MedicAide

An Informational Newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, **June 2017**

Division of Medicaid

In This Issue

Information Releases

No Information Releases Available

Do You Need to Have an Ordering, Referring, or Prescribing Provider on Your Claim?

Additional work by the department, in conjunction with our federal partners, has allowed us to exempt some of the providers who were originally included in the ORP requirements, for example Certified Family Homes do not require an ORP provider on their claims.

In compliance with federal regulations, Idaho Medicaid requires that claims include the name and the National Provider Identifier (NPI) of the health care professional that ordered, referred, or prescribed (ORP) the items or services. If the ORP provider's information is not included on a claim, or if the ORP provider is not enrolled with Idaho Medicaid, the provider billing Medicaid will not receive reimbursement.

Although this rule has been in effect for several years, many claims are being submitted without this information, or without the ORP provider being enrolled with Medicaid.

Providers who render services to Medicaid participants and submit claims to Medicaid should ensure that such services are being ordered, referred, or prescribed by an eligible provider who is enrolled in Idaho Medicaid.

As recommended in previous guidance by IDHW, providers billing Medicaid should be prepared to ensure all referring, ordering, and prescribing physicians and other health care professionals have NPIs and are enrolled in Medicaid. There is an abbreviated application process for providers who do not submit claims to Medicaid but who must enroll as ordering, referring, or prescribing providers.

If the NPI of the physician or health care professional that ordered, referred, or prescribed the item or Medicaid service is not included on the claim, Medicaid reimbursement will not be allowed.

PLEASE NOTE:
The edit is set to WARN as we work through different provider specialty concerns. Not all providers who are receiving the WARN edit today will have claims deny when we switch the edit to DENY. Please continue to watch for announcements and MedicAide articles as we move toward the final implementation.

The following providers have been confirmed as needing an ORP identified on their claims.

These Providers Must Report an ORP on their Claims (Continued on Next Page)	
ASSISTIVE TECHNOLOGY SUPPLIER	NUCLEAR MEDICINE - IN VIVO & IN VITRO
AUDIOLOGIST	NUCLEAR MEDICINE - NUCLEAR CARDIOLOGY
BEHAVIOR CONSULTANT/CRISIS MANAGEMENT	NUCLEAR MEDICINE - NUCLEAR IMAGING THERAPY
CLINIC/CENTER - AMBULATORY SURGICAL	NURSING AGENCY (PDN)
CLINIC/CENTER - HEARING & SPEECH	OCCUPATIONAL THERAPIST
CLINIC/CENTER - PHYSICAL THERAPY FACILITY	OPTOMETRIC SUPPLIES
CLINIC/CENTER - RADIOLOGY, MOBILE	PHARMACY
CLINIC/CENTER -BIRTHING	PHYSICAL THERAPIST
CLINICAL NEUROPSYCHOLOGIST - CLINICAL	PORTABLE X-RAY SUPPLIER

These Providers Must Report an ORP on their Claims (Continued on Next Page)	
CLINICAL NURSE SPECIALIST	PROSTHETIC/ORTHOTIC SUPPLIER
DIABETES EDUCATOR	PSYCHIATRIC HOSPITAL
DIAGNOSTIC SERVICES	PSYCHIATRIC UNIT
DIALYSIS UNIT	RADIOLOGIC TECHNOLOGIST
DIETICIAN, REGISTERED	REGISTERED NURSE INDEPENDENT (PDN)
DURABLE MEDICAL EQUIPMENT & MED. SUPP	REHABILITATION HOSPITAL
GENERAL ACUTE CARE HOSPITAL	REHABILITATION UNIT
HEARING AID VENDOR	RESPITE CARE
HOME HEALTH	SCHOOL BASED SERVICES
HOSPICE	SKILLED NURSING FACILITY
LABORATORY - CLINICAL MEDICAL LABORATORY	SOCIAL WORKER
LONG TERM CARE HOSPITAL	SPECIALIST/TECHNOLOGIST
MEDICARE DEFINED SWING BED UNIT	SPEECH-LANGUAGE PATHOLOGIST
MILITARY HOSPITAL	SUPPLIES ONLY

Why Do I Want a Trading Partner Account?

In Fall 2017, the Trading Partner Account (TPA) portal will be upgraded to a new version. In addition to a new look and feel, the upgrade will result in some content–such as enrollment, maintenance, and training–being moved behind the secure login.

By registering for a Trading Partner Account, not only will you be able to access provider enrollment, maintenance, and training after the upgrade occurs, but you will also be able to utilize the new Secure Messaging feature coming to the provider portal. This feature will enhance communications between providers and Molina and will enable providers to more easily associate their TPA accounts with billing agencies.

If you do not have a Trading Partner Account, register for one **now** at www.idmedicaid.com. Detailed instructions on how to register can be found in the Trading Partner Account (TPA) User Guide.

Watch for more news regarding the TPA upgrade in the MedicAide newsletters and in the Announcements on the Molina Medicaid website.

Process Update: Requests for Corrective Action Plans

This communication impacts all Medicaid Home and Community-Based Services (HCBS) providers, including Certified Family Homes (CFH), Residential Assisted Living Facilities (RALF), Adult Day Health (ADH), Developmental Disability Agencies (DDA), Supported-Living providers, Personal Care Services (PCS), Supported Employment, and any other entity providing HCBS.

Any time a Medicaid provider is found to be in violation of IDAPA rules and requirements, they may be asked to complete a Corrective Action Plan (CAP) explaining how the violation will be corrected and prevented in the future. Previously, each program providing oversight to the various provider types had their own process related to CAPs.

In order to simplify the procedure and provide consistency across all provider types, Medicaid's Bureau of Developmental Disability Services (BDDS) and Bureau of Long-Term Care (BLTC) have collaborated with the Division of Family and Community Services (FACS) to develop a single CAP process.

The new process includes standardization of timeframes and documentation. This will allow providers sufficient time to make needed correction. Additionally, this will give the Department time to provide any needed technical assistance to help providers reach compliance.

Changes to the process include the following.
If a provider receives a request for a CAP, the provider is expected to develop and implement an acceptable CAP within 45 days. Department Quality Assurance/Quality Improvement staff can help the provider by offering:

- Technical assistance;
- An onsite meeting; and/or
- Any other reasonable support needed to help the provider comply.

Once the CAP has been accepted, the provider will need to submit evidence demonstrating the CAP was successfully implemented.

If a provider is unable to supply an acceptable CAP, or provide proof of successful implementation, action(s) against their Medicaid Provider Agreement may be recommended. Provider Agreement Enforcement Actions can be found in *IDAPA 16.03.09, "Medicaid Basic Plan Benefits," subsection 205.03*.

These changes became effective May 15, 2017, and were preceded by e-mailed communication.

If you have questions, please contact Donny Jardine, at 1 (208) 364-1880 or Donny.jardine@dhw.idaho.gov.

Medicaid Program Integrity Unit

School-Based Service Providers

IEP-IDENTIFYING AMOUNT OF SERVICE

During recent audits, the Medicaid Program Integrity Unit has encountered instances of school-based providers identifying a range of services on the Individualized Education Program (IEP). As a reminder to school-based providers, the IEP is the plan of care and must identify the specific amount, type, and duration of the service as required in *IDAPA 16.03.09.012.05*. Ranges of time and/or stating "up to" an amount of time is not compliant with this requirement. In addition, the Idaho Special Education Manual (2016) states, in part:

> F. Supplementary Aids, Services, and Other IEP Considerations
>
> The description of services in the IEP shall:
>
> 4. List the anticipated time per session and frequency of sessions per week or month. The amount of service may not be stated as a range.

QUALIFIED STAFF

The school-based provider must ensure staff providing services billed to Medicaid meet the qualification requirements identified in IDAPA. For example, if the school is providing Speech-Language Pathology (SLP) services and billing Medicaid for a professional service, they must ensure the staff have an Idaho license from Idaho Bureau of Occupational Licenses (IBOL), in addition to a certificate of clinical competence (CCC) from the American Speech, Language, and Hearing Association, or who will be eligible for this certification within one year of employment. The provisional permit from IBOL or an SLP pupil personnel certificate does not meet the Idaho licensing requirements, therefore cannot be billed as a professional service.

PROVIDE SERVICES AS DEFINED IN ADMINISTRATIVE RULE

When submitting a claim to Medicaid, the school must provide the service as defined in administrative rule. For example, if a staff is providing Community Based Rehabilitation Services (CBRS), they must be actively assisting the student in gaining and utilizing skills necessary to participate in school. The school can bill for the time the staff are directly teaching a student the skills identified on the IEP. If the student's team determines that the student does not require a consistent staff and has them sitting in the back of the room waiting to assist the student with utilizing the skills taught, the school will not bill for the time the staff are in the back of the room and should only bill for Medicaid reimbursement when the staff are directly assisting that student.

DOCUMENTATION

IDAPA 16.05.07.101.02 requires that providers must grant to the Department and its agents immediate access to records for review and copying during normal business hours. If records are not maintained at the provider's location and immediately available, the provider is not complying with this rule.

Provider Self-Report of Overpayments

Federal regulations require providers to report and return overpayments within 60 days of identification of the overpayment. Providers also agree in their Idaho Medicaid Provider Agreement to immediately repay the Department for any items or services the Department or the Provider determines were not properly, provided, documented, or claimed.

Providers are now able to notify the Medicaid Program Integrity Unit of overpayments with an on-line Provider Self Report Form. When a provider discovers they have been paid improperly, it must be determined whether repayment can be handled by adjustments/reversals of claims through the Molina system or by self-reporting the overpayment to the Medicaid Program Integrity Unit.

Repayment of simple, routine occurrences of overpayments can be handled through the Molina system. Self-reporting is an alternative to assist the provider in the repayment of claim errors or overpayments. Some examples of when to self-report include:

- Provider's internal review process identifies services were incorrectly coded
- Provider discovers the services were provided by an unlicensed or excluded individual
- Provider's internal review process discovers services were not rendered
- Inability to process adjustments through the Molina system because claims are more than two years from the last date of claim payment or adjustment

Providers can access the Provider Self Report Form at:
http://healthandwelfare.idaho.gov/AboutUs/FraudReportPublicAssistanceFraud/ProviderSelfReportForm/tabid/3900/Default.aspx

After submission of the form providers will be contacted by the Medicaid Program Integrity Unit within five working days to discuss repayment.

Incentives to providers who participate in self-report:

- Extended repayment terms
- Waiver of civil monetary penalties
- Quick resolution of overpayments

Please contact the Medicaid Program Integrity Unit at 1 (208) 334-5754 if you have any questions.

Do You Submit Coordination of Benefit Secondary Claims to Medicaid?

Efficient Billing Tips

1. Medicaid is the payer of last resort.
2. All other insurances and liable third parties must be billed prior to submitting to Medicaid.
3. Report primary insurance payments on the line level. This will allow the system to consider and process the claim accordingly.
4. Attach required documents such as the primary Explanation of Benefits, including the summary page.

(Continued on next page)

(COB Secondary Claims Cont'd)

5. Ensure the Explanation of Benefits attached reflects the same dates of service, services provided, and provider and member information.
6. Ensure that you've entered the name and NPI of the ordering, referring, or prescribing provider.
7. Avoid manually adjudicating the claim; this could result in bypass of system process.

All the above functionality can be completed within your Trading Partner Account when your claim is originally submitted. Claims in pay and deny status should be allowed to process to a finalized status (PAID or DENIED) prior to making adjustments or modifications.

The Five Most Important Federal Fraud and Abuse Laws that Apply to Physicians

Spotlight – Exclusion Statute [42 U.S.C. § 1320a-7]

Most physicians strive to work ethically, render high-quality medical care to their patients, and submit proper claims for payment. Idaho Medicaid and the Federal Government rely 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. While Idaho statute and rule also address Fraud and Abuse, here we are only looking at the Federal laws.

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.

This month we are looking at the **Exclusion Statute [42 U.S.C. § 1320a-7]**.

The OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses:

(1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid;
(2) patient abuse or neglect;
(3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and
(4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

(Continued on next page)

(Fraud and Abuse Laws Cont'd)

The OIG has discretion to exclude individuals and entities on several other grounds, including misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud or misdemeanor convictions in connection with the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; and defaulting on health education loan or scholarship obligations.

If you are excluded by OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration, will not pay for items or services that you furnish, order, or prescribe. Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice. In addition, if you furnish services to a patient on a private-pay basis, no order or prescription that you give to that patient will be reimbursable by any Federal health care program.

In accordance with the expanded sanction authority provided in HIPAA and BBA, and with limited exceptions, an exclusion from Federal health care programs effectively precludes an excluded individual or entity from being employed by, or under contract with, any practitioner, provider or supplier to provide any items and services reimbursed by a Federal health care program. This broad prohibition applies whether the Federal reimbursement is based on itemized claims, cost reports, fee schedules or PPS. Furthermore, it should be recognized that an exclusion remains in effect until the individual or entity has been reinstated to participate in Federal health care programs in accordance with the procedures set forth at 42 CFR 1001.3001 through 1001.3005. Reinstatement does not occur automatically at the end of a term of exclusion, but rather, an excluded party must apply for reinstatement.

If you are an excluded individual or entity, or are considering hiring or contracting with an excluded individual or entity, and question whether or not the employment arrangement may violate the law, the OIG Advisory Opinion process is available to offer formal binding guidance on whether an employment or contractual arrangement may be in violation of the OIG's exclusion and CMP authorities. The process and procedure for submitting an advisory opinion request can be found at 42 CFR 1008, or on the OIG website at www.hhs.gov/oig.

1. A Federal health care program is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program) (section 1128B(f) of the Act). The most significant Federal health care programs are Medicare, Medicaid, Tricare and the Veterans programs.
2. A Federal program beneficiary is an individual that receives health care benefits that are funded, in whole or in part, by a Federal health care program.
3. For example, the prohibition against Federal program payment for items and services would continue to apply in the situation where an excluded pharmacist completes his or her medical degree and becomes a licensed physician.
4. In certain instances, a State health care program may request a waiver of an exclusion if an individual or entity is the sole community physician or the sole source of essential specialized services in a community (42 CFR 1001.1801(b)).

(Continued on next page)

(Fraud and Abuse Laws Cont'd)

You are responsible for ensuring that you do not employ or contract with excluded individuals or entities, whether in a physician practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors. This responsibility requires screening all current and prospective employees and contractors against OIG's List of Excluded Individuals and Entities. This online database can be accessed from OIG's Exclusion website. If you employ or contract with an excluded individual or entity and Federal health care program payment is made for items or services that person or entity furnishes, whether directly or indirectly, you may be subject to a civil monetary penalty and/or an obligation to repay any amounts attributable to the services of the excluded individual or entity.

Provider Training Opportunities in 2017

You are invited to attend the following webinars offered by Molina Medicaid Solutions Regional Provider Relations Consultants.

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

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

	10 a.m. - 11 a.m. MT	10 a.m. - 11 a.m. MT	10 a.m. - 11 a.m. MT	10 a.m. - 11 a.m. MT	2 p.m. - 3 p.m. MT	2 p.m. - 3 p.m. MT	2 p.m. - 3 p.m. MT
June Personal Care Services	6/14/2017	6/15/2017	6/20/2017	6/21/2017	6/8/2017	6/15/2017	6/20/2017
July Eligibility	7/12/2017	7/18/2017	7/19/2017	7/20/2017	7/13/2017	7/18/2017	7/20/2017
August Vision	8/9/2017	8/15/2017	8/16/2017	8/17/2017	8/10/2017	8/15/2017	8/17/2017
September Long Term Care	9/13/2017	9/19/2017	9/20/2017	9/21/2017	9/14/2017	9/19/2017	9/21/2017
October Respite Care	10/11/2017	10/17/2017	10/18/2017	10/19/2017	10/12/2017	10/17/2017	10/19/2017
November Residential Assisted Living Facilities	11/8/2017	11/15/2017	11/16/2017	11/21/2017	11/9/2017	11/16/2017	11/21/2017
December Home Health and Hospice	12/13/2017	12/19/2017	12/20/2017	12/21/2017	12/14/2017	12/19/2017	12/21/2017

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 14 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 **Authorization Status**. If you are unable to identify the reason for a denied service, a Molina Medicaid Solutions 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 Molina Medicaid Solutions 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.

	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 Veyo Logistics for all non-emergency medical transportation services. Please go to http://idahotransport.com_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

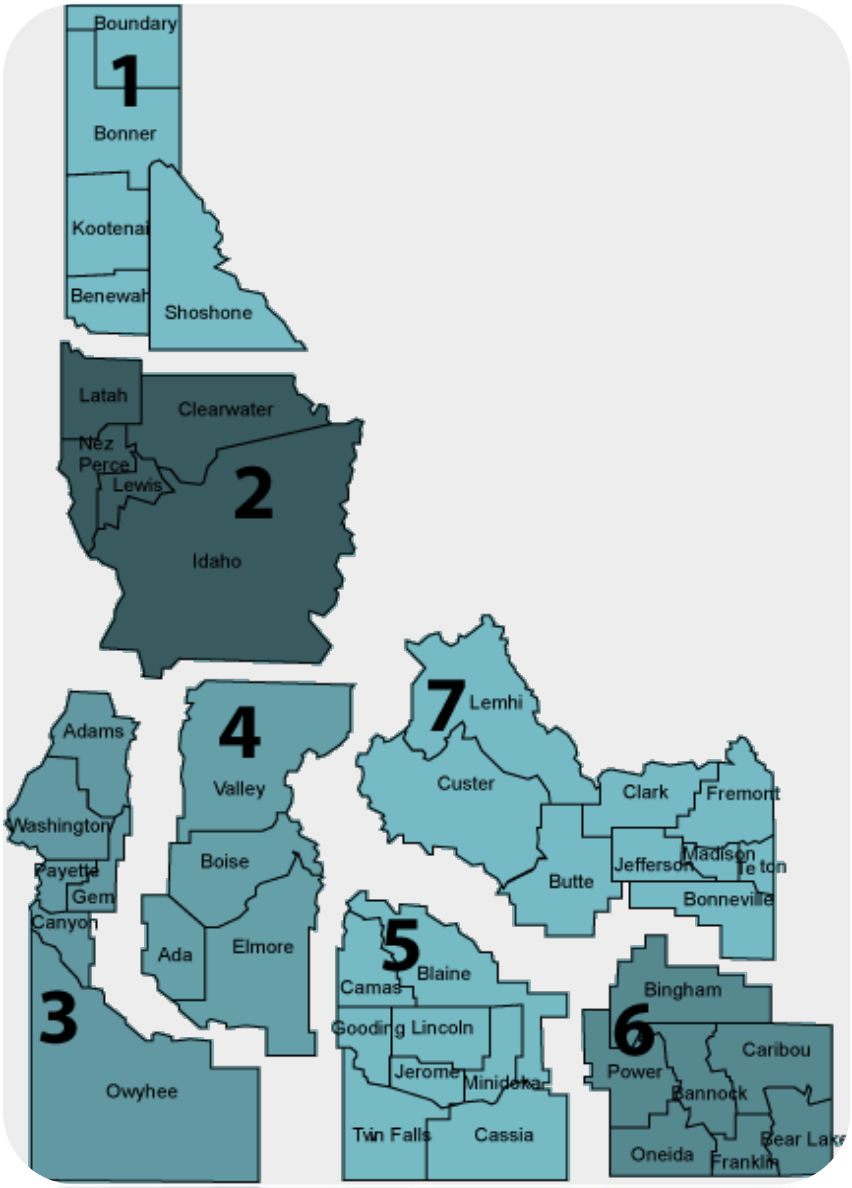
Molina Provider and Participant Services Contact Information

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

Molina 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
1120 Ironwood Drive Suite 102
Coeur d'Alene, ID 83814
1 (208) 559-4793
Region.1@MolinaHealthCare.com

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1118 F Street
P.O. Box Drawer B
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1 (208) 991-7138
Region.2@MolinaHealthCare.com

Region 3 and the state of Oregon
3402 Franklin
Caldwell, ID 83605
1 (208) 860-4682
Region.3@MolinaHealthCare.com

Region 4 and all other states
1720 Westgate Drive, Suite A
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1 (208) 373-1343
Region.4@MolinaHealthCare.com

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601 Poleline Road, Suite 7
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1 (208) 484-6323
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1 (208) 870-3997
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Region 7 and the state of Wyoming
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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

If you have any comments or suggestions, please send them to:
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