MedicAide

An Informational Newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **March 2018**

In This Issue

Information Releases

JW Modifier

The JW Modifier became effective January 1, 2017 for use on Medicare Part B claims with drugs or biologicals from single use vials and packages. The modifier is appended on claim lines for units that are not administered to a patient, and must be discarded. Idaho Medicaid is unable to reimburse for waste. Claim lines with the JW modifier will be denied as non-covered.

Therapies and Durable Medicaid Equipment (DME) on Adult Developmental Disability (DD) Service Plans

Effective March 1, 2018, the cost of physical therapy (PT) services, occupational therapy (OT) services, speech language pathologist (SLP) services, and DME will not need to be costed as part of an adult developmental disability (DD) **traditional** service plan.

If an adult DD participant is going to be accessing PT, OT, SLP, or DME services/supports during their plan year, it will still be necessary to include this information in the Personal Summary and the Supports and Services sections of the participant's service plan.

If a participant's current DD service plan includes costing for PT, OT, SLP, or DME, a participant will be able to access these monies for other supports or services. An addendum will need to be submitted to the Department to add back in the amount previously identified on the participant's plan for PT, OT, SLP, or DME.

Questions about PT, OT, SLP, or DME on a DD service plan should be directed to the participant's assigned Bureau of Developmental Disability Services (BDDS) Care Manager.

Impact on Self-Directed Support and Spending Plans (SSPs)

Just like traditional plans, effective March 1, 2018, a participant will no longer need to cost PT, OT, SLP, or DME services/supports as part of their DD **self-directed** service plan. However, if an adult DD participant is going to be accessing PT, OT, SLP or DME services/supports during their plan year, it will still be necessary to include this information in the My Voice My Choice Workbook.

In addition, if a participant's *current* self-directed DD service plan includes costing for PT, OT, SLP, or DME, a participant will be able to use any monies that have not already been paid out to a Community Support Worker (CSW) or Vendor for providing PT, OT, SLP, or DME services/supports. A plan change form will need to be submitted to the Department to add back in the amount available to purchase other supports or services.

Any questions about this change should be directed to the participant's assigned BDDS Care Manager.

Adult Developmental Disability Services: Service Coordination – Provider Qualifications

The Bureau of Developmental Disability Services (BDDS) would like to provide guidance related to the Service Coordination Provider Qualifications.

Service Coordination Agencies must review employee qualifications prior to hiring and be prepared to demonstrate how the employee meets the educational requirements during a quality assurance review conducted by the Department.
Under *IDAPA 16.03.10.729*, agency supervisors and service coordinators can meet the educational requirements if they have earned a bachelor or master's degree in a "human services field" from a nationally accredited university or college. A "human services field" is defined in *IDAPA 16.03.10.721.05* as "a particular area of academic study in health care, social services, education, behavioral science or counseling."

The Centers for Medicare and Medicaid Services (CMS) has provided regulatory and sub-regulatory guidance regarding what it means to be a "human services professional."

Under 42 CFR 483.430(b)(5)(x), a human services professional "must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology)."

In the CMS State Operations Manual (SOM), Appendix J, Part II titled "Interpretive Guidelines-Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities," CMS indicates that:

> Human Services is a diverse field focused on improving the quality of life of clients in communities in which the professional serves. A human services professional works directly with the population being served. Surveyors should see evidence that a human service professional has a bachelor's degree at a minimum.

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.

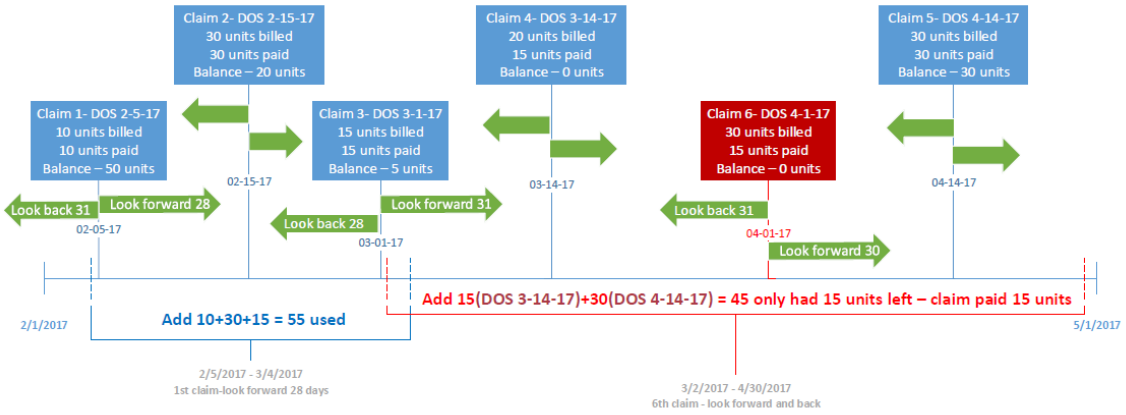
Attention DME Providers: Rolling Months and Limitations

On July 1, 2017, Idaho Medicaid implemented rolling month limitations composed of 30 days. This change was made to align with industry standards, address system limitations, implement program integrity recommendations and to comply with ***IDAPA 16.03.09.*, "Medicaid Basic Plan Benefits."**

***IDAPA 16.03.09.752.03.a* Coverage Conditions -- Supplies**.

"The Department will purchase no more than a one (1) month supply of necessary medical supplies per month for the treatment or amelioration of a medical condition identified by the attending physician. Supplies in excess of the limitations in the CMS/Medicare DME coverage manual must be prior authorized by the Department."

The following diagram provides an example of how the system calculates the rolling month.



Picture illustrates how calendar month is reviewed and calculated in our system. A 'calendar' month is not a set number of days it literally means the calendar month the service is delivered in. If a member receives a service on 02-01-17 and exhausts the limitation for the month at that time, the member will be eligible for the new month as of 03-01-17. There are only 28 days between those dates. If the member again exhausts the limit on 03-01-17, the member would be eligible for the new month as of 04-01-17. There are 31 days between those dates of service. The system truly reviews days by the calendar month the service is in. Remember to look backwards based on the previous month's days and forward based on the current month's days.

Limitations can be reviewed if the monthly allowed amount doesn't meet the majority of participant's needs for a 30-day supply. The Medicaid Policy Unit will review on a code by code basis requests to increase limitations. Limitation increases above a 30-day supply can be considered, but only for supplies that would be necessary before the next business day if a refill would fall on a weekend or holiday.

Requests may be submitted to MCPT@dhw.idaho.gov. Requests without supporting documentation will be denied. Supporting documentation should demonstrate why the current limitation would not meet the average participant's needs, or the nature of a potential emergency.

Requests should not be sent to the Medicaid Policy Unit for participants who have individual circumstances that exceed limitations. For participants that may individually need an exception, please, follow the DME prior authorization process.

As a reminder to providers, the date of dispense is the date of service. Claims with dates of service that do not match the date delivered are subject to recoupment.

Attention: DMEPOS Suppliers

Idaho Medicaid has composed a new PA request form for wheelchair repairs. The purpose of this form is to ensure that all pertinent information is included to the Department for consideration. This form is currently available on our DME page located at www.medunit.idaho.gov.

Effective April 2, 2018, Idaho Medicaid will require that this new form be used when requesting repairs to wheelchairs. Thank you for your understanding and cooperation.

Attention DMEPOS Suppliers

As a reminder, for codes with no price indicated on the Idaho Fee Schedule, you must submit documentation that demonstrates the usual and customary charge for that service item and it cannot be more than the usual and customary rate per *IDAPA 16.03.09.230.05. ii.* According to *IDAPA 16.03.09.755.06* and *16.03.09.010.19*, DMEPOS suppliers must provide documentation which supports the inquired charges for the requested service.

If Department documentation requirements are not met, the request for a PA cannot be authorized.

Department pricing documentation requirements are captured in detail in the Idaho Medicaid DMEPOS PA Policy and Medical Criteria. This policy can be found on the DME website under the **Resources** tab at http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DurableMedicalEquipment/tabid/271/default.aspx.

Attention DME Suppliers: Incontinence Supplies

Medicaid is revising the coverage for pull-ups based on participant and provider input. Effective February 1, 2018, pull-ups will be covered for participants over the age of four when:

- The participant can perform toileting activities on their own at least some of the time; and
- Use of the pull-ups instead of briefs will allow them to independently and safely complete toileting activities; and
- The pull-ups are not for the convenience of the caregiver

Toilet training plans for participants between four and 21 are no longer required, but are encouraged for participants transitioning out of diapers and briefs. The DME provider must keep documentation on file with a statement of necessity from the ordering physician or non-physician practitioner that the participant meets the requirements for coverage. For participants with existing orders on file, the new documentation isn't required until July 1, 2018.

Medicaid Program Integrity Unit Audit Surveys

As part of its ongoing commitment to provide the highest quality audits, the Medicaid Program Integrity Unit will survey audited providers. Feedback will be used to help improve audits in the future. Providers receiving e-mails requesting they complete the brief survey are encouraged to take a few minutes to respond.

Meetings on Proposed Audit Guidelines for Medicaid Program Integrity Unit

The Medicaid Program Integrity (MPI) Unit is creating unit audit guidelines and is encouraging Medicaid providers to provide input on the following:

- Defining what is considered repeated or substantial for purposes of assessing civil monetary penalties (CMP)
- Describing when statistical sampling is used
- Describing when overpayments are extrapolated
- Describing method for calculating extrapolated overpayments
- Describing when and how to extrapolate CMPs

Providers were given an opportunity to provide input through an on-line survey that was available from January 15 through February 15.

Providers are encouraged to attend meetings in Boise, Coeur d'Alene, and Pocatello to discuss proposed guidelines, review survey findings and provide additional input.

MEETING INFORMATION

DATE	March 5, 2018	March 7, 2018	March 8, 2018
TIME	10 a.m.	12:30 p.m.	10 a.m.
AREA	Central Idaho DHW Office	Eastern Idaho DHW Office	Northern Idaho DHW Office
ADDRESS	450 West State Street Boise	1070 Hiline Road Pocatello	1120 Ironwood Drive Coeur d'Alene
ROOM	7A conference room; 7th floor Pete T. Cenarrusa Bldg (PTC)	Conference room 230	Main conference room

Medicaid Program Integrity Unit

Licensed Midwife Providers

The Medicaid Program Integrity Unit wants to remind licensed midwife providers of the qualification and documentation requirements for services billed to Medicaid. Services must be rendered by a licensed midwife who is enrolled with Idaho Medicaid. Services provided by aides or midwife students are not reimbursable.

Services must be documented by the individual providing the service, and contain their signature and credentials. Providers are required to generate documentation at the time of service, which must be retained for five years from the date of the service.

The Idaho MMIS Provider Handbook, Licensed Midwives, identifies provider qualifications and states, in pertinent part:

(Continued on next page)

(MPIU – Licensed Midwife Cont'd)

2.1.2. Provider Qualifications
Medicaid covers midwife services rendered by an LM as defined in IDAPA 16.03.09, Medicaid Basic Plan Benefits and within the scope of practice as detailed in IDAPA 24.26.01, Rules of the Idaho Board of Midwifery.

Eligible LM providers must submit an enrollment application to Idaho Medicaid for approval prior to providing services for Idaho participants.

2.1.4. Out-of-state Care
Out-of-state providers who are licensed in Idaho and actively enrolled in the Idaho Medicaid Program may render services to Idaho Medicaid participants. Care by an out-of-state provider who renders services within Idaho, must follow Idaho Statute and Rule. All care provided outside the state of Idaho is subject to the same utilization review, coverage requirements, and restrictions as care provided within Idaho.

Section 2.1.11. identifies documentation requirements and states, in pertinent part:

2.1.11. Documentation of Services and Access to Records
According to IDAPA 16.05.07.101, "Providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five (5) years from the date the item or service was provided." All documentation must be made available to the Department immediately upon request.

Records limited to checklists with attendance/appointments, procedure codes, and units of time are insufficient to meet this requirement. Documentation must include at least the following:

- Informed consent
- Date and time of services
- Descriptions of the specific services provided
- Assessment of participant
- Signatures and credentials of the performing provider

All LM providers must maintain the Complete Practice Data as required by the Idaho Board of Midwifery, and make those records available to the Department upon request.

Services billed that are not in compliance with the Idaho Medicaid Provider Handbook, Idaho Medicaid Provider Agreement, and Idaho Administrative Code are subject to recoupment and civil monetary penalties.

New Independent Assessment Contractor for Children's Mental Health Services

As a result of the Jeff D. lawsuit, the Youth Empowerment Services (YES) program was developed and tasked with transforming mental health in Idaho for children. As of January 1st, Liberty Healthcare began providing mental health assessments for children up to the age of eighteen (18), to determine if that individual has a Serious Emotional Disturbance (SED) and a functional impairment. Liberty will also conduct a clinical diagnostic assessment (CDA) if one has not been provided in the last six (6) months. These assessments are provided at no cost to the family or member seeking YES program eligibility. If eligibility is met families between 185-300% FPL can apply for Medicaid eligibility and coverage.

If you know of a child who needs mental health services, including respite, please contact Liberty Healthcare at 1.877.305.3469 for a free assessment.

Oxygen Services

Medicaid covers medically necessary oxygen services for participants who meet the DME MAC coverage criteria.

A 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. A separate physician's order is not necessary. The laboratory evidence justifying the use of oxygen must be included with the first claim for oxygen therapy for the participant. 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. All claims submitted electronically must include the oxygen information on each transaction.

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, 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.

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.

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

Balance Billing Medicaid Participants: Reminder and Clarifications

This article offers clarification of a March 2016 MedicAide Newsletter on Balance Billing. Providers are prohibited from balance billing Medicaid participants (including QMB participants) by the Social Security Act, Section 1902(n)(1)-(3). Providers must accept Medicaid payment as payment in full for services rendered. Providers should also be aware that participants cannot be billed for missed appointments.

Providers can bill non-covered Medicaid services to the participant. Providers should first pursue all payment options including third party liability and prior authorizations for additional units. Services not covered by Idaho Medicaid may be charged to the participant, if the participant is advised in writing prior to receiving the service or item, and agrees to be responsible for payment. Notices must specify the non-covered service or item, and be signed by the participant.

A written agreement with a participant does not relieve a provider from their responsibilities to Idaho Medicaid. The provider is required by *IDAPA 16.03.09.230.03*, "Medicaid Basic Plan Benefits" to submit claims to Idaho Medicaid. There is not an option to bill participants instead of submitting a claim. Providers also may not bill the participant for failure to request a prior authorization, not billing in a timely manner, or other billing errors.

Special note: If a referral from the Healthy Connections provider is required and has not been received before the participant's care appointment, the provider should offer to reschedule the participant after a valid referral has been received. If the participant decides to continue without a referral, the service would be considered non-covered, and could be billed to the participant with the appropriate documentation.

Provider Handbook Updates

The UB04 Instructions handbook was updated to add:

- Changes to the therapy cap.
- CPT and HCPC requirements for Durable Medical Equipment through Home Health.

The Therapy Services – Occupational and Physical handbook was updated to add:

- Changes to the therapy cap.

The Hospital handbook was updated to add:

- Changes to the therapy cap.
- Clarification of diabetes education and training.

The Speech, Language, and Hearing handbook was updated to add:

- Changes to the therapy cap.

The NDC Format for Billing PDA was updated to add:

- Clarification that NDC may come from vial.

The Podiatric Medicine and Surgery handbook was updated to add:

- G0127 as a covered code under routine foot care.

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(Provider Handbook Updates Cont'd)

The Suppliers handbook was updated to add:

- Clarification on when to submit a toilet training plan for incontinence supplies.
- Detailed information on oxygen services.

The General Billing Instructions handbook was updated to add:

- Clarifications on an acceptable invoice for manual pricing.
- Information about the JW modifier.

A General Review of Reasonable and Necessary Services, Exclusions from Coverage, and Non-Covered Services

All medical services, surgeries, treatments, modalities, tests, and items, are subject to the same evidence-based standards accepted by the general medical community and must be medically necessary, regardless of provider type or specialty. Evidence-based treatment is medical treatment and therapies for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific conditions. Excluded services are defined by statute and rule and are those that Idaho Medicaid can never pay for.

Medicaid is a taxpayer funded entitlement program combining federal and state dollars to pay medically necessary services for the enrolled population. Medicaid services are limited to the most appropriate medical services to meet the needs of the participant. Statutorily excluded services are not a covered benefit and are not billable to Medicaid. Excluded services or items are those which do not meet coverage criteria.

A service or item may not be reimbursable by Idaho Medicaid for a variety of reasons which may include:

- Specific exclusions contained in federal law (for example, screening lab tests)
- Idaho state rule (for example, fertility services)
- Services which have not been proven safe and as effective, or more effective than standard care and therefore, not medically reasonable and necessary
- Procedures that are always considered cosmetic in nature and are denied on that basis
- Experimental or investigational services
- Services not approved by the FDA

The Idaho Administrative Procedures Act (IDAPA) 16.03.09 and 16.03.10 define covered, excluded and non-covered services and items for the entire Medicaid program as well as for specific benefits, and provider types and specialties. Providers and their billing staff should be familiar with all applicable rule in IDAPA in the general sections, and provider type specific sections, as well as the Idaho MMIS Provider Handbook. The IDAPA definition of medical necessity follows:

> **IDAPA 16.03.09.011.16. Medical Necessity (Medically Necessary)**. A service is medically necessary if: (3-30-07)
>
> a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-30-07)

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(General Review Cont'd)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-30-07)
c. Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-30-07)

Idaho Medicaid uses the information and criteria stated in Title XVIII of the Social Security Act, Section 1862(a)(1) which protects the spending of federal dollars for health care services and is the basis for denying payment for types of care, items or services that are not excluded by any other statutory clause. Some commercially available services or items may seem to meet all technical requirements for coverage, yet remain non-covered services or items. The following criteria applies to all manner of medical treatment, services and items, which are not covered payable benefits:

- Rendered for diversional, vocational, recreational, or avocational purposes or activities that can be conducted by non-medical or unskilled personnel.
- Not generally accepted in the medical community as safe and effective in the setting and for the condition for which it is used.
- Not proven to be safe and effective based on peer review or scientific literature.
- Not necessary and consistent with generally accepted professional medical standards and not experimental or investigational.
- New procedures, services, or items of unproven value and established procedures of questionable current usefulness that are excluded by Medicare, the Federal Drug Administration (FDA) and other commercial carriers, including inappropriate match of condition/diagnosis to service/item. Questionable procedures, etc. are reviewed using the criteria listed in IDAPA 16.03.09.443.
- Not medically necessary in the particular case, or not consistent with the symptoms or diagnosis of the illness or injury under treatment.
- Not furnished at a level, duration or frequency that is not medically appropriate.
- Not furnished in accordance with accepted standards of medical practice.
- Not furnished primarily for the convenience of the patient, the attending physician or other physician or supplier.
- Not furnished at the most appropriate level that can be provided safely and effectively to the patient.
- Not furnished in a setting appropriate to the patient's medical needs and condition.
- Is furnished primarily for the convenience of the patient, a family member, a caregiver, the attending physician or other physician or supplier.
- Elective medical and surgical treatments, except family planning services.
- Alternative treatments, services, therapies etc. such as acupuncture, biofeedback therapy, laetrile therapy.
- Excluded foot care services.
- No legal obligation to pay for or provide.
- Responsible payor is other federal or state governmental entities or funding source.
- Responsible payor is biological parent.

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(General Review Cont'd)

A new service or item is not automatically medically reasonable and necessary even when issued a national CPT, HCPCS code or becomes FDA approved for a specific indication or condition. Idaho Medicaid evaluates new CPT and HCPCS codes, new services, procedures, drugs or technology and considers Medicare national and local policies and analysis, national commercial insurer local policies and analysis, before new services may be considered payable by Idaho Medicaid. Idaho Medicaid will make payment only when a service is accepted as effective and proven by the general medical community. Some tests or services are obsolete and have been replaced by more advanced procedures. All tests, services, or items may be paid only if the performing, rendering or supplying provider satisfactorily justifies the medical need and benefit for the service or item. A medical service or item inappropriately applied, rendered or dispensed, is not useful or may be harmful to a participant without an appropriate indication or condition.

Research or Clinical Studies
Idaho Medicaid excludes services conducted within a research or clinical study, unless such study is registered and approved as a federally predetermined and authorized investigational program under CMS Medicare's three specific policies: (1) the Clinical Trial Policy (CTP), (2) the Investigational Device Exemption (IDE) policy, and (3) Coverage with Evidence Development (CED). Routine costs associated with Medicare approved Clinical Trials are payable by Idaho Medicaid. (For more information about this program, see the Medicare Benefit Policy Manual, Chapter 14)

Screening Services Not Mandated are Statutorily Excluded from Reimbursement

Tests or procedures rendered for screening purposes are excluded by federal and state law and rule for lack of medical necessity, except those approved and recommended by statute or rule. A billing CPT or HCPCS code found on an Idaho Medicaid Fee schedule, is non-covered when rendered for a screening, subclinical or unapproved diagnosis.

Testing is considered not medically necessary when:

- Testing is not considered standard of care, such as when the clinical diagnosis can be made without the use of a genetic or other lab/radiology test;
- Testing is not clinically appropriate for the participant's condition
- Testing is not appropriate when it would not change a participant's diagnosis, treatment and/or management.

Predictive Screening: Coverage is limited to those tests recommended by; the U.S. Preventive Services Task Force (USPSTF) A and B Recommendations; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and identified in the Bright Futures American Academy of Pediatrics (AAP) periodicity schedule. And preventive services for women recommended by the Institute of Medicine (IOM). Please see Idaho Administrative Code IDAPA 16.03.09, Sub Area: Prevention Services, (Sections 580 - 649)

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(Screening Services Cont'd)

For adult participants, including those who are pregnant, Idaho Medicaid follows the specified preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), and approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). If a USPTF recommendation is accurately represented by a CPT or HCPCS billing code listed on the Idaho Medicaid Fee Schedule (idmedicaid.com) the service may be reimbursable when rendered and documented in compliance with all applicable regulation or guidance. Coverage requirements include the clinical, diagnostic and frequency guidance with these recommendations.
https://www.uspreventiveservicestaskforce.org/Page/Name/home

For child and adolescent participants, Idaho Medicaid has adopted the American Academy of Pediatrics (AAP) periodicity schedule as the recommended frequency for child wellness exams. This periodicity schedule has been replicated in the tables found in Idaho MMIS Provider Handbook General Provider and Participant Information Section 2.9.1.29.1.2 Periodicity Schedule. The AAP periodicity schedule delineates the types of screening and testing that should be conducted during a wellness exam for each age group. https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

The Social Security Act (SSA) 1862(a)(1)(A) and Code of Federal Regulations (CFR) strictly exclude the use of federal dollars in payment for services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Federally funded programs such as Medicare and Medicaid, are required to pay services that meet coverage criteria and are reasonable and necessary to treat or diagnose a participant's illness or injury. Federal funds generally do not cover routine screening tests even if the treating physician or authorized non-physician practitioner considers the tests appropriate for the participant.

Preventive Health Services and Screening
Diagnostic testing leads to treatment services which control, correct, or ameliorate health problems found through evaluation and testing. Diagnostic laboratory, diagnostic radiology, and other diagnostic tests provided as a physician service or hospital outpatient service, are limited to physician ordered tests considered to be reasonable and necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury, or to improve the functioning of a malformed body member. The most specific CPT or HCPCS codes must always be used on claim submissions.

All covered diagnostic tests and screenings must be ordered by a physician, or non-physician practitioner as identified by the Idaho Medicaid Ordering, Referring and Prescribing Provider (ORP) policy, who is acting within the scope of their license as defined by State law, and is treating the participant. The results to be used in the management of a participant's specific medical problem.

Screening Tests or Diagnostic Tests
Many available lab, radiology, behavioral etc., tests are very informative, but do not meet the standards of medical necessity, have no clinical benefit and offer no information that can improve the health, diagnosis, or treatment of the eligible Medicaid participant.

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(Screening Services Cont'd)

Appropriate diagnostic tests will diagnose or determine treatment in the presence of signs and symptoms of disease. Screening tests, whether a lab test or another type of screening service, return predictive results. Screening services are only payable benefits when defined as required by statute or rule. Most all predictive screening tests do not meet the medical necessity standards set by the SSA, CFR, Idaho Statute or Idaho Administrative Code. All participants are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis when those services are identified as a covered benefit in Idaho IDAPA or the Idaho MMIS Provider Handbook.

Potential Harms of Unnecessary or Unproven Medical Screening or Testing
Medically unnecessary testing includes high potential for harm, if potential for false positive or negative results are not appropriately reported through professional specialty review. Any test result, especially for tests new to the market, may return false positives, false negatives, or even a "variant of uncertain significance." Newer tests are especially subject to false results and poor application of results. Such unnecessary screening may result in medical interventions which may cause harm, and other kinds of harm may result if a positive result comes with no known treatment.

The Social Security Act (SSA) 1862(a)(1)(A) and Code of Federal Regulations (CFR) strictly exclude the use of federal dollars in payment for services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Federally funded programs such as Medicare and Medicaid, are required to pay services that meet coverage criteria and are reasonable and necessary to treat or diagnose a participant's illness or injury. Federal funds generally do not cover routine screening tests even if the treating physician or authorized non-physician practitioner considers the tests appropriate for the participant.

If a test, treatment, or procedure is neither specifically covered nor excluded in rule or statute, Idaho Medicaid will make a coverage determination that is based upon review of the Social Security Act (SSA) 1862(a)(1)(A) and other applicable federal or state regulation, the general professional medical community acceptance of the test, if the test or procedure is as safe and effective, or more effective than current standard items or proven medical care for the condition for which it is being used. Medicaid will conduct analysis and consult nationally validated analysis and resources that include, but are not limited to: validated and professionally reviewed clinical data, including clinical study results which include a review of Clinical Trials.gov (https://clinicaltrials.gov/). Supportive study data should be advanced past an observational phase and progressed to Stage 3 Clinical Study, with consistent findings across studies, as described by the Federal Drug Administration (FDA) and the National Institutes of Health (NIH) to be considered valid and vetted results (https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/science-health-public-trust/understanding-clinical-studies).

Covered routine screening and testing of any participant should not be duplicated. See the current Idaho Medicaid Physician and DME Fee Schedule for treatment and procedures codes that may be reimbursed by Idaho Medicaid. Inclusion or exclusion of a procedure, diagnosis, or item code does not imply coverage or reimbursement. Please refer to the HealthPas (idmedicaid.com) to check each participant's eligibility status and benefits in effect for the date of service, at the time of service, to determine coverage or non-coverage of services. Extraordinary clinical circumstances may warrant individual coverage review on a case by case basis.

National Medical, Billing, and Coding Guidance Resources

Providers are reminded any service that is described as statutorily excluded, or as "non-covered" remains non-covered no matter which CPT code is selected for billing. The provider's adherence to Idaho Medicaid policies and rule is monitored partly by computer audits or edits of claims, pre-payment and post-payment or retrospective review of claims, as well as the Department or other federal or State authorized auditors. Computer audits or edits cannot account for all variables in submitted claims, or may fail to function properly and so, the application of policies in this document, the Idaho MMIS Provider Handbook, rule, statute, or Federal CFR or Statute, remain in effect. Providers are reminded that all paid claims/services will be subject to post-payment review and recoupment.

For covered services which do not require prior authorization, nor have guidance found in IDAPA rule or the Idaho MMIS Provider Handbook, Idaho Medicaid uses the Medicare and Noridian national and local coverage determinations for guidance on correct determination of medical necessity including appropriate diagnosis and clinical criteria, medical necessity, bundling, service limitations, documentation and medical record standards, etc. If an Idaho Medicaid document/guidance or a local or national coverage determination or other SSA, CFR, or CMS guidance does not exist, Idaho Medicaid will determine whether coverage is available on a case-by-case basis.

Medicare and Idaho Medicaid share many of the same benefits and cover services and items which are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member. Most Idaho Medicaid provider types and specialties are required to be actively enrolled with and/or certified by Medicare. Idaho Medicaid and Medicare share enrollment data to improve reporting and oversight of spending of federal and state dollars.

Providers should be aware that Idaho Medicaid payment rates are based on Medicare payment rates, per Idaho IDAPA. The presence of a payment amount on any Medicare physician fee schedule (MPFS) or other Medicare fee schedule, does not imply that the service may be covered by Medicare or Idaho Medicaid. The nature of the status indicator in the MPFS database does not control coverage except where the status is N for noncovered." [Medicare Claims Processing Manual (CMS Pub. 100-04, Chapter 23, Section 30 A)] The Medicare fee schedules are useful resources, for example Part B MPFS Indicator List does include national guidance on code status, and bundled status, Medicare excluded, Medicare reporting only, non-covered, incident to, restricted coverage etc., global days and modifiers 54, 55, 78, modifiers TC/26 (which Medicaid may differ per payment methodology), modifiers 50, 51, 80, 62, and 66.

Idaho Medicaid follows national procedure codes and standards as required by CMS and listed in the most current version of:

- Current Procedural Terminology (CPT) in cooperation with the American Medical Association
- Healthcare Common Procedure Coding System (HCPCS) developed and maintained by CMS
- International Classification of Diseases Procedure Coding System (ICD-10-PCS) developed and maintained by CMS for facility reporting of inpatient procedures
- International Classification of Diseases Clinical Modification (ICD-10-CM) developed by the World Health Organization and the National Center for Health Statistics (NCHS) for use in the United States as required by CMS

(Continued on next page)

(Resources Cont'd)

As required by CMS, Idaho Medicaid follows the National Correct Coding Initiative (NCCI) program to ensure correct coding methodologies to reduce overpayments to providers. This includes the NCCI tables and NCCI Manuals at Medicaid.gov, and Medicare guidance on modifier usage as it applies to NCCI. NCCI guidance specific to all state Medicaid programs is found at Medicaid.gov.

The NCCI edits do not contain all instances of bundled services or codes and provider must correctly code their claims to not generate overpayments. Services that Medicare/Medicaid considers a component of another service, kit, equipment etc., and never separately billable or payable are also non-covered.

Idaho Medicaid has recently referenced CMS and Noridian coverage guidance in terms of Hyperbaric Oxygen therapy and Drug Testing and Screening services. Three important examples of policy unique to Idaho, differing from Medicare, include but are not limited to:

- The provider types and specialties enrolled by Idaho Medicaid are not all the same as Medicare, for Medicaid eligible pay to, rendering or ordering, referring, prescribing providers (ORP).
- Idaho Medicaid does not match payment methodologies unique to Medicare (such as OPPS, DRG, MIPS) and some coding and modifier guidance will differ from Medicaid when affected by Medicare payment methodologies.
- IDAPA excluded fertility-related services from Idaho Medicaid payment. This includes testing; artificial insemination; consultations; counseling; donation of ovum, sperm, or surrogate womb; genetic testing and/or counseling for family planning; in vitro fertilization; office exams; penile implants; or reversal of sterilization.

Code Long or Lay Descriptions

When reporting a service or item, providers must consult the current ICD-10 CM or PCS, CPT, or HCPCS billing code long description to select the most specific and comprehensive code available. If no such specific code exists in any national standard medical coding system, then an unlisted code may be used per guidance as documented in the current AMA CPT Manual. Unlisted codes may require prior authorization. Payment of an unlisted code is based entirely on documentation in the medical records and evidence of medical necessity for the service, treatment, or item requested (IDAPA 16.03.09.732).

Providers must not submit any claim for a non-covered service, treatment, or item under any approximate other code or unlisted code. Provider adherence to national billing and coding standards is required for all provider types and specialties. If a CPT, HCPCS code does exits, but is not found listed as a covered benefit/code on the Idaho Medicaid Physician Fee Schedule (idmedicaid.com) or other specialty provider fee schedule, the service is either excluded, non-covered, is incident to a physician service, or is bundled into a covered primary code.

To shorten the time it takes for provider claims to process through the system, be sure to use the appropriate CPT/HCPCS that describes the service provided to the highest level of specificity. Using unlisted, miscellaneous, or dump billing codes results in slower claims processing because these are manually priced codes.

(Continued on next page)

(Resources Cont'd)

Many covered codes on an Idaho Medicaid Fee Schedule do not require prior authorization (PA), nor have service or coding instructions in the Idaho MMIS Handbook or other Department communications. Many Idaho Medicaid providers are also enrolled with Medicare and providing services under Medicare guidelines. When Idaho Medicaid has not given instruction unique to Idaho, national correct coding and billing standards are available (except when some coding guidance is unique to Medicare payment methodologies such as the Outpatient Prospective Payment Systems), as well as diagnostic criteria and clinical requirements, through:

- Medicare Correct Coding Guidance,
- Medicare Learning Network Publications
- Medicare National Coverage Description (NCD)
- Noridian Jurisdiction F or D Local Coverage Description (LCD)
- Noridian Jurisdiction F or D Provider Manuals and training resources
- National Correct Coding Edits and Manuals (NCCI) found at Medicaid.gov
- CMS Laboratory Tests Manual
- CMS Molecular Diagnostics Services Program (MOLDX)

When a covered code requires prior authorization, providers must comply with guidance available from the Medicaid Medical Care Unit, or the current Quality Insurance Organization (QIO), as well as correct coding standards. For example, providers should not request prior authorization for separate payment of any CPT or HCPCS that is a bundled service per Medicare or Noridian definition, or by the National Correct Coding Edits (NCCI) found at Medicaid.gov.

Submission of a claim for reimbursement of services or items, is a bill submitted to the Federal Government. All Medicare, Idaho Medicaid, and national criteria for medical standards of care and standard diagnostic and service limitations and guidelines, apply to reimbursement of all services and items, etc. by Idaho Medicaid.

Idaho Medicaid Fee Schedules and Table for Specific Provider Types and Specialties

The Idaho Medicaid Provider Handbook and fee schedule of covered CPT and HCPCS billing codes is always available on the Idaho Department of Health and Welfare website at http://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/tabid/214/Default.aspx.

The Numerical Fee Schedule includes enrolled DME suppliers and physician and non-physician practitioners who bill Medicaid. Other Fee Schedules are maintained for providers who are authorized to render services within a particular provider type or specialty. For example, Ambulatory Surgical Centers, Independent Therapy Providers, and School-Based Services have a unique fee schedule of billable service codes and rates.

Idaho Medicaid Fee Schedules list current approved and covered billing codes representing services or items which are covered payable benefits when diagnostic and clinical criteria are met. Any service not accurately identified on a provider type's posted Department fee schedule of medical billing CPT or HCPCS codes, is not a covered service or benefit for that provider type or specialty. Time or cost for non-covered items or services, should not be billed to Idaho Medicaid. Idaho Medicaid Fee Schedule lists are published as an information guide regarding coverage and reimbursement amounts, and do not guarantee coverage or payment.

(Continued on next page)

(Fee Schedules Cont'd)

A submitted claim coded to fit a misrepresented or under documented service, therapy, activity, treatment, or item in medical records constitutes provider fraud. An example includes, but is not limited to, records that do not identify the test, modality, instrument, form, method or treatment etc., rendered to a participant. Professional standards and documentation guidelines must be fully met to support services, procedures, and diagnoses at the level they are billed. Medical documentation should be legible and unambiguous to any prudent layperson to support the services as billed to Medicaid.

Specialty Provider Fee Tables:

- Ambulatory Surgical Centers
- Anesthesia
- Adult DD
- Aged and Disabled Waiver
- Certified Family Homes (A&D/PCS)
- Children's DD
- Home Health
- Hospice
- Independent Therapy
- Personal Assistance Agencies
- Residential Assisted Living Facility (RALF)
- School-Based Services
- Service Coordination
- Transportation

Providers must not submit any claim for a non-covered service, treatment, or item under any approximate other code or unlisted code. Provider adherence to national billing and coding standards is required for all provider types and specialties. If a CPT, HCPCS code does exist, but is not found listed as a covered benefit/code on the Idaho Medicaid Physician Fee Schedule (idmedicaid.com) or other specialty provider fee schedule, the service is either excluded, non-covered, is incident to a physician service, or is bundled into a covered primary code.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

March 1, 2018

MEDICAID INFORMATION RELEASE MA18-02

To: All Nursing Facility and ICF/ID Administrators

From: Matt Wimmer, Administrator

Subject: Information Request Related to Wage Determination

Each year the Idaho Department of Health and Welfare gathers information from all nursing facilities (including hospital-based facilities) and intermediate care facilities for persons with intellectual disabilities (ICF/ID) to determine wage data for select employees in the nursing home industry.*

If you were a Medicaid provider on or before **March 15, 2018**, you must complete the attached certification according to the attached instructions and return the required information to:

Myers and Stauffer LC
8555 West Hackamore Drive, Suite 100
Boise, ID 83709-1693
Fax: (208) 378-0660

You must respond by April 15, 2018.

Submission instructions are shown on page 3. If you have questions, please contact Myers and Stauffer at (800) 336-7721. Thank you for participating in Idaho Medicaid.

MW/kl

Attachments:
* *IDAPA 16.03.10.281.02 and IDAPA 16.03.10.603.02*

INFORMATION REQUEST INSTRUCTIONS

(Please read carefully as strict adherence to these standards is required)

As of March 15, 2018, we are requesting the following information regarding select staff at all nursing facilities (including hospital-based facilities) and intermediate care facilities for individuals with intellectual disabilities (ICF/ID).*

You must submit the following information on the WAHR Survey Form 2018, in an Excel format, to Myers and Stauffer no later than April 15, 2018.* Early submissions are greatly appreciated. **Please see below for additional requirements for email submissions.**

- Employee Name: Include only the name or identifier for each employee (e.g., ID number). Do not include employee social security numbers.

- Employment Class: Do not send information for staff who are not involved in the routine, direct care of residents who receive long-term care (e.g., physical therapy, occupational therapy, speech therapy, restorative aides, staff development, social service, activities, health information, administration, or ward clerks should not be included).

- Include and assign only the staff that fall into these categories (do not include outside contract labor):

    - RN - Registered Nurses (indicate Director of Nursing, Mini Data Set (MDS) Staff, Care Manager, etc.)
    - LPN - Licensed Practical Nurses
    - CNA - Certified Nurse Aides
    - NA - Nurse Aides
    - Dietary Aide
    - Housekeeping Aide
    - Laundry Aide
    - QIDP - Qualified Intellectual Disabilities Professional (ICF/IDs only)
    - THT - Therapy Technicians (ICF/IDs only)

- Hourly Wage: Include only the hourly wage. If the individual is paid a salary, please convert it to an hourly wage (full time = 2,080 hours/year).

- Weekly Hours: Include the number of hours that the individual works in an average work week and round figures to the nearest hour. Include Pro Re Nata (PRN) staff only if a weekly average can be determined.

- Time Frame: The wage data must be the rate paid as of March 15, 2018. Do not include personnel hired after this date.

* According to *IDAPA 16.03.10.281.02 and IDAPA 16.03.10.603.02*

- Format: **All providers are now required to use the standardized reporting form, WAHR Survey Form 2018.** The form is available for download at http://www.mslc.com/Idaho. Navigate to the download folder and select the "WAHRS" folder.

- Submission Requirements: Electronic files that can be sent through a **secured** email system should be sent directly to IDWAHRS@mslc.com. If you do not have access to this type of program the information can be submitted through the Myers and Stauffer LC Secure File Transfer Portal (SFTP). If you do not have an account, please contact Pamela Perry of Myers and Stauffer LC at (800) 336-7721 to request access to the SFTP.

- Certification: The cover sheet/certification page below must be completed, signed, and included with the information requested above. APDF of the signed certification is acceptable.

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
* * *
PERSONNEL LISTING WITH WAGE DATA
* * *
REQUESTED TO COMPLY WITH
IDAPA 16.03.10.281.02 and IDAPA 16.03.10.603.02
* * *
AS OF MARCH 15, 2018

_____
Name of Facility

_____
Address

_____
City, State, Zip

_____
Medicaid Provider Number

I certify that, to the best of my knowledge, the information reflected herein is an accurate representation of the facts.

_____
Administrator's Signature

_____
Print or Type Name

_____
Date

_____
Phone Number

_____
Email Address

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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

April 1, 2018

MEDICAID INFORMATION RELEASE MA18-03

TO: Hospital Administrators

FROM: Matt Wimmer, Administrator

SUBJECT: Notice of 2018 Medicaid Rates for Swing-bed Days and Administratively Necessary Days (ANDs)

Effective for dates of service on or after **January 1, 2018,** Medicaid will pay the following rates:

- Swing-bed Day $263.94
- Administratively Necessary Day $237.41

If you have questions about this information, please contact the Senior Financial Specialist in the Office of Reimbursement Policy at the Division of Medicaid at (208) 287-1162.

Thank you for participating in the Idaho Medicaid Program.

MW/ln

Provider Training Opportunities in 2018

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

March: Coordination of Benefits
The Coordination of Benefits training will review COB pricing calculations, entering COB in your Trading Partner Account, and attaching EOBs.

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.

	March	April	May
	Coordination of Benefits	**Claims Adjustments**	**Residential Assisted Living Facility**
10:00 - 11:00 AM MT	3/1/2018	4/10/2018	5/8/2018
	3/14/2018	4/11/2018	5/9/2018
	3/15/2018	4/12/2018	5/10/2018
	3/26/2018		
2:00 - 3:00 PM MT	3/8/2018	4/11/2018	5/9/2018
	3/15/2018	4/12/2018	5/10/2018
	3/20/2018	4/17/2018	5/15/2018
		4/19/2018	5/17/2018

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 28 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 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.

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

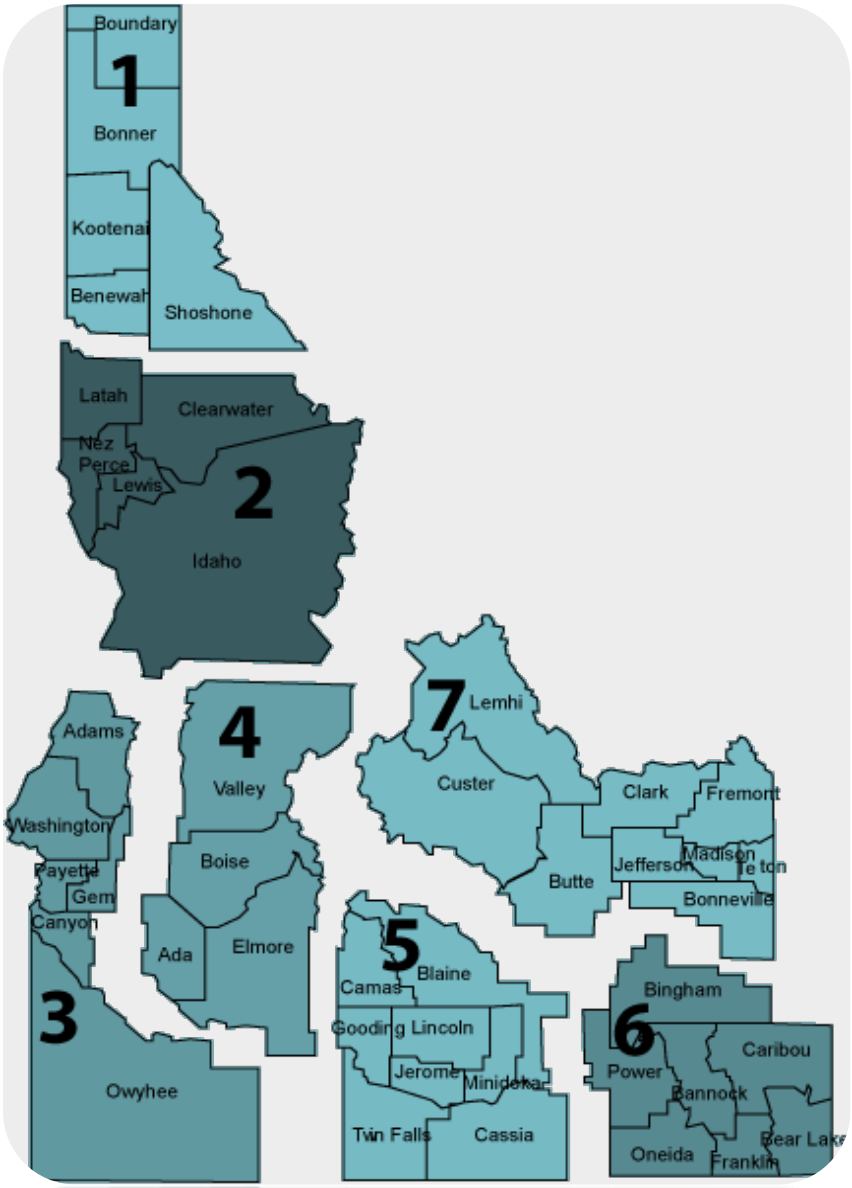
Molina Provider and Participant Services Contact Information

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

Region 2 and the state of Montana
1118 F Street
P.O. Box Drawer B
Lewiston, ID 83501
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
Boise, ID 83704
1 (208) 912-3970
Region.4@MolinaHealthCare.com

Region 5 and the state of Nevada
601 Poleline Road, Suite 7
Twin Falls, ID 83301
1 (208) 484-6323
Region.5@MolinaHealthCare.com

Region 6 and the state of Utah
1070 Hiline Road
Pocatello, ID 83201
1 (208) 870-3997
Region.6@MolinaHealthCare.com

Region 7 and the state of Wyoming
150 Shoup Avenue
Idaho Falls, ID 83402
1 (208) 991-7149
Region.7@MolinaHealthCare.com

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Boise, Idaho 83707

IDAHO DEPARTMENT OF HEALTH & WELFARE

Digital Edition

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

MedicAide **is the monthly informational newsletter for Idaho Medicaid providers.**
Editors: Shelby Spangler and Shannon Tolman

If you have any comments or suggestions, please send them to:
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Shelby.Spangler@dhw.idaho.gov
Shannon Tolman,
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