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Information Releases

No Information Releases Available
Idaho Medicare-Medicaid Coordinated Plan (MMCP) Update

Two Health Plan Choices Starting January 1, 2018

Idaho Medicaid is excited to announce a new health plan, in addition to Blue Cross of Idaho, that will be offering the Medicare-Medicaid Coordinated Plan (MMCP) in 2018. The MMCP is a program available to Idaho Dual Eligible residents who are 21 or older and are eligible and enrolled in Medicare and full Medicaid coverage. The program covers all medically necessary and preventive services covered under Medicare Part A, Part B, and Part D prescription drug coverage as well as most services covered by Medicaid, including Aged and Disabled (A&D) Waiver, Behavioral Health services, Personal Care Services, and Targeted Service Coordination for individuals with developmental disabilities. The program also includes a care coordination component to ensure that Medicare and Medicaid services are integrated and meet each participants’ unique needs.

Today’s MMCP is currently administered by Blue Cross of Idaho. Molina Healthcare of Idaho is looking forward to joining the MMCP network in Idaho starting January 1st, 2018.

Currently, the MMCP program is available in the following counties administered by Blue Cross of Idaho: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Clark, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, and Twin Falls

Beginning January 1, 2018:

<table>
<thead>
<tr>
<th>Blue Cross of Idaho</th>
<th>Molina Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Number</td>
<td>Member: (844) 239-4913</td>
</tr>
<tr>
<td></td>
<td>Provider: (844) 239-4914</td>
</tr>
<tr>
<td>Counties Served</td>
<td>Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Kootenai, Nez Perce, Twin Falls</td>
</tr>
<tr>
<td><strong>In addition to above counties:</strong></td>
<td>Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Kootenai, Nez Perce, Twin Falls</td>
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<tr>
<td>Boise, Boundary, Cassia, Clark, Elmore, Fremont, Gem, Jefferson, Madison, Minidoka, Owyhee, Payette, Power</td>
<td></td>
</tr>
</tbody>
</table>

**Providers are encouraged to contract with each health plan for the MMCP. For more information contact:**

**Blue Cross of Idaho**
1 (888) 495-2583 or Contact the regional provider relations department

**Molina Healthcare**
Rachelle Lopez 1 (801) 316-9564 or toll free 1 (888) 562-5442 ext. 179564
Rachelle.Lopez@MolinaHealthcare.com
The Trading Partner Account Upgrade
is Only One Month Away!

Over 200 providers registered for a Trading Partner Account (TPA) with Idaho Medicaid last month. Were you one of them? If not, time is running out!

The TPA portal is being upgraded in December 2017. If you do not have a TPA account, register for one today to avoid delays in your Medicaid transactions.

After the upgrade, billing agencies will no longer have access to the provider enrollment and maintenance materials and resources. Providers must have a TPA account in order to access provider enrollment and provider maintenance forms. Go to www.idmedicaid.com to sign up for your TPA today. Don’t wait until it’s too late!

If you have any questions regarding the upgrade, or if you need assistance registering for a TPA account, please contact your regional Provider Relations Consultant (PRC) or the Molina provider services line at 1 (866) 686-4272.

Medicaid Coverage of Hyperbaric Oxygen Treatment

Per the Idaho MedicAide newsletter from December 2009, Idaho Medicaid follows Medicare guidelines for hyperbaric oxygen treatment. Idaho Medicaid providers who order or render services for hyperbaric oxygen therapy should review Noridian’s Local Coverage Determinations (LCD), appropriate to the dates of service, for compliance with national billing, diagnostic and clinical coverage, and medical necessity guidelines, frequency and duration, and documentation requirements, etc., on hyperbaric oxygen therapy (DL36686).

Additional information can be found under: Hyperbaric Oxygen (HBO) Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N).
https://med.noridianmedicare.com/web/jfb/specialties/podiatry/lower-extremity-wound-care

Laboratory Tests: Controlled Substances/Drug Testing and Non-Covered Testing for Legal Purposes

Medicaid covers laboratory testing based on documentation of medical necessity. All providers who submit claims to Idaho Medicaid are submitting a bill to the federal government. The Center for Medicare and Medicaid Services (CMS) and Idaho Medicaid requires all laboratory tests be documented as medically necessary, be ordered by an Idaho Medicaid authorized provider who is treating the participant, and not be billed to Idaho Medicaid if performed without documentation of medical necessity, including but not limited to: residential monitoring pursuant to a court order, as a condition of probation, as a condition of employment, or for another administrative purpose.

The exception to this when an Idaho Medicaid authorized provider establishes medical necessity testing and is actively treating a participant for substance abuse disorders regardless of whether a court is involved. All laboratory tests covered by Idaho Medicaid must be documented as

(Continued on next page)
medically necessary in order to diagnose and treat the patient. The Idaho Medicaid provider must follow national diagnostic, clinical and standard of care frequency and limitations, etc., established by CMS and the Idaho regional Medicare contractor, Noridian A/B Jurisdiction F for medical and surgical services, and Noridian Jurisdiction D for durable medical equipment, prosthetics, orthotics and supplies.

Both the American Medical Association Current Procedural Terminology manual (AMA CPT) and CMS guidance and correct coding limit reimbursement to a single manual or automated laboratory service, reported only once per day per patient, regardless of the number of drug classes, sample validations, or specimen validity tests performed on any date of service. Idaho Medicaid may recoup duplicative services of more than one presumptive and/or one definitive drug test per day regardless of the number of billing providers. For guidance on appropriate ICD-10 CM diagnosis, clinical guidelines, CLIA requirements, presumptive and definitive test frequency, and limitations and documentation requirements, refer to Noridian A/B Jurisdiction F policy and guidance on appropriate covered drug testing.

At this time, Idaho Medicaid has not implemented system limits or edits to manage unnecessary drug testing claims, and has relied on provider compliance with Idaho Medicaid and national guidance regarding service limits based on medical necessity. All claims submitted to Idaho Medicaid are subject to post-payment and retrospective review, including services which were prior authorized.

All providers must comply with Idaho Medicaid policy on Ordering, Referring, or Prescribing (ORP) Providers, which are any physicians or other approved health care providers who write orders, prescriptions, or referrals for Medicaid participants for healthcare services or supplies. Idaho Medicaid differs from Noridian Medicare on which provider types are authorized to order services. The Idaho Medicaid ORP Policy document is in the right column of:
1115(d) Demonstration Waiver

Idaho Department of Health and Welfare Demonstration Waiver for Complex Medical Needs Notice of Public Hearing and Public Comment Period

The Idaho Department of Welfare gives notice of intent to apply to the Centers for Medicare and Medicaid Services (CMS) for an 1115(d) demonstration waiver on or about January 5, 2018. The purpose of the Complex Medical Needs (CMN) waiver is to provide Medicaid coverage to children and adults who have a complex medical condition(s). The waiver will provide access to consistent and comprehensive coverage, which fully meets the needs of this population. The proposed effective date for the waiver is July 1, 2018.

Today, Idahoans living with complex, life-threatening medical conditions rely on a mix of federally subsidized insurance, catastrophic health care fund coverage, and charity care to meet their needs. This variable coverage results in challenges for people who are trying to manage their complex conditions at a time when they have the most difficulty in managing those challenges effectively due to their conditions. By providing a reliable and comprehensive source of coverage, the CMN waiver will allow for better outcomes for this population while reducing the negative impacts of unpredictable costs for these consumers and for the healthcare marketplace.

The Department’s comprehensive public notice, tribal notice, and the waiver application are available on our website at complexmedicalneeds.dhw.idaho.gov. The Department is seeking public comment through public hearings, the interactive form available on the website, and via e-mail or traditional mail as indicated below. Public hearings will be held at the following locations:

**Boise Public Hearing**
Location: Pete T. Cenarrusa Bldg.
7th Floor, Conference Rm. 7A
450 W. State St.
Date: December 7, 2017
Time: 11:00AM - 1:00 PM

**Pocatello Public Hearing**
Location: DHW Region VI
Suite #230
1070 Hiine Rd.
Date: December 8, 2017
Time: 11:00AM - 1:00PM

**Cour d’Alene Public Hearing**
Location: DHW Region I
Large Conference Rm.
1120 Ironwood Dr.
Date: December 12, 2017
Time: 10:00AM - 12:00PM PDT

Conference line for all dates and locations:
Call: 1-877-820-7831
Guest Code: 701700

Interested parties may also request hard copies of the waiver packet or submit comments via e-mail or traditional USPS mail to:

Attention: Cindy Brock
Alternative Care Coordinator
Division of Medicaid
P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: CMNwaiver@dhw.idaho.gov

Public comments will be accepted until December 15, 2017

MedicAide November 2017
Medicaid Program Integrity Unit

Screening for Excluded Individuals and Entities

The Health and Human Services Office of Inspector General (HHS-OIG) excludes individuals and entities from participating in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), and all federal health care programs (as defined in Section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act. The Idaho Department of Health and Welfare (IDHW) has its own exclusion authority (as described later in this article).

Because it is prohibited by federal law from doing so, Idaho Medicaid will make no payments for any amount expended for items or services furnished by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in 42 CFR section 1001.1901(c)). Any such payments constitute an overpayment and are subject to recoupment. Civil monetary penalties may also be imposed against Medicaid providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid participants.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded (42 CFR Section 1001.1901(b)).

Providers are responsible for screening employees and contractors to identify excluded individuals and are responsible for searching HHS-OIG Exclusion List and the Idaho Medicaid Exclusion List to ensure that new hires and current employees are not listed.

The HHS-OIG Exclusion List can be accessed at: http://exclusions.oig.hhs.gov.


When the HHS-OIG excludes a provider, federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities (Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)). This payment ban applies to any items or services reimbursable under a Medicaid Program that are furnished by an excluded individual or entity, and extends to the following:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system.
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid participants when those payments are reported on a cost report or are otherwise payable by the Medicaid Program.
- Payment to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid Program.

(Continued on next page)
The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency, or physician practice, where such services are related to administrative duties, preparation of surgical trays, or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid Program, even if the individuals do not furnish direct care to Medicaid participants.
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing, or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid Program.
- Services performed by excluded ambulance drivers, dispatchers, and other employees involved in providing transportation reimbursed by a Medicaid Program to hospital patients or nursing home residents.
- Services performed for program participants by excluded individuals who sell, deliver, or refill orders for medical devices or equipment being reimbursed by a Medicaid Program.
- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid participants, and whose services are reimbursed, directly or indirectly, by a Medicaid Program.
- Services performed by an excluded administrator, billing agent, accountant, claims processor, or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid Program.
- Items or services provided to a Medicaid participant by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid Program.
- Items or equipment sold by an excluded manufacturer or supplier; used in the care or treatment of participants; and reimbursed directly or indirectly, by a Medicaid Program.

**Idaho Medicaid Exclusions**

**Mandatory Exclusions From the Idaho Medicaid Program (IDAPA 16.05.07.240 and 245)**

The Idaho Department of Health and Welfare will exclude from the Medicaid program for a period not less than ten years any provider, entity, or person convicted under federal or state law for the following:

- A criminal offense related to the delivery of an item or service under a federal or any state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program.
- A criminal offense related to the neglect or abuse of a patient, in connection with the delivery of a health care item or service, including any offense that IDHW concludes entailed, or resulted in, neglect or abuse of patients. The conviction need not relate to a patient who is a program participant.

The Department of Health and Welfare will also exclude any entity or person identified by the Centers for Medicare and Medicaid Services (CMS) as having been excluded by another state or the Office of Inspector General or any person CMS directs IDHW to exclude.

Mandatory exclusions may exceed ten years if aggravating factors are present (IDAPA 16.05.07.260).
Permissive Exclusions From the Idaho Medicaid Program (IDAPA 16.05.07.250)
The Department of Health and Welfare may exclude any person or entity from the Medicaid program for a period of not less than one year:

- Where there has been a finding by a governmental agency against such person or entity of endangering the health or safety of a patient, or of patient abuse, neglect, or exploitation.
- That has failed or refused to disclose, make available, or provide immediate access to IDHW, or its authorized agent, or any licensing board any records maintained by the provider or that are required to be maintained, which IDHW deems relevant to determining the appropriateness of payment.
- For any reason for which the Secretary of Health and Human Services, or his designee, could exclude an individual or entity.

Reinstatements
Providers, individuals, and entities are not automatically reinstated at the end of the state or federal exclusion period. Excluded individuals and entities wishing to again participate in the Medicare, Medicaid, and all Federal health care programs must apply for reinstatement and receive authorized notice that reinstatement has been granted. If providers, individuals, or entities on the state or federal exclusion lists do not have reinstatement dates listed, they are not eligible to provide services.

Friendly Reminder: Non-Covered Services and Provider Responsibilities and Compliance with Medicaid Policy
Idaho Medicaid is concerned by provider misinterpretation of what is a “non-covered service.” A non-covered service is excluded in federal or state statute or rule. Covered services are all Idaho Medicaid benefits which are covered in federal or state statute or rule. Idaho Medicaid publicly posts fee schedules specific to different enrolled provider types and specialties. Many of the billing codes listed represent a bundle of services, or an episode of care. Providers are responsible for correct coding of submitted claims per national billing guidelines and standards which begin with the Social Security Act.

Please see the included reprint from the MedicAide Newsletter dated June 2014:

Billing Medicaid Participants – FAQs
Idaho Medicaid covers a comprehensive set of benefits. You can find more detailed information on covered services and verifying participant eligibility in:

- The Provider Handbook located on [www.idmedicaid.com](http://www.idmedicaid.com)

Providers must accept Medicaid payment as payment in full for services rendered if they bill Medicaid for covered services. Providers can bill non-covered Medicaid services to the participant. Medicaid requires the provider to inform the participant, preferably in writing, before rendering

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service if the service is not covered or if a particular covered service will not be billed to Medicaid. (Refer to item 7.2 under section 7. Payment in the Idaho Medicaid Provider Agreement.) If the participant agrees to pay for the service before it is provided, then the provider may bill the participant for the entire amount of the fee.

What is a covered service? A covered service is any service within the participant’s Medicaid benefit package that does not exceed service limitations, and for which any applicable prior approval and/or referral requirements have been met.

What if payment is denied for a covered service? Denial of a covered service provided by a qualified provider will only occur in three circumstances, and in each of these cases billing the participant is not allowed:
1. A third party is liable for payment. In this circumstance, the provider must pursue the third party for payment.
2. A billing error occurred. In this situation, the provider must resubmit a corrected billing. Molina is available to help providers resolve billing problems.
3. The provider submitted the billing in excess of one year after the service was provided and did not reference an earlier timely filing date. Providers must submit an initial billing within one year of providing the service (see IR MA04-59).

What if the service to be provided is not covered by Medicaid? If the provider informs the participant that the specific service in question is not covered by Medicaid before providing the service, and both the provider and the participant agree (preferably in writing) that the participant will be liable for payment, then, and only then, can the provider bill the participant. An acceptable written agreement might read as follows and can be part of a larger generic patient liability document, as long as it is clear that this is the only part of the document that is pertinent for a Medicaid participant:

Prior to receiving the following services: ___________________________, I have been informed by ___________________________ that these services will not be covered by Medicaid and I agree to assume responsibility for the total associated costs.

Signed ___________________________ Date ___________________________

What if the provider does not typically meet with the participant before providing the service (for example, anesthesiologist, laboratory, etc.) and does not have an opportunity to obtain the participant’s consent to accept liability? An initial provider (PCP, surgeon, hospital, etc.) that had an opportunity to meet with the participant arranged for these specialty services. If the initial provider has informed the participant (preferably in writing) that all services associated with the procedure to be performed are not covered by Medicaid and will be the liability of the participant, then the associated specialty provider can bill the participant as well. The specialty provider needs to confirm, before billing, that this condition has been met.

(Continued on next page)
What if a necessary referral from the Healthy Connections provider has not been received before the participant’s care appointment? A service within the Medicaid scope of care, but lacking a necessary, valid referral, is considered a non-covered service. The provider and participant can agree to a private pay arrangement or the provider can refer the participant back to the Healthy Connections provider who can then determine if a referral is warranted.

What if a referral is received from a provider other than the Healthy Connections provider? A valid Healthy Connections referral can only be initiated by the participant’s Healthy Connections provider. Before serving the participant, it is important to confirm that the referring provider is, in fact, the participant’s Healthy Connections provider. A service within the Medicaid scope of care, but lacking a necessary, valid referral, is considered a non-covered service.

How does a provider determine if a participant is eligible for Medicaid and who the participant’s Healthy Connections primary care provider is? This information can be accessed three different ways:

- Medicaid Automated Customer Service (MACS) 1 (866) 686-4272
- Trading Partner Account on www.idmedicaid.com
- HIPAA-compliant vendor software (tested with Molina)

To obtain information, submit either the participant’s Medicaid ID number or two participant identifiers from the following list:

- Social Security Number (SSN)
- Last name, first name
- Date of birth

Is it acceptable to hold the Medicaid participant primarily responsible for all medical expenses and then offset any liability for services paid for by Medicaid, as is a common arrangement with persons covered by private insurance? No. Medicaid participants are different from individuals covered by insurance policies. Medicaid is an entitlement program, not an insurance program. A person insured under a private insurance program is primarily liable for covered charges, while the insurer indemnifies the person’s liability as to those charges. In the Medicaid program, the State Medicaid Agency and the Medicaid provider enter into an agreement to provide services to persons entitled to Medicaid coverage. Only when the service provided is not covered under Medicaid and the above prior arrangement, specific to the non-covered service is in place, can the participant be held responsible for payment.

What if the provider is unsure if a service will be covered by Medicaid? The provider can contact Molina at 1 (866) 686-4272 to determine if a specific service, as defined by CPT code, is covered. Providers with any doubts as to whether Medicaid will cover a service should notify the patient in advance and make arrangements for the participant to accept liability on the assumption that the specific service is non-covered. If, and only if, the subsequent Medicaid billing is denied as a non-covered service, then the provider can bill the participant.
Provider Training Opportunities in 2017 & 2018

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

**November: Trading Partner Account Upgrade**
This training will walk all providers through the upgraded Trading Partner Account portal. Providers will learn how to navigate the new site and how to utilize new functionality such as Secure Messaging and billing agent/provider association requests.

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.

<table>
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<tr>
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<th>November</th>
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|                      | 10:00 - 11:00 AM MT | 11/9/2017 | 12/14/2017 | 1/10/2018 | 2/6/2018 | 3/8/2018 |
|                      | 11/21/2017 | 12/21/2017 | 1/16/2018 | 2/14/2018 | 3/20/2018 |
|                      |            |            | 1/18/2018 | 2/15/2018 |            |

|                      | 2:00 - 3:00 PM MT | 11/9/2017 | 12/14/2017 | 1/10/2018 | 2/6/2018 | 3/8/2018 |
|                      | 11/21/2017 | 12/21/2017 | 1/16/2018 | 2/14/2018 | 3/20/2018 |
|                      |            |            | 1/18/2018 | 2/15/2018 |            |

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 15 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.

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<tr>
<th>Service Category</th>
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</tr>
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<tbody>
<tr>
<td>Administratively Necessary Days</td>
<td>1 (877) 314-8779</td>
<td>1 (866) 205-7403</td>
</tr>
<tr>
<td>Ambulance*</td>
<td>1 (877) 314-8781</td>
<td>1 (800) 362-7648</td>
</tr>
<tr>
<td>Breast &amp; Cervical Cancer</td>
<td>1 (877) 314-8779</td>
<td>1 (208) 364-1826</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>1 (877) 314-8782</td>
<td>1 (866) 205-7403</td>
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<tr>
<td>Hospice</td>
<td>1 (877) 314-8779</td>
<td>1 (866) 205-7403</td>
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<tr>
<td>Preventive Health Assistance</td>
<td>1 (877) 845-3956</td>
<td>1 (208) 364-1843</td>
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<tr>
<td>Service Coordination</td>
<td>1 (877) 314-8779</td>
<td>1 (866) 205-7403</td>
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<tr>
<td>Surgery-Procedural-Lab</td>
<td>1 (877) 314-8779</td>
<td>1 (866) 205-7403</td>
</tr>
<tr>
<td>Therapy: OT, PT, SLP</td>
<td>1 (877) 314-8779</td>
<td>1 (866) 205-7403</td>
</tr>
<tr>
<td>Vision</td>
<td>1 (877) 314-8779</td>
<td>1 (866) 205-7403</td>
</tr>
</tbody>
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* 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

<table>
<thead>
<tr>
<th>DHW Website</th>
<th><a href="http://www.healthandwelfare.idaho.gov">www.healthandwelfare.idaho.gov</a></th>
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</thead>
<tbody>
<tr>
<td><strong>Idaho CareLine</strong></td>
<td>2-1-1</td>
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<tr>
<td></td>
<td>1 (800) 926-2588</td>
</tr>
<tr>
<td><strong>Medicaid Program Integrity Unit</strong></td>
<td>P.O. Box 83720</td>
</tr>
<tr>
<td></td>
<td>Boise, ID 83720-0036</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:prvfraud@dhw.idaho.gov">prvfraud@dhw.idaho.gov</a></td>
</tr>
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<td></td>
<td>Fax: 1 (208) 334-2026</td>
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<tr>
<td><strong>Telligen</strong></td>
<td>1 (866) 538-9510</td>
</tr>
<tr>
<td></td>
<td>Fax: 1 (866) 539-0365</td>
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<tr>
<td></td>
<td><a href="http://IDMedicaid.Telligen.com">http://IDMedicaid.Telligen.com</a></td>
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</tbody>
</table>

## 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 | 1 (800) 873-5875 |
|     | 1 (208) 375-1132 |
|     | Fax: 1 (208) 375-1134 |

PO Box 2894
Boise, ID 83701
## Molina Provider and Participant Services Contact Information

### Provider Services

<table>
<thead>
<tr>
<th>MACS (Medicaid Automated Customer Service)</th>
<th>1 (866) 686-4272</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 (208) 373-1424</td>
</tr>
<tr>
<td>Provider Service Representatives</td>
<td>1 (866) 686-4272</td>
</tr>
<tr>
<td>Monday through Friday, 7 a.m. to 7 p.m. MT</td>
<td>1 (208) 373-1424</td>
</tr>
<tr>
<td>E-mail</td>
<td><a href="mailto:idproviderservices@molinahealthcare.com">idproviderservices@molinahealthcare.com</a></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:idproviderenrollment@molinahealthcare.com">idproviderenrollment@molinahealthcare.com</a></td>
</tr>
<tr>
<td>Mail</td>
<td>P.O. Box 70082</td>
</tr>
<tr>
<td></td>
<td>Boise, ID 83707</td>
</tr>
</tbody>
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### Participant Services

<table>
<thead>
<tr>
<th>MACS (Medicaid Automated Customer Service)</th>
<th>1 (866) 686-4752</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 (208) 373-1432</td>
</tr>
<tr>
<td>Participant Service Representatives</td>
<td>1 (866) 686-4752</td>
</tr>
<tr>
<td>Monday through Friday, 7 a.m. to 7 p.m. MT</td>
<td>1 (208) 373-1424</td>
</tr>
<tr>
<td>E-mail</td>
<td><a href="mailto:idparticipantservices@molinahealthcare.com">idparticipantservices@molinahealthcare.com</a></td>
</tr>
<tr>
<td>Mail – Participant Correspondence</td>
<td>P.O. Box 70081</td>
</tr>
<tr>
<td></td>
<td>Boise, ID 83707</td>
</tr>
</tbody>
</table>

### 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
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Region.5@MolinaHealthCare.com

Region 6 and the state of Utah
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Region 7 and the state of Wyoming
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Idaho Falls, ID 83402
1 (208) 991-7149
Region.7@MolinaHealthCare.com
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*MedicAide* is the monthly informational newsletter for Idaho Medicaid providers. **Editors: Shelby Spangler and Shannon Tolman**

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- Shannon Tolman, [Shannon.Tolman@dhw.idaho.gov](mailto:Shannon.Tolman@dhw.idaho.gov)

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