MedicAide

An Informational Newsletter for Idaho Medicaid Providers

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

Division of Medicaid

In This Issue

Information Releases

No Information Releases Available

Once in a Lifetime Procedures and Modifiers

Idaho Medicaid will reimburse certain procedures only once during a patient's lifetime. Once in a Lifetime Procedures are not limited to a single CPT code, but may be represented by Code Families, which are a group of CPT codes that describe the same or similar type of service. Under this policy, Medicaid provides reimbursement for only one procedure from a designated Code Family during a patient's lifetime.

For example, there are four separate appendectomy CPT codes that can be used, based upon the particular circumstance, to report the removal of the appendix. The four codes, listed below, make up the Code Family that describes the removal of an appendix.

Appendectomy Code Family	
CPT Code	**Description**
44950	Appendectomy
44955	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis
44970	Laparoscopy, surgical, appendectomy

When any health care professional reports a code from the Once in a Lifetime Procedures, that code or any code from the same Code Family will be reimbursed only once during a patient's lifetime.

In the appendectomy example, a single code from the Appendectomy Code Family will be reimbursed only once during a patient's lifetime, because each person usually has only one appendix and can have only one appendectomy during his or her lifetime.

Modifiers

Providers are responsible for accurately, completely, and legibly documenting services performed and billed to Medicaid. Procedure codes may be modified under certain circumstances to more accurately represent the service or item rendered. For this purpose, modifiers are used to add information or change the description of service in order to improve accuracy or specificity.

Procedural Modifiers

There may be situations that require the code(s) for a Once in a Lifetime Procedure to be submitted more than once during a patient's lifetime. In such cases, more than one Once in a Lifetime Procedure, whether the same code or a different code from the same Code Family will be considered separately for reimbursement if reported with one of the following modifiers:

53 Discontinued procedure
55 Postoperative management only
56 Preoperative management only
58 Staged or related procedure or service by the same physician

Anatomical Modifiers

Anatomical modifiers designate the area or part of the body on which the procedure is performed and assist in prompt, accurate adjudication of claims. Medicaid's policy is that a claim is incomplete without an anatomical modifier, when applicable.

(Continued on page 3)

(Once in a Lifetime Procedures Cont'd)

Right (RT) and Left (LT) Side Modifiers

Modifiers RT and LT are the most commonly used anatomical modifiers. These modifiers indicate on which side of the body a procedure or service is performed and must be used, when applicable.

RT – Right side (used to identify procedures performed on the right side of the body)
LT – Left side (used to identify procedures performed on the left side of the body)

Eyelid Modifiers

Anatomical modifiers E1 – E4 identify the eyelid on which a procedure or service was performed at a single session.

E1 – Upper left, eyelid
E2 – Lower left, eyelid
E3 – Upper right, eyelid
E4 – Lower right, eyelid

Coronary Artery Modifiers

Coronary artery modifiers identify the coronary artery on which a procedure or service was performed during a single session.

LC – Left circumflex coronary artery
LD – Left anterior descending coronary artery
LM – Left main coronary artery
RC – Right coronary artery
RI – Ramus intermedius coronary artery

Finger Modifiers

Anatomical modifiers FA – F9 identify the finger on which a procedure or service was performed at a single session.

FA – Left hand, thumb
F1 – Left hand, second digit
F2 – Left hand, third digit
F3 – Left hand, fourth digit
F4 – Left hand, fifth digit
F5 – Right hand, thumb
F6 – Right hand, second digit
F7 – Right hand, third digit
F8 – Right hand, fourth digit
F9 – Right hand, fifth digit

Toe Modifiers

Anatomical modifiers TA – T9 identify the toe on which a procedure or service was performed at a single session.

TA – Left foot, great toe
T1 – Left foot, second digit
T2 – Left foot, third digit
T3 – Left foot, fourth digit
T4 – Left foot, fifth digit
T5 – Right foot, great toe
T6 – Right foot, second digit
T7 – Right foot, third digit
T8 – Right foot, fourth digit
T9 – Right foot, fifth digit

Billing Tip for Trading Partner Account Users

Avoid Delays Associated with Stuck Revsync Claims

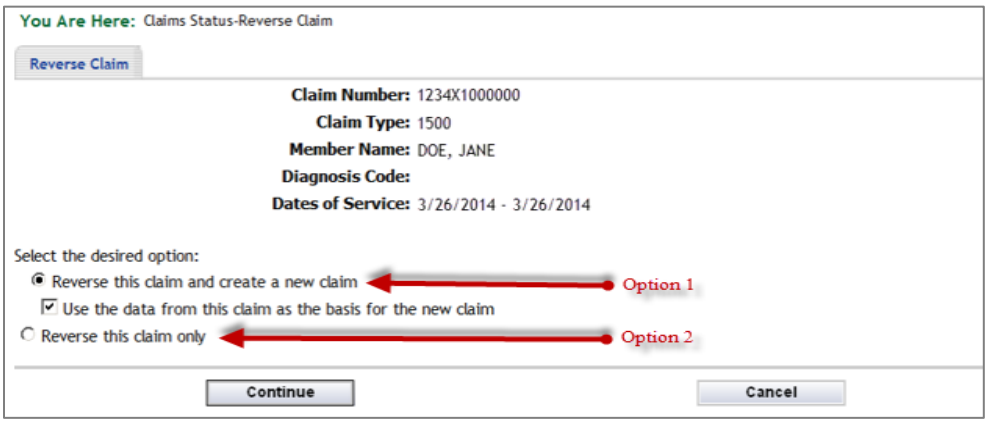
Claims can get stuck when a Trading Partner Account user begins a reversal of a claim, but does not complete the action. There are two options available when reversing or adjusting a claim. Select the appropriate option on the Reverse Claim Tab and confirm the action is complete by viewing the confirmation message generated.

Option 1 – Reverse this claim and create a new claim

- Use this option to correct the information on a claim previously submitted and resubmit the claim
- A confirmation message will indicate the reversal and adjustment was successful
- The confirmation message will display the original claim number followed by the letter A and the adjustment number. Example: A1, A2 etc.

Option 2 – Reverse this claim only

- Use this option to eliminate the claim and return all money paid on the claim without resubmitting the claim
- A confirmation message will indicate the reversal was successful
- The confirmation message will display the original claim number followed by R1
- No further adjustments can be made on this claim



Medically Necessary Infant Formula

Idaho Medicaid recently reminded medical suppliers of our coverage policy for infant formula. Traditional infant formula will be considered for coverage by Idaho Medicaid when it is fed via tube. Traditional infant formulas, which can be purchased at a retail store and consumed orally, are not considered medically necessary and are not covered. Examples of formulas that are not considered medically necessary include, but are not limited to, non-milk formulas and formulas designed to address fussiness, gas, or spitting up.

If your Medicaid patient utilizes traditional formula for oral feedings, they are available at no cost to the participant through the Women, Infant, and Children's (WIC) program. Please refer Medicaid participants to your local WIC office to access these formulas.

(Continued on page 5)

(Infant Formula Cont'd)

Idaho Medicaid covers medical grade formulas when they are:

- Prescribed by a physician
- Labeled solely to provide dietary management for specific diseases or conditions that are clinically serious or life-threatening
- Generally are required for a prolonged period of time

These items typically are represented and labeled for use by an infant who has an inborn error of metabolism or low birth weight or who otherwise has an unusual medical or dietary condition. If you feel your patient requires a medical grade infant formula, please follow the procedure to obtain DME services through Medicaid (see the "Oral, Enteral, or Parenteral Nutritional Products, Equipment, and Supplies" section of the Suppliers handbook for additional information).

Attention DME Suppliers and Medical Providers

The Medical Care Unit has received requests for services in which the submitted documentation is incomplete, invalid, or outdated. To ensure we can serve our participants as effectively and efficiently as possible, Medicaid is asking for DME suppliers and medical providers to ensure they check the accuracy and thoroughness of their submitted documentation when requesting authorization for services.

When Medical Care receives a request for service, the staff need to ensure that the requested service aligns with state and federal regulation, statutes, and policies. When staff are reviewing the requested service, it's imperative that all required documentation is provided, up to date, and accurate with the request. Please refer to the Suppliers Idaho MMIS Provider Handbook clarification as to what documentation is required from the Department for specific DME items. For example, if a requested service references "current Medicare Coverage Determination Guidelines," please use that reference and ensure the required documentation required by those guidelines are being submitted with your request.

For requests for services starting May 1, 2017 there will be a new DME PA request form. Please use this form and review the Suppliers Idaho MMIS Provider handbook to ensure you are submitting a complete and valid prior authorization request. If a request for service doesn't contain the required documentation set by the Department, then Medicaid may not be able to complete a review. If the Department cannot complete a review for service, then the request may be denied and it will be asked for the supplier to resubmit with the required and proper documentation. It is important for DME suppliers to be knowledgeable about Medicaid's current procedure when they submit prior authorization requests for services. Please review *IDAPA 16.03.09.750-779* and the Suppliers Idaho MMIS Provider Handbook to ensure you are in alignment with the proper procedure.

Items which require a PA are reflected on the most current fee schedule. Please note that there may be PA requirement change from one month to the next, so please check the fee schedule when requesting prior authorizations for services. The status of a prior authorization request may be checked online by logging into the Molina Medicaid website and choosing *Authorization Status*, or by contacting Molina at 1 (866) 686-4272.

Thank you for the service you provide to our participants and working with us to ensure Medicaid participants receive their requested services in a timely matter.

Medicaid Program Integrity Unit

Developmental Disability Services Documentation

During audits of development disability providers, the Medicaid Program Integrity Unit has found instances when providers have not followed the documentation requirements for the services they have billed. For example, documentation has been reviewed that was missing client's signatures, signatures of professional/paraprofessionals providing service, participant's responses, specific place of service, time in and time out and/or duration of service.

IDAPA 16.05.07.101.01 outlines documentation requirements and states:

> 01. Documentation of Services. Providers must generate documentation at the time of service sufficient to support each claim or service, *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. Documentation to support claims for services includes, but is not limited to, medical records, treatment plans, medical necessity justification, assessments, appointment sheets, patient accounts, financial records or other records regardless of its form or media.

Providers need to ensure they document their services in compliance with documentation requirements for the specific services being billed, as listed in the rules listed below.

IDAPA 16.03.10.654 Developmental Therapy: Procedural Requirements
IDAPA 16.03.10.664 Children's HCBS State Plan Option: Procedural Requirements
IDAPA 16.03.10.684 Children's Waiver Services: Procedural Requirements
IDAPA 16.03.10.704 Adult DD Waiver Services: Procedural Requirements
IDAPA 16.03.09.854 School-Based Service: Procedural Requirements

By signing their Idaho Medicaid Provider agreements, providers agree to document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of Idaho Code, § 56-209h (3), as amended, applicable rules, and this Agreement.

Services billed to Medicaid when documentation does not meet the requirements in rule will be subject to recoupment and civil monetary penalties.

Attention All Medical Providers Working with Calendar Month Limits

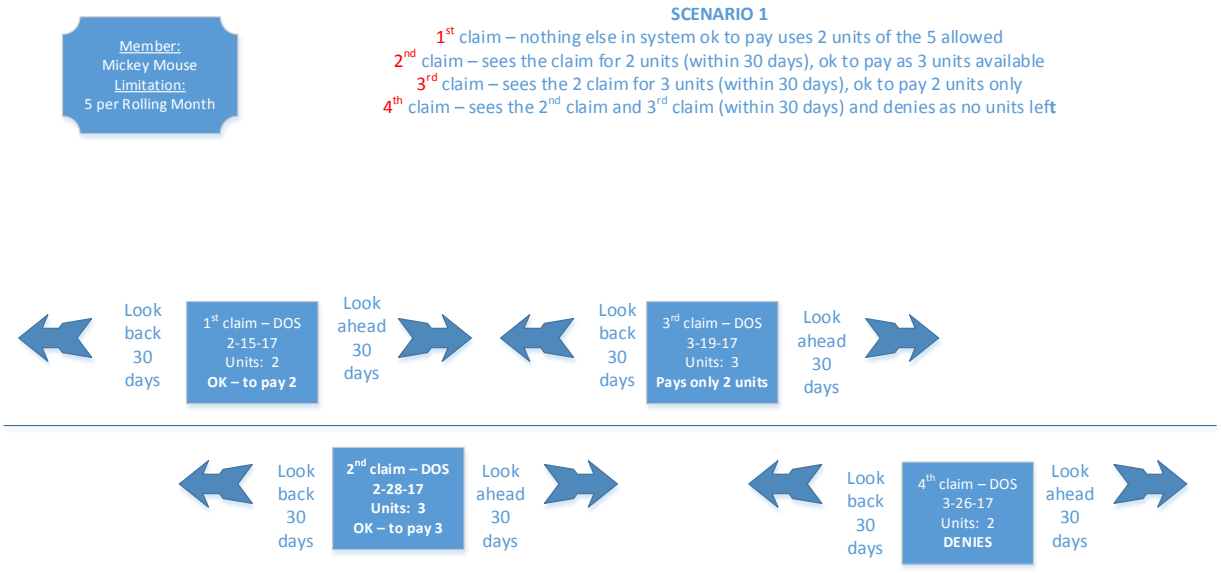
Current calendar month medical service/unit limits will change to rolling thirty (30) day/month limits as of July 1, 2017. The unit number limit remains the same, but monthly limits will be counted on claim submissions by the **service date** (dispense date) when claims are submitted. The first claims to hit the system will be paid first if multiple providers are submitting claims for the same service. The MMIS system counts 30 days both forward and back from the service date when determining units to pay up to the 30 day rolling limit. This change applies primarily to DMEPOS suppliers, but will cross all medical services with monthly limits.

(Continued on page 7)

(Calendar Month Limits Cont'd)

Developmental Disabilities provider types are exempt from this change and will remain on calendar month limits.

Please refer to the graphic below.



SCENARIO 2

1st claim DOS 2-15-17 – nothing else in system ok to pay uses 2 units of the 5 allowed
2nd claim DOS 2-28-17 – sees the claim for 2 units (within 30 days), ok to pay as 3 units available
4th claim DOS 3-26-17 comes in next – sees the 2nd claim (within 30 days) and pays as there was 2 units left
3rd claim DOS 3-19-17 comes in last – sees the 2 claims DOS 3-26-17 and 2-28-17, denies as no units left

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

Spotlight- Physician Self-Referral Law [42 U.S.C. § 1395nn]

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 addresses Fraud and Abuse, here we are only looking at the Federal laws.

(Continued on page 8)

(Fraud and Abuse Laws Cont'd)

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 **Physician Self-Referral Law [42 U.S.C. § 1395nn]**.

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- Clinical laboratory services;
- Physical therapy, occupational therapy, and outpatient speech-language pathology services;
- Radiology and certain other imaging services;
- Radiation therapy services and supplies;
- DME and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

Provider Training Opportunities in 2017

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

May: Durable Medical Equipment
This training will walk Durable Medical Equipment 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
May Durable Medical Equipment	5/10/2017	5/16/2017	5/17/2017	5/18/2017	5/11/2017	5/16/2017	5/18/2017
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 13 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

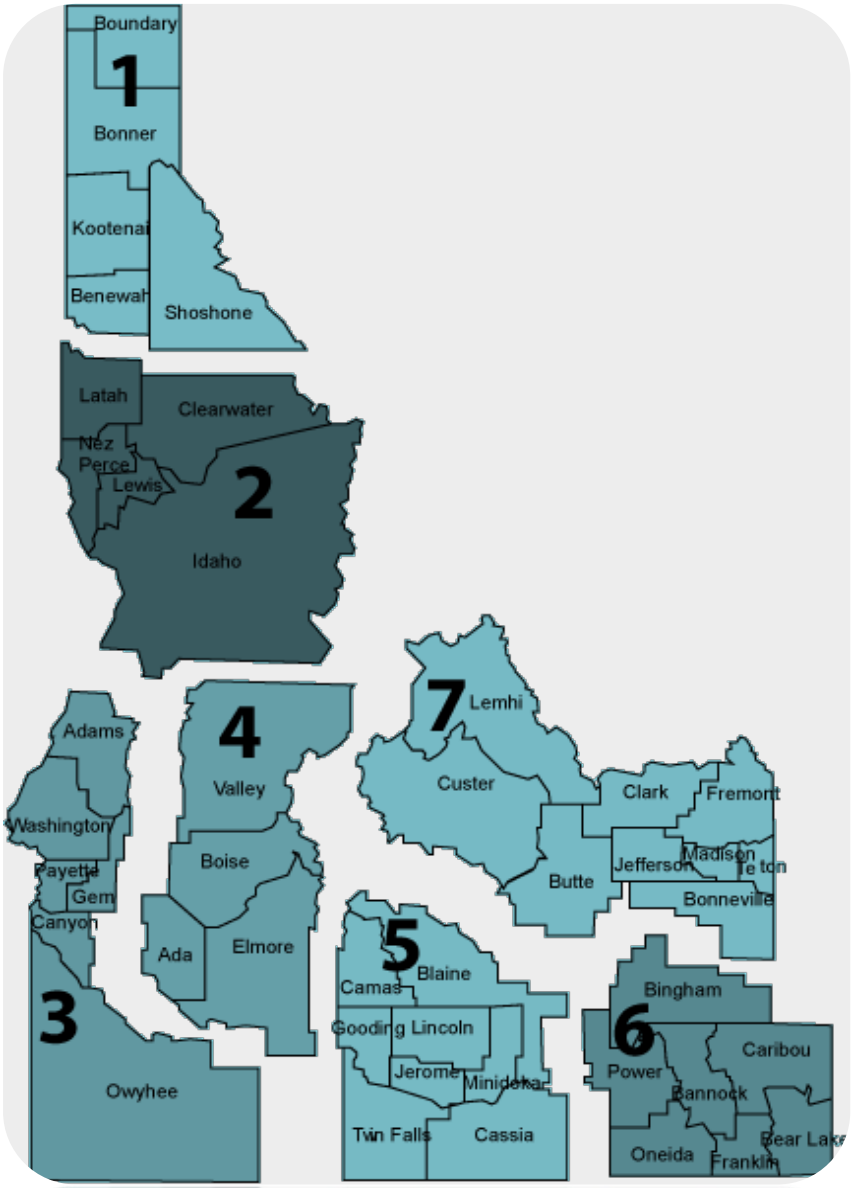
Molina Provider and Participant Services Contact Information

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

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) 373-1343
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

Molina Medicaid Solutions
PO Box 70082
Boise, Idaho 83707

IDAHO DEPARTMENT OF HEALTH & WELFARE

Digital Edition

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

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

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