization. Criteria may be found in the Idaho Medicaid DMEPOS PA Policy and Medical Criteria.
- The most recently completed Certificate of Medical Necessity CMS-484_Oxygen (CMN) signed by the physician must be attached to each claim.
- Medicaid does not accept Oxygen, "PRN," or "As-needed" prescriptions.

- If a participant is on both stationary and portable oxygen, the RUL will be calculated separately.
- Children under the age of 6 months don't require laboratory tests.
- The laboratory evidence justifying the use of oxygen must be included with the first claim for oxygen therapy for the participant.
- All claims submitted electronically must include the oxygen information on each transaction.
- In the event of theft or damage beyond repair, a prior authorization will be required to receive new equipment.
- If the participant owns a stationary or portable oxygen delivery system Medicaid will pay the monthly all-inclusive rate for the compressed gas or liquid contents.
- Supplies are only separately payable for oxygen concentrators, and only if the participant owns the equipment.

Providers should bill the following modifiers on claims for oxygen supplied through stationary equipment:

Modifier	Description	Reimbursement
QE	Prescribed amount of oxygen is less than 1 liter per minute (LPM)	Paid at 50%.
QF	Prescribed amount of oxygen is greater than 4 liters per minute (LPM) and portable oxygen is prescribed	Paid at 150%.
QG	Prescribed amount of oxygen is greater than 4 liters per minute (LPM)	Paid at 150%.

Please see the Suppliers section of the Idaho Medicaid Provider Handbook for more information.

Attention Therapy Providers: Duplicate Therapy Definition

Since 2008, IDAPA 16.03.09.732.03.f has prohibited duplicate services for occupational, physical and speech therapies. Therapy services are considered duplicative when participants receive any combination of physical therapy, occupational therapy, or speech-language pathology services that have the same treatments, interventions, evaluations, treatment plans, or goals. In addition, more than one type of therapy cannot be provided during the same session.

All services are subject to medical necessity. It is important to remember that visits made more than once daily per therapy type are generally not considered medically necessary. A noted exception is feeding therapy and speech-language therapy, which may be rendered in the same day if the services are not otherwise duplicative.

Therapy providers are also reminded that group therapy is specifically excluded in accordance with IDAPA 16.03.09.0732.03g , except for school-based services. Group therapy services provided through the schools are not coverable under our telehealth policy. See the October 2018 edition of the MedicAide for more information on group therapy or the therapy provider handbook for additional information on allowed services.

Adult Participants Accessing Developmental Disability (DD) Services Enrolled in Medicare—Medicaid Coordinated Plan (MMCP)—Traditional and Self-Directed Options

Traditional Option

Effective January 1, 2019, Developmental Disability (DD) Service Coordination (SC), Plan Development (PD) and DD Crisis Assistance services for adult participants accessing traditional DD services will no longer be a MMCP benefit but will be a fee for service benefit through Idaho Medicaid. Currently, Blue Cross of Idaho and Molina Healthcare are responsible for reimbursing Service Coordination Agencies for SC, PD and DD Crisis Assistance services provided to adult participants accessing traditional DD services who are enrolled in MMCP.

Beginning January 1, 2019, all DD State Plan Option and DD Waiver services will be carved out of the MMCP. Therefore, PD, SC and DD Crisis Assistance services must be requested and prior authorized through a DD ISP, Addendum or Crisis Assistance request form.

The Individual Support Plan (ISP) Supports and Services Authorization Worksheet, ISP Signature Page and the ISP Addendum have been updated to reflect this change. These updated documents:

- No longer require a PD to mark the MMCP box to identify a participant is accessing MMCP; and
- Do not require the PD to identify in the DD Service Coordination Services section (ISP Supports and Services Authorization Worksheet only) whether a participant is MMCP or Non—MMCP; and
- No longer require a PD to obtain the signature of an ICT Care Coordinator on the ISP Signature Page and ISP Addendum.

The updated ISP Supports and Services Authorization Worksheet, ISP Signature Page and ISP Addendum are now available on the Adult DD Care Management webpage at https://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/AdultDDInformationforProviders/tabid/2310/Default.aspx under Plan Developer/Service Coordinator Information & Forms. Effective January 1, 2019, any plans or addendums must be submitted using the updated forms. Plans or addendums submitted after January 1, 2019 that do not include the updated forms will be returned to the Plan Developer.

An addendum will not be required to request prior authorization for service coordination or plan development services for plans already approved for MMCP participants. The Department will create prior authorizations for service coordination services, as approved on the participant's current plan, to allow service coordination services to be billed as fee for service through Idaho Medicaid from January 1, 2019, forward. For plans already submitted with a start date of January 1, 2019, forward, service coordination services will be prior authorized as fee for service.
Plan Development Authorization Coversheets for plan development services that are anticipated to be provided January 1, 2019, or later should be submitted to the Department at the following:

<u>To request plan development units</u>, please submit all *Plan Development Authorization Coversheets* to the email address that corresponds with the participant's last name. The alphabet has been divided as follows:

A – Gon	BDDSR1CMDocs@dhw.idaho.gov Questions? Phone: 208-769-1567 option #2
Goo – Oh	BDDSR4CMDocs@dhw.idaho.gov Questions: Phone: 208-334-0940 option #3
Oi – Z	BDDSR5CMDocs@dhw.idaho.gov Questions? Phone: 208-736-3024 option #2

Service Coordination Agencies must seek reimbursement from the applicable MMCP provider for any plan development, service coordination or crisis assistance services provided to an adult DD participant prior to January 1, 2019.

Self-Directed Option

For adults who access services through the Self-Directed Service Option, the Support Broker is no longer required to obtain the signature of an ICT Care Coordinator on the Support and Spending Plan Signature Page or on the Support and Spending Plan Change form after January 1st, 2019. Thank you for your participation in the Medicaid program.

DMEPOS Suppliers and Medical/Surgical Providers Who Order, Certify or Prescribe Items/Services for Medicaid Participants

The Idaho Regional Medicare website for Medicare Pricing, Data Analysis and Coding (PDAC) is operated by Noridian Medicare. All Medicaid suppliers and Medicaid billing providers and ORP providers who order, certify or prescribe DMEPOS items or services must confirm correct coding per the Noridian PDAC site. It is fraudulent billing to submit a claim using an invalid CPT®/HCPCS, or unlisted, miscellaneous CPT® or HCPCS billing code, when a more specific code exists, even if that correct code is not payable/covered by Idaho Medicaid. Unlisted and miscellaneous codes are generally used to report an unusual service or item that may be experimental or investigational which are and not a covered benefit by Idaho Medicaid.
Per the Noridian Medicare PDAC Home Page, https://www.dmepdac.com/:

> **Noridian Healthcare Solutions, LLC** has served as the Pricing, Data Analysis and Coding (PDAC) Contractor since August 2008. The PDAC performs the following activities:
>
> - Receives, evaluates and processes coding verification applications for DMEPOS
> - Establishes, maintains and updates all coding verification decisions on the Product Classification List that is available on DMECS
> - Provides coding guidance for manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS)
> - Maintains and publishes the NDC/HCPCS Crosswalk and OACD pricing files
> - Conducts DMEPOS data analysis

The left column of the PDAC site includes the menu of the topics below:

- Search DMECS for codes and fees
- DME coding system (DMECS) Information
- Code verification
- Articles/Publications
- NDC/HCPCS crosswalk
- Oral Anti-Cancer Drug (OACD)
- Reports
- Applications and Forms
- Related websites

Noridian DMEPOS advisory articles are available to help confirm Medicare and Noridian coverage and correct coding guidance. As a sample of this important resource, articles are listed below from mid-December 2018, back to January 1, 2018. Supplier and provider claims may be subject to pre-payment and/or post-payment review in accordance with the Medicare DMEPOS benefit requirements and Noridian guidance:

Articles/Publications

Advisory Articles - View articles, by published date, written jointly by PDAC and the DME MAC Medical Directors. These provide additional, clarifying information related to coding of DMEPOS. It is advised to review any Local Coverage Determinations (LCDs) and Policy Articles that may be related to the Advisory Article topic as well.

ADVISORY ARTICLES

PDAC Articles 08/16/2008 to Current.

Title	Date Posted
Topical Oxygen Therapy Used for Wound Care – an Update	10/18/18
Correct Coding - Porta-Lung Negative Pressure Ventilator - Revised	08/20/18
Correct Coding - A9286 - Hygienic Item or Device, Disposable or Non-disposable, Any Type, Each	08/20/18
Correct Coding - Q9994 (IN-LINE CARTRIDGE CONTAINING DIGESTIVE ENZYME(S) FOR ENTERAL FEEDING, EACH) Coverage Indicator Changed	07/27/18
Continuous Glucose Monitors - Use of Smart Devices	07/18/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Battery Charger	07/18/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for a Drive Wheel Gear Box	07/18/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for a Wheelchair Headrest	07/18/18
Correct Coding - Replacement Cecostomy Tube	07/18/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Replacement of Wheelchair Seat and Back Upholstery	07/18/18

Title	Date Posted
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Battery Replacement	07/18/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Wheelchair Tray	07/18/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Wheelchair Ventilator Tray	07/18/18
Correct Coding - Custom Fabricated Wheelchair Seat and Back Cushions	03/27/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for a Privacy Flap	03/27/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for a Wheel Lock Brake Extension for Manual Wheelchairs	03/27/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for an Actuator	03/27/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Transit System and Associated Bracket	03/27/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Anti-Tip Devices for Manual Wheelchairs	03/27/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Front Riggings: Calf Pad or Calf Support	03/27/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Labor Charges	03/27/18
Correct Coding - Incorrect Use of HCPCS Code K0108 To Bill for Front Riggings: Shoe Holder or Shoe Holder Replacement Straps	03/27/18
Correct Coding - Warranty, Reasonable Useful Lifetime (RUL), and the Minimum Lifetime Requirement (MLR) for Durable Medical Equipment	02/15/18
Correct Coding - Inserts Used with Therapeutic Shoes for Persons with Diabetes (A5512, A5513, K0903)	02/05/18

DMEPOS Suppliers and Ordering, Prescribing Physician and Non-Physician Practitioners, Written Order Prior To Delivery (WOPD) Requirements, and Order/Prescription Maximum Duration of One Year

Idaho Medicaid continues to follow Medicare/Noridian guidance regarding orders or prescriptions for DMEPOS services or items, including requirement for a **written order prior to delivery (WOPD)**.

Per Medicare guidance, certain specified covered items of DME require a written order prior to delivery (WOPD) of the item. Current lists of the certain specific items are maintained on-line by CMSs Medicare and Noridian Medicare Part D. Claims submitted to Idaho Medicaid must meet all

required documentation and other policy and guidance for the date the service was rendered or dispensed.

Someone other than the prescribing physician/non-physician practitioner (NPP) may complete the WOPD of the item unless statute, manual instructions, Medicaid policy, or Noridian LCD or policy articles specify otherwise. However, the WOPD must be both signed and dated by the prescribing physician/NPP before the item is dispensed. The supplier must have received the WOPD before dispensing the item. The date of the written order shall be on or before the date of delivery. **The DMEPOS supplier shall have on file the completed written order prior to the delivery of these items.**

There are two multi-element-specific WOPD:

- 42 CFR 410.38(c), requires Power Mobility Devices (PMDs) require a 7 Element Order (7EO). A separate Detailed Product Description (DPD) is also required for any associated options and accessories.
- 42 CFR 410.38(g), requires certain specified covered items of DME require a written order prior to delivery of the item (5 Element Order or 5EO).

For any medical/surgical service or item to be covered and payable by Idaho Medicaid, it must 1) be eligible for an Idaho Medicaid benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable federal and state statutory and regulatory requirements. The criteria "reasonable and necessary" is based on Social Security Act §1862(a)(1)(A) provisions.

National healthcare industry standards limit duration of a physician/NPP order or prescription to a maximum of one calendar year. Many orders and prescriptions require a physician/NPP indication of duration, frequency, description of service or item, and appropriate diagnosis as proof of medical necessity. **Any service or item requiring an order or prescription must not be dispensed beyond one-year duration unless a specific national exemption applies (ex. oxygen orders per Medicare guidance). To be medically necessary and eligible for reimbursement, orders and prescriptions MUST be renewed within one calendar year.**

Face to Face and Written Order Prior To Delivery (WOPD) Requirements

42 CFR 410.38(g) contains provisions that are applicable to certain specified DMEPOS items. CMS provides a list of the specified items, which is periodically updated, and located on the CMS website.

These items require an in-person**, face-to-face interaction between the beneficiary and their treating physician/practitioner prior to prescribing the item**.

As a condition for payment, 42 CFR 410.38(g) requires that a treating physician/practitioner has had a **face-to-face examination with a beneficiary within the six (6) months prior to the written order for certain items of DME.**

A written order prior to delivery (**WOPD**) is required for certain durable medical equipment items. The date of the written order must not be prior to the date of the face-to-face encounter. Below are three informative links to Noridian Medicare Part D as of 12/14/18.

https://med.noridianmedicare.com/web/jddme/topics/affordable-care-act-face-to-face-and-detailed-written-order

ACA: Face-to-Face and Detailed Written Order

42 CFR 410.38(g) contains provisions that are applicable to certain specified DMEPOS items. CMS provides a list of the specified items, which is periodically updated, and located on the CMS website.

These items require an in-person, face-to-face interaction between the beneficiary and their treating physician/practitioner prior to prescribing the item. This face-to-face requirement includes examinations conducted via the CMS-approved use of telehealth examinations (as described in the CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 and CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 12).

This face-to-face evaluation must specifically document that the beneficiary was evaluated and/or treated for a condition that supports the need for the DME item(s) ordered. A dispensing order is not sufficient to provide these items. A 5EO must be received prior to delivery. Refer to the applicable LCD-related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about these statutory requirements.

Documentation Types

- ACA Face-to-Face - A practitioner (MD, DO, DPM, PA, NP, CNS) has had a F2F examination with a beneficiary within the six (6) months prior to the written order for certain DME items.
- ACA 5EO - For some items to be covered by Medicare, a written order is required to be in the supplier's file prior to delivery of the specified item(s).

ACA Items

This list is subject to CMS annual review and may change as necessary.

HCPCS Code	Description
E0185	Gel or gel-like pressure mattress pad
E0188	Synthetic sheepskin pad
E0189	Lamb's wool sheepskin pad
E0194	Air fluidized bed
E0197	Air pressure pad for mattress standard length and width

(Above list continued at Noridian Medicare Part D…)

Last Updated Oct 22, 2018

https://med.noridianmedicare.com/web/jddme/search-result/-/view/2230703/aca-section-6407-face-to-face-examinations

ACA: Section 6407 Face-to-Face Examinations

As a condition for payment, 42 CFR 410.38(g) requires that a treating physician/practitioner has had a **face-to-face examination with a beneficiary within the six (6) months prior to the written order for certain items of DME.**

For the treating physician/practitioner prescribing a specified DME item:

- Face-to-face examination with beneficiary must be conducted within the six (6) months prior to date of prescription
- Face-to-face examination must document that beneficiary was evaluated and/or treated for a condition that supports need for DME item(s) ordered

All other Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that all other applicable coverage criteria are met. Refer to the applicable Local Coverage Determination (LCD) for information about the medical necessity criteria for the item(s) being ordered.

The treating physician/practitioner that conducted the face-to-face examination is not required to be the prescriber for the DME item; however, the prescriber must:

- Verify that the qualifying in-person visit occurred within the 6-months prior to date of prescription; and,
- Have documentation of qualifying face-to-face examination that was conducted

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered.

Upon request by a contractor, all DMEPOS suppliers must provide documentation of the face-to-face examination.

Resources

- CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15
- CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 12

Last Updated Oct 26, 2018

https://med.noridianmedicare.com/documents/2230703/16619307/Clinician+Checklist+Face-to-Face

Noridian Healthcare Solutions, Clinician Checklist, Face-to-Face Evaluation
Documentation References: Standard Documentation Requirements Policy Article (PA) A55426

A face-to-face examination (FTF) for a condition that supports the need for the item must be conducted within six (6) months prior to writing the order.

Documentation of FTF needs to include;

Date of the visit

Beneficiary (*participant*) Name

The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

The face-to-face encounter must be documented in the pertinent portion of the medical record (e.g. history, physical examination, diagnostic tests, summary of findings, diagnoses, treatment plan)

Signature of provider

A FTF is needed for the following reasons;

For an initial prescription of the DME item

When there is a change in the prescription for an accessory, etc.

When an item is replaced

When there is a change in the supplier

https://med.noridianmedicare.com/documents/2230703/16619307/Clinician+Checklist+Orders

Noridian Healthcare Solutions, Clinician Checklist, Orders
Documentation References: Standard Documentation Requirements Policy Article (PA) A55426

Dispensing Order – can be called or faxed into the supplier and must contain:
Description of the item
Prescribing clinician's name
Beneficiary's (*participant's*) name
Date of the order
Prescribing clinician's signature (if a written order)

Detailed Written Order (DWO) – required for all separately billable items or accessories. If the DWO is completed by someone other than the prescribing clinician, the prescribing clinician must review the content and sign and date the DWO which must contain:

Beneficiary's (*participant's*) name
Date of the order
Prescribing clinician's signature

For supplies:
List all supplies that are separately billable and for each include:
The frequency of use (if applicable)
The quantity dispensed

For drugs:

Beneficiary's (*participant's*) name
Dosage or concentration (if applicable)
Frequency of administration (if applicable)
Duration of infusion (if applicable)
Quantity to be dispensed
Number of refills

All items, options or additional features that are separately billed or require an upgraded code - The description of items can be either a narrative description (e.g. nasal mask), a HCPCS code, a HCPCS code narrative, or a brand name/model number.

5 Element Order (5EO)

Beneficiary's (*participant's*) name
Signature of the prescribing practitioner
Date of the order
Prescribing practitioner's National Practitioner Identifier (NPI)
Item of DME ordered – *The description can be either a narrative description (e.g. manual wheelchair), a HCPCS code, a HCPCS code narrative, or a brand name/model number.*

Federal Sterilization Consent Form, HHS-687

Providers who perform any elective sterilization procedure must submit to Medicaid a federally compliant sterilization consent form meeting all requirements per 42 CFR 441.258. Some providers may be using the federal HHS-687 form which displays an expiration date of 12/31/18. This form will continue to meet all current requirements even if signed after 12/31/18 or submitted for dates of service after 12/31/18, until a new federal consent form is published. Available at idmedicaid.com, is interactive sterilization consent form HW0034, which has no displayed expiration date.

See the *Idaho Medicaid Provider Handbook Physician and Non-Physician Practitioner, November 1, 2018* pages 30 to 32 of 47, for additional information about sterilization services. Per page 30 of 47*:*

2.5.10 Sterilization Procedures

Sterilizations (tubal ligations/vasectomies) do not require prior authorization from the Department or QIO; however, participant consent must be obtained with strict adherence to federal regulations. Claims will be denied if consent is not documented correctly. Providers may not bill the participant for errors related to completing the form.

An interactive sterilization consent form can be downloaded from the DXC Technology Medicaid website. The form is available in English (HW0034) and Spanish (HW0034S). Three copies are needed – one for the patient, one for the physician, and one is required to be attached to the claim. Although this form is not required to be used, any form that is submitted must have at a minimum all of the same information as the HW0034/HW0034S forms.

Sterilization claims must include the consent form and the ICD-10-CM code Z30.2

Provider Responsibilities for the Prevention of Waste, Fraud and Abuse

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

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

Compliance with these laws is a condition of payment. Failure to comply will result in termination of your provider contract, and potential recoupment and penalties.

Providers of Medical, Surgical, and DMEPOS, Medicaid Does Not Pay for Services Rendered or Performed by Spouses and Legally Responsible Parents of Minors

Federal regulations exclude from payment Medicaid covered services or items imposed by/rendered by/performed by an immediate relative or member of a participant's household.

Medicare and Medicaid federal rule, as defined in 42 CFR 440.167 and 42 CFR 411.12 (current text is cited at the end of this article and the reference to Medicare is inclusive of Medicaid), bars billing of Medicare or Medicaid for services rendered by a parent, immediate relative or member of a participant's household.

Federal policies governing the management and spending of federal healthcare dollars prohibit paying spouses or parents of minor children for personal care services. The basis of this prohibition is that Medicaid payments may not be made for services or resources that are already available to a person without charge. Additionally, a Medicaid provider's responsibility is to care only for the Medicaid patient; whereas, parental responsibility is to care for their child's needs and other members of the household.

Idaho Medicaid policy is based on the federal CFR and accepted national standards of ethical medical practice, and national standards of reimbursable services by third party payors of healthcare. While reimbursing a parent for services such as private duty nursing may not specifically prevented by statute, the State is not obligated to reimburse for services rendered to minor children by their parents.

The American Medical Association (AMA) guidelines, Code of Medical Ethics Opinion 1.2.1 states, "In general, physicians should not treat themselves or members of their own families…Treating oneself or a member of one's own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

Idaho Medicaid recommends providers refer to Medicare guidance such as included below which further describes the federal prohibition on payment for covered services or items when imposed by/rendered by/performed by an immediate relative or member of a participant's household.

Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage (Rev. 198, 11-06-14)
130 - Charges Imposed by Immediate Relatives of the Patient or Members of the Patient's Household
(Rev. 1, 10-01-03):

A. General

These are expenses that constitute charges by immediate relatives of the beneficiary or by members of their household. The intent of this exclusion is to bar Medicare payment for items and services that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. This exclusion applies to items and services rendered by providers to immediate relatives of the owner(s) of the provider. It also applies to services rendered by physicians to their immediate relatives and items furnished by suppliers to immediate relatives of the owner(s) of the supplier.

B. Immediate Relative

The following degrees of relationship are included within the definition of immediate relative.

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties. For example, if a provider treats the stepfather of the owner after the death of the owner's natural mother or after the owner's stepfather and natural mother are divorced, or if the provider treats the owner's father-in-law or mother-in-law after the death of their spouse, the services are considered to have been furnished to an immediate relative, and therefore, are excluded from coverage.

C. Members of Patient's Household

These are persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

D. Charges for Provider Services

Payment is not made under Part A or Part B for items and services furnished by providers to immediate relatives of the owner(s) of the providers. This exclusion applies whether the provider is a sole proprietor who has an excluded relationship to the patient, or a partnership in which even one of the partners is related to the patient.

E. Charges for Physician and Physician-Related Services

This exclusion applies to physician services, including services of a physician who belongs to a professional corporation, and services furnished incident to those services (for example, by the physician's nurse or technician) if the physician who furnished the services or who ordered or supervised services incident to their services has an excluded relationship to the beneficiary.

Professional corporation means a corporation that is completely owed by one or more physicians, and is operated for the purpose of conducting the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by State law. Any physician or group of physicians which is incorporated constitutes a professional corporation. (Generally, physicians who are incorporated identify themselves by adding letters such as P.C. or P.A. after their title.)

F. Charges for Items Furnished by Nonphysician Suppliers

This exclusion applies to charges imposed by a nonphysician supplier that is not incorporated, whether the supplier is owned by a sole proprietor who has an excluded relationship to the patient, or by a partnership in which even one of the partners is related. It does not apply to charges imposed by a corporation (other than a professional corporation), regardless of the patient's relationship to any of the stockholders, officers, or directors of the corporation or to the person who furnished the service.

42 CFR 411.12 Charges imposed by an immediate relative or member of the beneficiary's household.

(a) Basic rule. Medicare does not pay for services usually covered under Medicare if the charges for those services are imposed by -

(1) An immediate relative of the beneficiary; or

(2) A member of the beneficiary's household.

(b) Definitions. As used in this section -

Immediate relative means any of the following:

(1) Husband or wife.

(2) Natural or adoptive parent, child, or sibling.

(3) Stepparent, stepchild, stepbrother, or stepsister.

(4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.

(5) Grandparent or grandchild.

(6) Spouse of grandparent or grandchild.

Member of the household means any person sharing a common abode as part of a single family unit, including domestic employees and others who live together as part of a family unit, but not including a mere roomer or boarder.

Professional corporation means a corporation that is completely owned by one or more physicians and is operated for the purpose of conducting the practice of medicine, osteopathy dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by State law.

(c) Applicability of the exclusion. The exclusion applies to the following charges in the specified circumstances:

(1) Physicians' services.

(i) Charges for physicians' services furnished by an immediate relative of the beneficiary or member of the beneficiary's household, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation.

(ii) Charges for services furnished incident to a physician's professional services (for example by the physician's nurse or technician), only if the physician who ordered or supervised the services has an excluded relationship to the beneficiary.

(2) Services other than physicians' services.

(i) Charges imposed by an individually owned provider or supplier if the owner has an excluded relationship to the beneficiary; and

(ii) Charges imposed by a partnership if any of the partners has an excluded relationship to the beneficiary.

(d) Exception to the exclusion. The exclusion does not apply to charges imposed by a corporation other than a professional corporation.

Physician Supervision of Medical and Surgical Services, Levels of Supervision per the Centers for Medicare & Medicaid Services

CMS rules continue that **only fully licensed physicians/NPP may supervise diagnostic tests.**

CMS has three general levels of physician supervision. General, Direct, and Personal supervision. Each provider type submitting claims to Idaho Medicaid must be in compliance with CMS regulations and guidance for their provider type and specialty, when Idaho Medicaid has not given Idaho specific direction in sources which include but not limited to: the Department of Health and Welfare (DHW) web site and Fee Schedules (healthandwelfare.idaho.gov), the provider claim submission site idmedicaid.com, the Idaho Medicaid Provider Handbooks, the MedicAide newsletter archives, and Idaho Administrative Code, 16.03.09 and 16.03.10.

Idaho Medicaid follows the following CMS definitions for physician supervision for hospital outpatient departments as:

General supervision: The physician or non-physician practitioner (NPP) must be available by telephone to provide assistance and direction if needed.

Direct supervision: The physician or NPP providing supervision must be "immediately available" and "interruptible" to provide assistance and direction throughout the performance of the procedure; however, he or she does not need to be present in the room when the procedure is performed.

Personal supervision: The physician or NPP must be in attendance in the room during the procedure

The meaning of “direct supervision” differs between office and hospital outpatient place of service. Tests performed in physician offices and Independent Diagnostic Testing Facilities (IDTF) “direct supervision” is means the supervising physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of that test. For tests performed in hospital outpatient departments whether on-campus or off-campus, “direct supervision” means the physician must be immediately available to furnish assistance and direction throughout the performance of the procedure. The rule for hospital outpatient departments does not impose a proximity requirement (such as present in the office suite) only when the supervising physician can be immediately available to furnish assistance and direction.

When Providers can Bill for Global Procedures
Surgical, radiology, and laboratory procedures may be billed as global procedures, or when appropriate, may be submitted with appropriate modifiers when the performing provider does not render the complete procedure/service represented by the billing codes.

Global Diagnostic Test Procedures
The global billing code is appropriate ONLY when the billing provider both performs the test and interprets the results.

Global Diagnostic Test Procedure means: (1) personally performed both the professional and technical components; or (2) personally performed the professional component and supervised your own non-clinical employees who performed the technical component.

In Idaho Medicaid, all licensed staff performing/rendering services must be enrolled in Idaho Medicaid and submit claims under their own NPI. For example, Medicare 'incident to' billing guidance is not followed by Idaho Medicaid (see Misrepresentation of Services in the Idaho Medicaid Physician and Non-Physician Practitioner Handbook at idmedicaid.com).

When the Provider does not Perform the Complete Global Diagnostic Test Procedure
Both the Interpreting and Technical component providers MUST be enrolled with Idaho Medicaid. If only one provider is enrolled with Medicaid, only that component of the diagnostic procedure may be paid.

Professional Component Only - CPT Modifier 26
Physician or NPP who interprets the test but does not perform the test
Submit the appropriate billing procedure code using CPT modifier 26 (professional component).

Technical Component Only - HCPCS Modifier TC
Physician or NPP who performs the test but does not interpret the results
Submit the appropriate billing procedure code using HCPCS modifier TC (technical component).

Examples of Physician Supervision Requirements for Diagnostic Procedures
For Independent Diagnostic Testing Facility (IDTF) see the Noridian Part B table *Physician and Technician Qualification Requirements*, which includes billing codes, provider qualifications and a right side column titles - *Supervision – TC Only General, Direct, or Personal*. Appearance of a billing code on this Noridian table does not imply coverage by Idaho Medicaid, and Medicaid providers must use idmedicaid.com provider portal and the DHW Fee Schedule appropriate for their provider type and specialty to check on payable/coverage and limits on billing codes. (at https://med.noridianmedicare.com/web/jfb/search-result/-/view/10542/independent-diagnostic-testing-facility-idtf-physician-and-technician-qualification-requirements)

Physician Supervision, and 2019 New CMS Radiology Supervision Rules
For 2019, Centers for Medicare & Medicaid Services (CMS) has revised physician and non-physician practitioner (NPP) supervision rules for certain radiology diagnostic tests for both place of service physician office and hospital outpatient departments. CMS rules remain in place that only fully licensed physicians/NPP may supervise tests. The new 2019 CMS supervision rules are in the Medicare Physician Fee Schedule Final Rule and the Medicare Outpatient Prospective Payment System Final Rule, and apply to Idaho Medicaid services, except for differences required in payment methodology, to the extent permitted by state law and state scope of practice regulations. An example of different payment methodology is in Medicare 'incident to' guidance which is not followed by Idaho Medicaid (see Misrepresentation of Services in the Idaho Medicaid Physician and Non-Physician Practitioner Handbook at idmedicaid.com).

CMS Levels of Physician Supervision for Diagnostic Tests

In office diagnostic tests may be personally performed in a physician office when in compliance with federal **CLIA regulations and submitted by the physician office (place of service 11). Newborn screening/PKU and histocompatibility tests, when mandated by the State of Idaho, can also be purchased by the physician office and submitted to Medicaid, even though processed at a different site.**

The CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80 defines the various levels of physician supervision required for diagnostic tests.

The supervision requirement for physician billing is not met when the test is administered by supplier personnel, regardless of whether the test is performed at the physician's office or at another location. The ONLY exception to this CMS rule is State of Idaho mandated newborn screening and histocompatibility testing.

The NPI of the ordering physician is required on all claims for diagnostic tests, except when the ordering and performing physician are the same NPI.

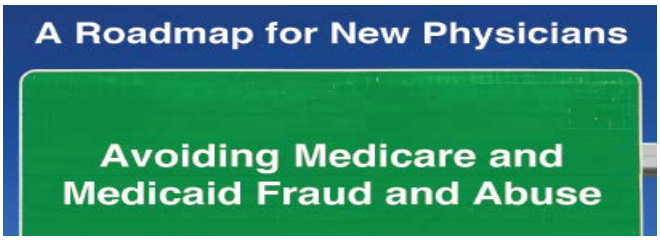
Providers of Medical, Surgical, and DMEPOS Services and Items, Services Compliance Resource Available at oig.hhs.gov

In 2017, the MedicAide newsletters issued a series of articles titled ***The Five Most Important Federal Fraud and Abuse Laws that Apply to Physicians***. The MedicAide articles were sourced from the Office of Inspector General's (OIG) booklet titled ***A Roadmap for New Physicians, Avoiding Medicare and Medicaid Fraud and Abuse,*** available at https://oig.hhs.gov/compliance/compliance-resource-portal/

The Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries and participants of both federally funded Medicare and Medicaid programs.

Per MedicAide March 2017, Page 6 of 11:

> Over the next few months we will address the five most important Federal fraud and abuse laws that apply to physicians. These laws are the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Law (Stark law), the Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL). Government agencies, including the Department of Justice, the Department of Health & Human Services, Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws. It is crucial that providers understand these laws not only because following them is the right thing to do, but also because violating them could result in criminal penalties, civil fines, exclusion from the Federal and State health care programs, or loss of your medical license from your State medical board.



A Roadmap for New Physicians, Avoiding Medicare and Medicaid Fraud and Abuse, *https://oig.hhs.gov/compliance/physician-education/index.asp*

Physician Education Training Materials
The Office of Inspector General (OIG) for the U.S. Department of Health & Human Services has created the educational materials listed below to assist in teaching physicians about the Federal laws designed to protect the Medicare and Medicaid programs and program beneficiaries from fraud, waste, and abuse.

- *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse* (PDF), which is a booklet for physicians' self-study.
- A companion PowerPoint presentation (PPT) that we encourage you to use to teach the material contained in the Roadmap.
- The speaker note set (PDF), which will assist you in giving the PowerPoint presentation.
- For physicians who may be unable to attend a live, didactic presentation of the material contained in the Roadmap, we also have provided a narration of the speaker notes to accompany the PowerPoint slides.

The following presentation summarizes the five main Federal fraud and abuse laws (the False Claims Act, the Anti-Kickback Statute, the Stark Law, the Exclusion Statute, and the Civil Monetary Penalties Law) and provide tips on how physicians should comply with these laws in their relationships with payers (e.g., the Medicare and Medicaid programs), vendors (e.g., drug, biologic, and medical device companies), and fellow providers (e.g., hospitals, nursing homes, and physician colleagues).

Download this audio narration as a file (WMV, 300 mb)

Per the booklet***, A Roadmap for New Physicians, Avoiding Medicare and Medicaid Fraud and Abuse***:

Table of Contents

Per the booklet***, A Roadmap for New Physicians, Avoiding Medicare and Medicaid Fraud and Abuse*** Page 2 of 31, from paragraph two:

> The Federal Government also places enormous trust in physicians. Medicare, Medicaid, and other Federal health care programs rely on physicians' medical judgment to treat beneficiaries with appropriate services. When reimbursing physicians and hospitals for services provided to program beneficiaries, the Federal Government relies on physicians to submit accurate and truthful claims information.
>
> The presence of some dishonest health care providers who exploit the health care system for illegal personal gain has created the need for laws that combat fraud and abuse and ensure appropriate quality medical care. This brochure assists physicians in understanding how to comply with these Federal laws by identifying "red flags" that could lead to potential liability in law enforcement and administrative actions. The information is organized around three types of relationships that physicians frequently encounter in their careers:
>
> I. Relationships with payers,
>
> II. Relationships with fellow physicians and other providers, and
>
> III. Relationships with vendors.
>
> The key issues addressed in this brochure are relevant to all physicians, regardless of specialty or practice setting.

Per the booklet***, A Roadmap for New Physicians, Avoiding Medicare and Medicaid Fraud and Abuse***, Page 12 of 31:

> Physician Documentation
> Physicians should maintain accurate and complete medical records and documentation of the services they provide. Physicians also should ensure that the claims they submit for

payment are supported by the documentation. The Medicare and Medicaid programs may review beneficiaries' medical records. **Good documentation practice helps ensure that your patients receive appropriate care from you and other providers who may rely on your records for patients' past medical histories.** It also helps you address challenges raised against the integrity of your bills. You may have heard the saying regarding malpractice litigation: **"If you didn't document it, it's the same as if you didn't do it."** The same can be said for Medicare and Medicaid billing.
For more information on physician documentation, see CMS's Documentation Guidelines for Evaluation and Management Services available at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp.

Enrolling as a Medicare and Medicaid Provider With CMS
CMS is the Federal agency that administers the Medicare program and monitors the Medicaid programs run by each State. To obtain reimbursement from the Government for services provided to Federal health care program beneficiaries, you must:

1. **Obtain a National Provider Identifier (NPI).** An NPI is a unique health identifier for health care providers. You may apply for your NPI at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

2. **Complete the appropriate Medicare Enrollment Application.** During the enrollment process, CMS collects information to ensure that you are qualified and eligible to enroll in the Medicare Program. Information about Medicare provider enrollment is available at http://www.cms.gov/MedicareProviderSupEnroll/.

3. **Complete your State-specific Medicaid Enrollment Application.** Information about Medicaid provider enrollment is available from your State Medicaid agency.

Once you become a Medicare and/or Medicaid provider, you are responsible for ensuring that claims submitted under your number are true and correct.

Sound Fiscal, Business, Child Care or Medical Practices

The Medicaid Program Integrity Unit (MPIU) investigates providers who provide and bill medical services to Idaho Medicaid. Provider practices that are inconsistent with sound fiscal, business, child care, or medical practices, and result in an unnecessary cost to a public assistance program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a medical assistance recipient are defined as abusive practices. (See IDAPA 16.05.07.010.01)

MPIU audits have found abusive practices that include credit balances and using unqualified staff. When providers do not reconcile Medicaid payments with individual patient accounts, credit balances can result due to duplicate billings and coordination of benefits conflicts. Credit balances due to duplicate Medicaid payments or incorrect secondary insurance payments must be refunded pursuant to the Idaho Medicaid provider agreement.

Some providers have used unqualified staff to provide Medicaid services. Providers should ensure individuals providing services have the required licenses, training, clearance, and education necessary to provide quality services in a professional manner. Providers must comply with staff qualifications as outlined in Medicaid program rules.

Providers who fail to follow sound fiscal business practices, who fail to meet professionally recognized standards for health care, or provide services that are not medically necessary, will be subject to identification and recoupment of overpayments and/or civil monetary penalties.

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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December 20, 2018

MEDICAID INFORMATION RELEASE #MA18-15

To: Aged and Disabled Waiver Service Providers

From: Matt Wimmer, Administrator

Subject: **Aged and Disabled Waiver Service Codes and Participant Share of Cost**

Information Release #MA12-14, which included updates to the Aged and Disabled (A&D) waiver procedure codes to which participant Share of Cost is applied, contained an error and is hereby rescinded. Procedure code H2022, Residential Habilitation Daily Supported Living – High Support, was not included.

Some participants are not responsible for a Share of Cost, including participants who are:

- Eligible for and receive Supplemental Security Income (SSI);
- Eligible for and receive Aid to the Aged, Blind and Disabled (AABD) Cash; or
- Eligible for Medicaid via the Medicaid for Workers with Disabilities program

Providers are responsible for collecting the share of cost from participants when applicable. Participant Share of Cost information is available to providers in the Medicaid Management Information System (MMIS) provider portal.

The following is a complete list of A&D Waiver services for which a share of cost may be applied:

A&D Waiver Services With Share of Cost	Procedure Code(s)
Residential Habilitation	H2015, H2016, H2022
Supported Employment	H2023
Adult Day Health	S5100
Chore Service	S5120

A&D Waiver Services With Share of Cost	Procedure Code(s)
Personal Emergency Response System	S5160, S5161
Home Delivered Meals	S5170
Skilled Nursing	T1001, T1002, T1003
Respite	T1005
Consultation	S5115
Attendant Care	S5125
Homemaker	S5130
Companion Services	S5135
Adult Residential Care	S5140
Day Habilitation	T2021

If you have questions about this information, please contact the Bureau of Long Term Care at (208) 287-1171.

Thank you for participating in the Idaho Medicaid Program.

MW/kd

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November 21, 2018

MEDICAID INFORMATION RELEASE #MA18-16

TO: All providers who provide services or supports to children and/or adults with developmental disabilities

FROM: Matt Wimmer, Administrator

SUBJECT: DEPARTMENT APPROVED ASSESSMENT TOOLS EFFECTIVE JULY 1, 2018

Effective July 1, 2018, the Department is accepting the following tools, or the most current version of the tool, to determine eligibility for individuals with developmental disabilities.

TEST INSTRUMENTS FOR ADULTS IN THE COMMUNITY

Any community provider working within the scope of their practice can determine IQ for diagnostic purposes using one of these Department Approved Cognitive Test Instruments for Adults:

- Wechsler Adult Intelligence Scale-Third Edition (WAIS-III), for ages sixteen (16) years to ninety (90) years, eleven (11) months;
- Stanford Binet Intelligence Scales, for ages two (2) years through adult;
- Test of Nonverbal Intelligence, Fourth Edition (TONI-4), for ages six (6) years through eighty-nine (89) years, eleven (11) months.

To determine eligibility, the Department's Independent Assessment Provider (IAP) can use the following Department Approved Functional Test Instruments for Adults:

- Scales of Independent Behavior-Revised (SIB-R), for ages birth through adult.

TEST INSTRUMENTS FOR CHILDREN IN THE COMMUNITY

Any community provider working within the scope of their practice can determine IQ for diagnostic purposes using one of these Department Approved Cognitive Test Instruments for Children:

- Bayley Scales of Infant Development, for ages birth through forty-two (42) months;
- Stanford Binet Intelligence Scales, for ages two (2) years through adult;
- Weshsler Preschool and Primary Scale of Intelligence, for ages two (2) years, six (6) months to seven (7) years, seven (7) months;
- Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), for ages six (6) years through sixteen (16) years, eleven (11) months;

- Wechsler Adult Intelligence Scale-Third Edition (WAIS-III), for ages sixteen (16) years to ninety (90) years, eleven (11) months;
- Test of Nonverbal Intelligence, Fourth Edition (TONI-4), for ages six (6) years through eighty-nine (89) years, eleven (11) months.

To determine eligibility for community services, the Department's Independent Assessment Provider (IAP) can use the following Department Approved Functional Test Instruments for Children:

- Scales of Independent Behavior-Revised (SIB-R), for ages birth through adult;
- Mullen Scales of Early Learning (MSEL), for ages birth to three (3) years;
- Vineland Adaptive Behavior Scales, Third Edition (Vineland-3), for ages birth to ninety (90) years.

TEST INSTRUMENTS FOR CHILDREN AND/OR ADULTS IN THE SCHOOL

Any school-based provider working within the scope of their practice can determine IQ for diagnostic purposes using one of these Department Approved Cognitive Test Instruments for Children or Adults:

- Bayley Scales of Infant Development, for ages birth through forty-two (42) months;
- Stanford Binet Intelligence Scales, for ages two (2) years through adult;
- Weshsler Preschool and Primary Scale of Intelligence, for ages two (2) years, six (6) months to seven (7) years, seven (7) months;
- Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), for ages six (6) years through sixteen (16) years, eleven (11) months;
- Wechsler Adult Intelligence Scale-Third Edition (WAIS-III), for ages sixteen (16) years to ninety (90) years, eleven (11) months;
- Test of Nonverbal Intelligence, Fourth Edition (TONI-4), for ages six (6) years through eighty-nine (89) years, eleven (11) months;
- Woodcock-Johnson Tests of Cognitive Abilities, Fourth Edition (WJ-IV), for ages birth to ninety plus (90+) years.

To determine eligibility for School-Based Services, a School District or Charter School can use the following Department Approved Functional Test Instruments for Children or Adults:

- Battelle Developmental Inventory, Second Edition (BDI-2), for ages birth to ninety-fine (95) months;
- Scales of Independent Behavior-Revised (SIB-R), for ages birth through adult;
- Mullen Scales of Early Learning (MSEL), for ages birth to three (3) years;

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December 20, 2018

MEDICAID INFORMATION RELEASE #MA18-17

TO: Idaho Dual Eligible Stakeholders

FROM: Matt Wimmer, Administrator

SUBJECT: Idaho Medicaid Plus Program Expansion – Bonneville, Bingham, and Bannock Counties Planned for April 1, 2019 Implementation

Idaho Medicaid is pleased to expand its managed care coverage for Idaho dual eligible members, also known as "Duals." As you may be aware, Molina Healthcare of Idaho has joined Blue Cross of Idaho as a second health plan that offers the Medicare Medicaid Coordinated Plan (MMCP) in certain Idaho counties.

Idaho Medicaid implemented a new program for duals, called Idaho Medicaid Plus, in **Twin Falls County** on November 1, 2018. Idaho Medicaid Plus is a single managed care source of all Medicaid benefits for duals that have not enrolled in the MMCP and are not in an excluded population. Tribal members, pregnant women, and individuals receiving Adult Developmental Disability Waiver services are excluded from mandatory enrollment into Idaho Medicaid Plus.

Duals must select and enroll in one of the available health plans to administer their Medicaid benefits once Idaho Medicaid Plus is implemented in their county of residence. If the member does not choose a health plan by a certain deadline, they will be randomly assigned to one of the available health plans.

As a result of the successful implementation in Twin Falls County, Idaho Medicaid plans to implement Idaho Medicaid Plus in Bonneville, Bannock, and Bingham counties effective April 1, 2019.

Members in these counties that have not enrolled in the MMCP and are not in an excluded population will receive initial enrollment notices shortly after **January 1, 2019.**

Please visit http://MMCP.dhw.idaho.gov for ongoing updates, a calendar of outreach events, and additional information. If you have further questions, please contact IdahoDuals@dhw.idaho.gov.

MW/af

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December 27, 2018

MEDICAID INFORMATION RELEASE MA18-18

To: Prescribing Providers, Pharmacists, and Hospitals

From: Matt Wimmer, Administrator
Division of Medicaid

Subject: Update to Idaho Medicaid Preferred Drug List per Pharmacy and Therapeutics Committee Meetings on October 19, 2018 & November 16, 2018.

Drug/Drug Classes:	Noted below. Agents shaded indicate changes in preferred drug status.
Implementation Date:	Effective for dates of service on or after January 1, 2019

The attached document is an update to the Idaho Medicaid Preferred Drug List. It reflects decisions based on recommendations from the Idaho Medicaid Pharmacy and Therapeutics Committee at the October and November 2018 meetings.

The preferred drug list and drug-class specific prior authorization criteria are based on nationally recognized peer-reviewed information and evidence-based clinical criteria. Medicaid designates preferred agents within a drug-class based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes in comparison with other therapeutically interchangeable alternative drugs and, secondarily, on cost.

Questions regarding the Preferred Drug List can be referred to the Idaho Medicaid Pharmacy Unit at (208) 364-1829. A current listing of preferred agents, non-preferred agents, and prior authorization criteria for all drug classes is also available online at **www.medicaidpharmacy.idaho.gov**.

MW/sf

Idaho Medicaid Preferred Drug List Recommendations
November 19, 2018

Idaho Medicaid makes the following recommendations for the Idaho Medicaid Preferred Drug List. These recommendations are based on the clinical recommendations of the Pharmacy and Therapeutics Committee from the October 19 and November 16 meetings and take into consideration public and prescriber input, utilization patterns and cost data.

Therapeutic Class	Preferred Drugs	Non-Preferred Drugs
ALZHEIMER'S DRUGS CL	donepezil CL –except 23 mg tablets donepezil ODT CL EXELON (rivastigmine) transdermal CL memantine tablets CL rivastigmine capsules CL	donepezil 23 mg tablets CL galantamine tablets, solution CL galantamine ER CL memantine ER CL memantine soln CL NAMENDA (memantine) XR CL NAMZARIC (donepezil and memantine ER) CL rivastigmine transdermal CL
ANTI-ALLERGENS		GRASTEK (Timothy grass pollen allergen extract) CL ODACTRA (House dust mite-Dermatophagoides farinae and Dermatophagoides pteronyssinus) ORALAIR (grass pollen extract-Cocksfoot, Sweet Vernal Grass, Rye Grass, Meadow Grass, Timothy) CL RAGWITEK (Short Ragweed pollen allergen extract) CL
ANTICONVULSANTS	Adjuvants, Epilepsy APTIOM (eslicarbazepine) CL divalproex sprinkle CL GABITRIL (tiagabine) CL levetiracetam solution, tablets CL oxcarbazepine suspension CL oxcarbazepine tablets CL topiramate sprinkles CL VIMPAT (lacosamide) tablets, soln CL zonisamide CL Adjuncts, Pain and Mood	BANZEL (rufinamide) tablets, suspension CL BRIVIACT (brivaracetam) tablets, solution CL felbamate tablets, suspension CL FYCOMPA (perampanel) tablets, suspension CL lamotrigine XR CL levetiracetam ER CL OXTELLAR XR (oxcarbazepine) CL SABRIL (vigabatrin) tablets, powder packet CL SPRITAM (levetiracetam) susp CL tiagabine CL VIGABATRIN powder packet CL

ANTICONVULSANTS (continued)	carbamazepine ER (generic for CARBATROL) carbamazepine chewable tablets carbamazepine IR tablets carbamazepine XR (generic for TEGRETOL XR) divalproex ER divalproex tablets gabapentin capsules, tablets lamotrigine chewable tablets, tablets [CL] TEGRETOL (carbamazepine) suspension topiramate ER (for Qudexy XR) capsules [CL] topiramate tablets [CL] valproic acid capsules, solution	carbamazepine suspension EQUETRO (carbamazepine ER) LAMICTAL ODT (lamotrigine) [CL] lamotrigine ODT [CL] TROKENDI XR (topiramate ER) [CL]
	<u>Barbiturates</u> phenobarbital tablets, suspension primidone	
	<u>Benzodiazepines</u> clonazepam tablets diazepam rectal ONFI (clobazam) tablets [CL]	clobazam tablets [CL] clonazepam ODT [CL] ONFI (clobazam) suspension [CL]
	<u>Hydantoins</u> DILANTIN (phenytoin) capsules DILANTIN INFATAB (phenytoin) phenytoin capsules, chewable tablets, suspension phenytoin sodium extended (for PHENYTEX)	PEGANONE (ethotoin)
	<u>Succinimides</u> ethosuximide capsules, syrup	CELONTIN (methosuximide)
	<u>Anticonvulsants, Other</u>	EPIDIOLEX (cannabidiol) [C]

ANTIDEPRESSANTS, OTHER	bupropion IR bupropion SR bupropion XL duloxetine [CL] mirtazapine tablets trazodone venlafaxine IR venlafaxine ER capsules	APLENZIN (bupropion HBr) desvenlafaxine ER desvenlafaxine fumarate ER desvenlafaxine succinate ER (generic for KHEDEZLA ER) desvenlafaxine succinate (generic for PRISTIQ) EMSAM (selegiline) transdermal [CL] FETZIMA (levomilnacipran) FORFIVO XL (bupropion) IRENKA (duloxetine) [CL] MARPLAN (isocarboxazid) mirtazapine ODT nefazodone PARNATE (tranylcypromine) phenelzine tranylcypromine TRINTELLIX (vortioxetine) venlafaxine ER tablets VIIBRYD (vilazodone)
ANTIDEPRESSANTS, SSRIs	citalopram tablets, solution escitalopram tablets, solution fluoxetine capsules, tablets, solution fluvoxamine IR sertraline tablets, solution	BRISDELLE (paroxetine) [CL] fluoxetine weekly [CL] fluvoxamine ER paroxetine CR paroxetine tablets paroxetine (for BRISDELLE) PAXIL (paroxetine) suspension PEXEVA (paroxetine) PROZAC (fluoxetine) weekly [CL]
ANTIHISTAMINES, MINIMALLY SEDATING	cetirizine solution, tablets levocetirizine tablets loratadine ODT, solution, tablets	cetirizine capsules cetirizine chewable desloratadine desloratadine ODT fexofenadine levocetirizine solution loratadine capsules, chew tablets XYZAL (levocetirizine) solution, tablets

ANTIHYPERURICEMICS	allopurinol MITIGARE (colchicine) capsules CL probenecid	colchicine CL capsules, tablets DUZALLO (allopurinol/lesinurad) CL KRYSTEXXA (pegloticase) CL probenecid/colchicine CL ULORIC (febuxostat) CL ZURAMPIC (lesinurad) CL
ANTIPARKINSON'S DRUGS	amantadine capsules, syrup benztropine bromocriptine carbidopa/levodopa IR tablets carbidopa/levodopa ER carbidopa/levodopa/entacapone pramipexole IR ropinirole IR selegiline capsules, tablets trihexyphenidyl tablets, solution	amantadine tablet AZILECT (rasagiline) carbidopa carbidopa/levodopa ODT entacapone GOCOVRI (amantadine) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) transdermal OSMOLEX ER (amantadine) pramipexole ER rasagiline ropinirole ER RYTARY (carbidopa/levodopa ER) tolcapone XADAGO (safinamide) ZELAPAR (selegiline) disintegrating tablets
ANTIPSYCHOTICS	aripiprazole tablets chlorpromazine clozapine tablets FAZACLO (clozapine ODT) fluphenazine tablets, solution LATUDA (lurasidone) loxapine olanzapine tablets olanzapine ODT ORAP (pimozide) perphenazine perphenazine/amitriptyline quetiapine tablets quetiapine ER risperidone solution, tablets, ODT thiothixene trifluoperazine ziprasidone capsules **Injectable:**	aripiprazole disintegrating tablet aripiprazole solution clozapine ODT FANAPT (lloperidone) haloperidol NUPLAZID (pimavanserin) CL capsules, tablets olanzapine/fluoxetine (must use individual agents) paliperidone ER pimozide REXULTI (brexiprazole) SAPHRIS (asenapine) thioridazine VERSACLOZ (clozapine) VRAYLAR (cariprazine)

ANTIPSYCHOTICS (continued)	ABILIFY MAINTENA (aripiprazole) [CL] ARISTADA (aripiprazole) [CL] ARISTADA INITIO (aripiprazole) [CL] fluphenazine decanoate GEODON (ziprasidone) haloperidol lactate INVEGA SUSTENNA (paliperidone) [CL] INVEGA TRINZA (paliperidone) [CL] olanzapine RISPERDAL CONSTA (risperidone) [CL]	haloperidol decanoate PERSERIS (risperidone) [CL] ZYPREXA RELPREVV (olanzapine) [CL]
ANXIOLYTICS/ BENZODIAZEPINES	alprazolam alprazolam ER buspirone clonazepam tablets diazepam tablets, solution lorazepam tablets	alprazolam intensol, ODT chlordiazepoxide clonazepam ODT clorazepate diazepam syringe, vial diazepam intensol lorazepam intensol meprobamate oxazepam
ATOPIC DERMATITIS	ELIDEL (pimecrolimus)	DUPIXENT (dupilumab) [CL] EUCRISA (crisaborole) [CL] PROTOPIC (tacrolimus) tacrolimus
BOTULINUM TOXINS	BOTOX (onabotulinumtoxinA) [CL] - except for cervical dystonia DYSPORT (abobotulinumtoxinA) [CL] MYOBLOC (rimabotulinumtoxinB) [CL] XEOMIN [CL](incobotulinumtoxinA) [CL]	BOTOX (onabotulinumtoxinA)-for cervical dystonia [CL]
BRONCHODILATORS, BETA AGONIST	**Inhalers, Short-Acting:** PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) **Inhalers, Long-Acting:** SEREVENT (salmeterol) [CL] **Inhalation Solution:** albuterol **Oral:**	levalbuterol HFA PROAIR RESPICLICK (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol) ARCAPTA (indacaterol) [CL] STRIVERDI RESPIMAT (olodaterol) levalbuterol BROVANA (arformoterol) PERFOROMIST (formoterol)

BRONCHODILATORS, BETA AGONIST (Continued)	terbutaline	albuterol tablets, solution albuterol ER metaproterenol tablets, solution
COLONY STIMULATING FACTORS	GRANIX (tbo-filgrastim) NEUPOGEN (filgrastim)	FULPHILA (pegfilgrastim-jmdb) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) ZARXIO (filgrastim-sndz)
COPD AGENTS	albuterol/ipratropium ATROVENT HFA (ipratropium) BEVESPI AEROSPHERE (glycopyrrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ipratropium) ipratropium nebulizer solution SPIRIVA (tiotropium) inhalation capsules STIOLTO RESPIMAT (tiotropium/olodaterol)	ANORO ELLIPTA (umeclidium/vilanterol) DALIRESP (roflumilast) [CL] INCRUSE ELLIPTA (umeclidinium) LONHALA MAGNAIR (glycopyrrolate) SEEBRI NEOHALER (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA PRESSAIR (aclidinium) UTIBRON NEOHALER (glycopyrrolate/indacaterol)
CYTOKINE & CAM ANTAGONISTS	COSENTYX (secukinumab) [CL] ENBREL (etanercept) ENBREL (etanercept) MINI Cartridge HUMIRA (adalimumab)	ACTEMRA (tocilizumab) ARCALYST (rilonacept) CIMZIA (certolizumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab -asmn) INFLECTRA (infliximab) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinimab) ORENCIA (abatacept) OTEZLA (apremilast) REMICADE (infliximab) RENFLEXIS (infliximab-abda) SILIQ (brodalumab) SIMPONI ARIA (golimumab) SIMPONI SQ (golimumab) STELARA (ustekimumab) TALTZ (ixekizumab) TREMFYA (guselkumab) XELJANZ (tofacitinib) XELJANZ XR (tofacitinib)
EPINEPHRINE, SELF-INJECTED	epinephrine (generic for EPIPEN, EPIPEN JR)	epinephrine (ADRENACLICK)

ERYTHROPOIESIS STIMULATING PROTEINS	ARANESP (darbepoetin) PROCRIT (rHuEPO)	EPOGEN (rHuEPO) RETACRIT (epoetin alfa-epbx)
GLUCOCORTICOIDS, INHALED	ASMANEX (mometasone) Twisthaler FLOVENT HFA (fluticasone) PULMICORT RESPULES (budesonide) CL	AEROSPAN (flunisolide) ALVESCO (ciclesonide) ARMONAIR RESPICLICK (fluticasone) ARNUITY ELIPTA (fluticasone) ASMANEX (mometasone) HFA budesonide respules FLOVENT DISKUS (fluticasone) PULMICORT (budesonide) Flexhaler QVAR (beclomethasone) QVAR (beclomethasone) REDIHALER
GLUCOCORTICOID /BRONCHODILATOR COMBINATIONS CL	ADVAIR (fluticasone/salmeterol) CL SYMBICORT (budesonide/formoterol) CL	AIRDUO (fluticasone/salmeterol) RESPICLICK CL BREO ELLIPTA (fluticasone/vibanterol) CL DULERA (mometasone/formoterol) CL fluticasone/salmeterol TRELEGY ELLIPTA (fluticasone /umeclidinium/vilanterol) CL
IMMUNE GLOBULINS	CARIMUNE NF nanofiltered powder for intravenous solution CL CYTOGAM (cytomegalovirus immune globulin) intravenous solution CL FLEBOGAMMA DIF IV solution CL GAMASTAN S/D intramuscular CL GAMMAGARD LIQUID injection solution CL GAMMAGARD S/D powder for intravenous solution CL GAMUNEX-C injection solution CL HYPERHEP B S-D injection solution HIZENTRA subcutaneous solution CL PRIVIGEN intravenous solution CL VARIZIG (Varicella-Zoster immune globulin) intramuscular CL	BIVIGAM intravenous solution CL CUVITRU subcutaneous solution CL GAMMAKED injection solution CL GAMMAPLEX intravenous soln CL HEPAGAM B (hepatitis B immune globulin) intramuscular CL HYPERRAB CL HYQVIA subcutaneous solution CL IMOGAM RABIES-HT IM CL KEDRAB CL OCTAGAM intravenous solution CL

IMMUNOMODULATORS, ASTHMA	No agents are recommended to be preferred at this time.	CINQAIR (reslizumab) [CL] FASENRA (benralizumab) [CL] NUCALA (mepolizumab) [CL] XOLAIR (omalizumab) [CL]
INTRANASAL RHINITIS AGENTS	azelastine (for ASTELIN) fluticasone ipratropium	azelastine (for ASTEPRO) BECONASE AQ (beclomethasone) DYMISTA (azelastine/fluticasone) flunisolide mometasone olopatadine OMNARIS (ciclesonide) QNASL (beclomethasone) SINUVA (mometasone furoate) sinus implant [CL] TICANASE (fluticasone) VERAMYST (fluticasone) XHANCE (fluticasone propionate) nasal spray [CL] ZETONNA (ciclesonide)
LEUKOTRIENE MODIFIERS	montelukast tablets, chewable tablets	montelukast granules zafirlukast zileuton ER ZYFLO (zileuton) ZYFLO CR (zileuton)
MOVEMENT DISORDERS		AUSTEDO (deutetetrabenazine) [CL] INGREZZA (valbenazine) [CL] tetrabenazine [CL] XENAZINE (tetrabenazine) [CL]
NSAIDS **NSAIDS (continued)**	diclofenac SR flurbiprofen ibuprofen (Rx only) indomethacin IR capsules meloxicam tablets nabumetone naproxen (Rx only) tablets, naproxen EC sulindac VOLTAREN Gel (diclofenac) [CL]	celecoxib diclofenac gel diclofenac IR diclofenac/misoprostol diclofenac solution diflunisal DUEXIS (ibuprofen/famotidine) [CL] etodolac IR etodolac SR fenoprofen FLECTOR (diclofenac) [CL] patches INDOCIN (indomethacin) rectal INDOCIN (indomethacin) suspension indomethacin ER capsules

		ketoprofen ER ketoprofen IR ketorolac meclofenamate mefenamic acid meloxicam suspension NAPRELAN (naproxen) naproxen (Rx only) suspension naproxen CR (375 and 500mg) naproxen sodium oxaprozin PENNSAID (diclofenac) CL topical solution piroxicam SPRIX (nasal ketorolac) TIVORBEX (indomethacin) tolmetin VIMOVO (naproxen/esomeprazole) VIVLODEX (meloxicam) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)
OPHTHALMIC ANTIBIOTICS	bacitracin/polymyxin B CILOXAN (ciprofloxacin) ointment ciprofloxacin solution erythromycin gentamicin MOXEZA (moxifloxacin) polymyxin/trimethoprim tobramycin solution TOBREX (tobramycin) ointment	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) solution gatifloxacin levofloxacin moxifloxacin NATACYN (natamycin) neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin ofloxacin sulfacetamide ointment sulfacetamide solution ZYMAXID (gatifloxacin)
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment and suspension	BLEPHAMIDE (sulfacetamide/prednisolone) BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) neomycin/bacitracin/polymyxin/HC neomycin/polymyxin/dexamethasone

OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS (continued)		neomycin/polymyxin /HC PRED-G (prednisolone/gentamicin) TOBRADEX ST (tobramycin/dexamethasone) tobramycin/dexamethasone susp ZYLET (tobramycin/loteprednol)
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	cromolyn PAZEO (olopatadine)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) ALREX (loteprednol) azelastine BEPREVE (bepotastine) EMADINE (emedastine) epinastine LASTACAFT (alcaftadine) olopatadine 0.1% (generic PATANOL) olopatadine 0.2% (generic PATADAY)
OPHTHALMICS, ANTI-INFLAMMATORY/ IMMUNOMODULATORS	RESTASIS (cyclosporine) CL	XIIDRA (lifitegrast) CL
OTIC ANTIBIOTICS	CIPRODEX (ciprofloxacin/dexamethasone) ciprofloxacin CIPRO HC (ciprofloxacin/hydrocortisone) COLY-MYCIN S (colistin/neomycin/HC) neomycin/polymyxin/hydrocortisone	ofloxacin OTOVEL (ciprofloxacin/fluocinolone)
PAIN, OTHER	duloxetine CL 20 mg, 30mg, 60 mg gabapentin capsules, tablets lidocaine transdermal CL LYRICA (pregabalin) capsuleS CL	duloxetine CL 40 mg (for Irenka) gabapentin solution CL GRALISE (gabapentin) CL HORIZANT (gabapentin enacarbil) CL LYRICA (pregabalin) solution CL LYRICA CR (pregabalin) SAVELLA (milnacipran) CL
SEDATIVE HYPNOTICS **SEDATIVE HYPNOTICS (Continued)**	doxepin 10 mg ROZEREM (ramelteon) zolpidem IR	BELSOMRA (suvorexant) EDLUAR (zolpidem) SL estazolam eszopiclone

		flurazepam HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) sublingual SILENOR (doxepin) temazepam all strengths triazolam zaleplon zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)
STIMULANTS AND RELATED DRUGS CL	ADDERALL XR (amphetamine salt combination) CL amphetamine salt combination IR CL APTENSIO XR (methylphenidate) CL atomoxetine clonidine IR FOCALIN (dexmethylphenidate) CL FOCALIN XR (dexmethylphenidate) CL guanfacine ER guanfacine IR methylphenidate IR tablets CL methylphenidate ER (generic for Concerta) CL QUILLICHEW ER (methylphenidate) CL QUILLIVANT XR (methylphenidate) solution CL VYVANSE (lisdexamfetamine) CL	ADZENYS ER Suspension (amphetamine) CL ADZENYS XR ODT (amphetamine) CL amphetamine salt combination ER CL armodafinil CL COTEMPLA XR-ODT (methylphenidate) clonidine ER CL DAYTRANA (methylphenidate) CL dexmethylphenidate CL dexmethylphenidate XR CL dextroamphtamine IR, ER CL dextroamphetamine solution CL DYANAVEL XR (amphetamine) CL EVEKEO (amphetamine) CL KAPVAY (clonidine ER) CL methylphenidate CD methylphenidate chewable tablets methylphenidate ER (generic for METADATE) CL methylphenidate ER CL (generic Ritalin LA) methylphenidate solution CL modafanil CL MYDAYIS (amphetamine salt combination ER) NUVIGIL (armodafanil) CL PROCENTRA (dextroamphetamine solution) CL ZENZEDI (dextroamphetamine) CL
TOBACCO CESSATION	bupropion SR 150 mg CHANTIX (varenicline) CL	NICOTROL (nicotine) inhalation NICOTROL NS (nicotine)nasal

	nicotine gum (nicotine polacrilex) nicotine lozenge buccal (nicotine polacrilex) nicotine patch OTC (nicotine)	

Note: Changes are indicated by highlighted area. Non-preferred drugs require failure of 1, 2 or 3 preferred agents for prior authorization approval. Those drugs with a [α] also have clinical prior authorization criteria for use associated with them.

Provider Training Opportunities in 2019

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

January: Eligibility
This course is designed to instruct primary care physicians on how to determine eligibility.

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.

	January	February	March
	Eligibility	**Claims Adjustment**	**Coordination of Benefits**
10:00 - 11:00 AM MT	1/15/2019	2/19/19	3/19/19
	1/16/2019	2/20/19	3/20/19
	1/17/2019	2/21/19	3/21/19
2:00 - 3:00 PM MT	1/9/2019	2/13/19	3/13/19
	1/10/2019	2/14/19	3/14/19
	1/15/2019	2/19/19	3/19/19
	1/17/2019	2/21/19	3/21/19

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 60 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. Click on **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 (208) 364-1826
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 (208) 364-1843
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 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

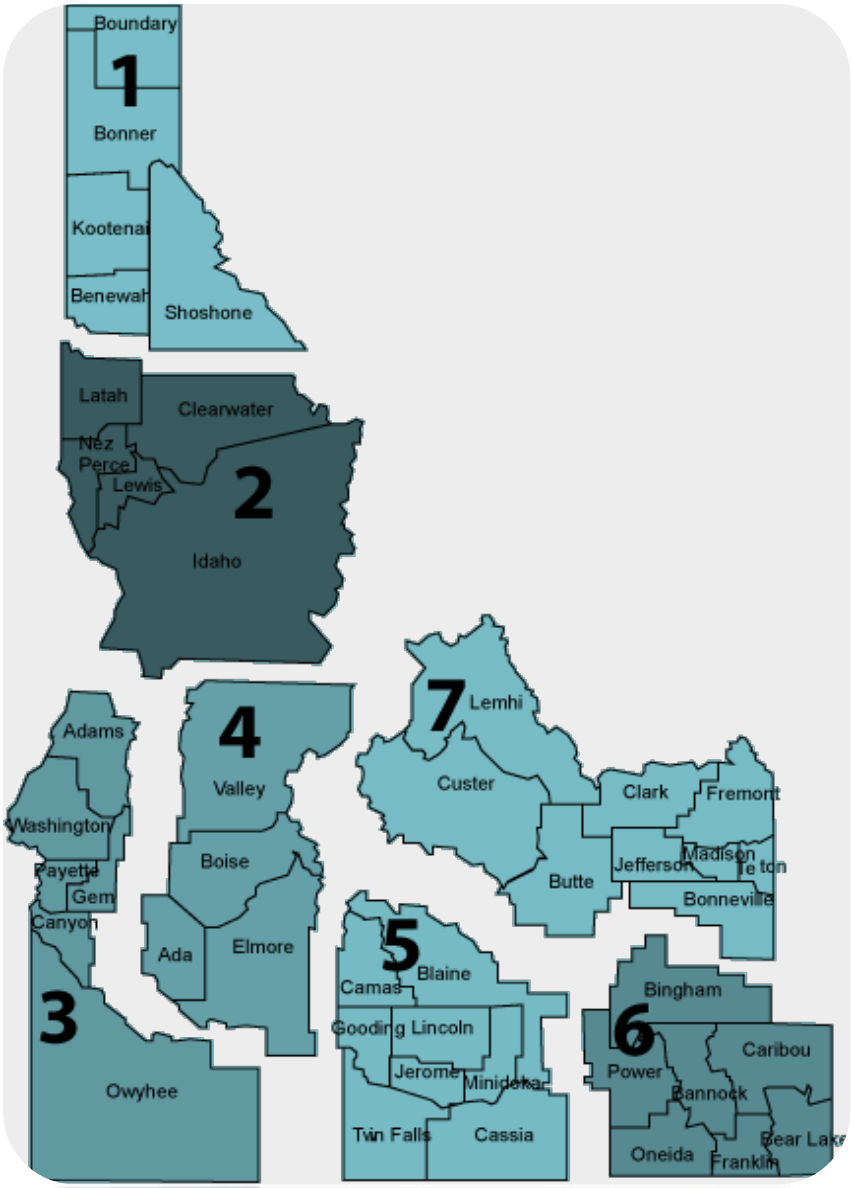
DXC Technology Provider and Participant Services Contact Information

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

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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.**
Editors: Shelby Spangler and Shannon Tolman

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