# MedicAide

An Informational Newsletter for Idaho Medicaid Providers

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

**November 2018**

## In This Issue



## Information Releases

# Notice of Upcoming Provider Meetings

| Home Health Provider Meeting |
|---|
| Friday, December 14, 2018 – 10:30 a.m. (MDT) |
| Department of Health & Welfare |
| Medicaid Central Office |
| 3232 Elder Street |
| Conference Room D-West |
| Boise, ID 83705 |
| **Teleconference Call-in** |
| USA Toll: 1-240-454-0879 |
| Access Code: 805 280 207 |

| Idaho Primary Care Association Meeting |
|---|
| Monday, December 17, 2018 – 1:00 p.m. (MDT) |
| Department of Health & Welfare |
| Medicaid Central Office |
| 3232 Elder Street |
| Conference Room D-East |
| Boise, ID 83705 |
| **Teleconference Call-in** |
| USA Toll: 1-240-454-0879 |
| Access Code: 806 825 697 |

| Therapy Providers Quarterly Meeting |
|---|
| Friday, December 21, 2018 – 10:30 a.m. (MDT) |
| Department of Health & Welfare |
| Medicaid Central Office |
| 3232 Elder Street |
| Conference Room D-West |
| Boise, ID 83705 |
| **Teleconference Call-in** |
| USA Toll: 1-240-454-0879 |
| Access Code: 803 137 768 |

| Big Sky / AMES Quarterly DME Provider Meeting |
|---|
| Friday, December 21, 2018 – 1:30 p.m. (MDT) |
| Department of Health & Welfare |
| Medicaid Central Office |
| 3232 Elder Street |
| Conference Room D-West |
| Boise, ID 83705 |
| **Teleconference Call-in** |
| USA Toll: 1-240-454-0879 |
| Access Code: 804 954 582 |

If you would like to be added to the contact list for these meetings, or you have an issue you'd like to appear on the agenda, e-mail your request to MCPT@dhw.idaho.gov.

# Code Updates

**Codes being added that will be reimbursable:**

| Code | Description | Effective Date |
|---|---|---|
| C9033 | Injection, fosnetupitant 235 mg and palonosetron 0.25 mg | 10/01/2018 |
| C9034 | Injection, dexamethasone 9%, intraocular, 1 mcg | 10/01/2018 |
| Q5108 | Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg | 7/12/2018 |
| Q5110 | Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram | 10/01/2018 |

# Medicaid Program Integrity Unit

### *Billing for Incarcerated Clients*

During recent audits, the Medicaid Program Integrity Unit has found instances of clinics billing outpatient prescription services provided to inmates. Federal law does not allow for federal Medicaid funding, Federal Financial Participation (FFP), to pay for outpatient medical care provided to individuals who are inmates (including juveniles) of a public institution. This means Medicaid benefits are not available for inmates of government jail, detention, or prison facilities, unless the inmate becomes an inpatient in a medical institution for 24 hours or more.

*The Idaho Medicaid Provider Handbook, General Provider and Participant Information, Section 2.3.2.1. states:*

> 2.3.2.1. ***Medicaid Exceptions for Inmates***
> Medicaid benefits are not available for inmates of government jail or prison facilities, unless the inmate becomes an inpatient in a medical institution. In that case, Medicaid coverage begins the day the inmate is admitted and ends the day of discharge from the medical institution. The inmate must also meet all other Medicaid eligibility requirements

Providers must not bill outpatient medical care and medications for a Medicaid eligible inmate unless the inmate meets an exception outlined below:

- Admitted to a medical institution for at least 24 hours
- The individual can “voluntarily” leave the institution
- Home confinement – unless reporting for overnight stay
- Probation
- Paroled

Although federal law does not allow for FFP once an individual is classified as an inmate in a public institution, the law does not require that individuals lose their Medicaid eligibility. Regardless of a provider’s *actual knowledge* of a Medicaid client’s inmate status federal law requires states to return federal dollars for payments made on behalf of an inmate of a public institution.

# Provider Handbook Updates

The Agency Professional, Nursing and Custodial Care Facilities, and Nursing Services handbooks have been updated to correct the following outdated acronyms/terms Qualified Mental Retardation Professional (QMRP) replaced by Qualified Intellectual Disabilities Professional (QIDP) and Regional Medicaid Services (RMS) replaced by Bureau of Long Term Care (BLTC).

The Ambulatory Health Care Facility, CMS 1500 Instructions, Directory, Long Term Care, and Suppliers handbooks have been updated to correct the following outdated acronyms/term Regional Medicaid Services (RMS) replaced by Bureau of Long Term Care (BLTC).

The General Billing Instructions and General Provider and Participant Information handbooks have been updated adding clarification between the Idaho Medicaid Plus (IMPlus) and Medicare Medicaid Coordinated Plan (MMCP) managed care programs. The term Regional Medicaid Services (RMS) was also replaced by Bureau of Long Term Care (BLTC).
The Glossary has been updated to add the terms Idaho Medicaid Plus (IMPlus) and Medicare Medicaid Coordinated Plan (MMCP), to remove the term Regional Medicaid Services (RMS) which

was replaced by BLTC, and to replace Qualified Mental Retardation Professional (QMRP) with Qualified Intellectual Disabilities Professional (QIDP).

## Requirement for Rental of Durable Medical Equipment

Beginning January 1, 2019 Idaho Medicaid will align the claims processing system to enforce IDAPA 16.03.09, "Medicaid Basic Plan Benefits" requirements for defaulting to the capped rental of durable medical equipment. Unless otherwise stated in the Idaho Medicaid Provider Handbook, items are required to be rented and are considered purchased after the tenth payment.

## Facility Claims for Private Room Accommodations

Accommodation rates are reimbursed at semiprivate room rates except when a private room or isolation room is medically necessary. Documentation for a private room or isolation room must be attached to claims with a statement of medical necessity signed by the physician. Providers have been instructed to bill Idaho Medicaid with semiprivate room codes when private rooms are used, and medical necessity doesn't exist. In the interest of correct coding, and the understanding that many facilities only have private rooms, Idaho Medicaid will begin January 1, 2019 to allow these facilities to bill private room revenue codes with condition value code 02 (Hospital has no semi-private rooms). Claims will pay the same as semi-private room rates or all-inclusive room and board.

Claims with private room revenue codes that don't include value code 02 will pend for review of attached documentation to verify a statement of medical necessity from the physician. Claims with private room revenue codes that don't have a value code 02 or documentation of medical necessity will be denied.

## BDDS Process for Citation Disputes

The Bureau of Developmental Disability Services (BDDS) is responsible for oversight and periodic review of approved Medicaid providers who serve adults with developmental disabilities (DD). During a periodic review or a complaint investigation, a BDDS Quality Assurance (QA) Specialist may identify areas in which a provider is operating out of compliance with IDAPA rule, the Idaho Medicaid Provider Handbook, current Information Releases (IRs), or other official policy guidance. In these instances, the BDDS QA Specialist will request the provider identify what corrective actions they will take to come back into compliance.

In order to assist DD providers, BDDS would like to provide clarification regarding the Corrective Action Plan (CAP) process and potential enforcement actions if a CAP is not timely submitted.

If areas of non-compliance are identified during a periodic review or complaint investigation, a Request for a Corrective Action Plan form will be sent to the DD provider. This form will identify the specific areas of non-compliance. In addition, it will require the DD provider to develop and submit a CAP to BDDS that answers the following questions:

a. What corrective action(s) will be taken?
b. Who will be responsible for the corrective action?
c. How will the corrective action(s) be monitored to ensure consistent compliance with IDAPA Rule?
d. Date(s) the corrective action will be implemented?

e. What documentation will be provided to the Department demonstrating the corrective action plan has been implemented?

*NOTE: If a DD provider believes a corrective action plan has been requested for a practice they believe is allowable, the provider may contact the QA Specialist who led the review within three (3) business days of the date the CAP form was emailed to the provider to discuss their concerns. In BDDS's ongoing effort to ensure consistency, any concerns a DD provider communicates to a lead reviewer will be presented to and discussed with the BDDS management/policy team.*

In the event the DD provider disagrees with the Department's final findings and the subsequent citation(s) identified in the Request for a Corrective Action Plan form, the provider has the following options:

1. Choose to submit a corrective action plan, as requested; or
2. Choose not to submit a corrective action plan, as requested.

If the DD provider chooses not to submit a CAP, the provider will receive an Action Against Provider Agreement (AAPA) letter from the BDDS Bureau Chief.

The AAPA letter will identify which of the following enforcement actions the Department will take, as allowed by IDAPA 16.03.09.205.03.c.—e.

- Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; (3-20-14)
- Limit or suspend provision of services to participants who have not previously established services with the provider pending the submission, acceptance, or completion of a corrective action plan; or (3-20-14)
- Terminate the provider's agreement.

The DD provider will have the right to appeal the Department's decision noticed in the AAPA letter. The DD provider will have twenty-eight (28) days from the date the AAPA letter is mailed to file an appeal through the Administrative Procedures Section (APS) of the Idaho Department of Health and Welfare:

Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
FAX: (208) 639-5741
APS@dhw.idaho.gov

If an appeal is filed, the enforcement action outlined in the Department's AAPA letter will not be enforced until the appeal process has been completed.

## IHC Sustainability

The Idaho Home Choice Money Follows the Person Demonstration Grant was established in 2011 to eliminate barriers that restrict the use of Medicaid funds to allow individuals to transition from institutional care settings to a community-based setting. Starting January 1, 2019, the Idaho Home Choice (IHC) program will begin implementing a plan to sustain the program benefits after the demonstration grant period ends. To effectively sustain these benefits, the following changes will be made effective January 1, 2019:

• The length of stay eligibility requirement for participants will be reduced from 90 to 45 consecutive days over and above any Medicare Part A stay
• Residential Assisted Living Facilities (RALFs) will be considered a Qualified Residence for participants utilizing IHC benefits
• Transition Service funds can no longer be used to pay for first month's rent/utilities, or groceries/food
• Utility and Security deposits and application fees will still be eligible expenses
• Individuals who are ages 22 to 64 and reside in an Institution for Mental Diseases (IMD) will not qualify for these benefits
• The Transition Management benefit will be added to the Medicaid Enhanced Benefits Plan. The benefit limit will remain 72 hours (288 units), with participants having access to transition management for up to 365 days after discharge from an institutional setting
• The Transition Service benefit will be added to the Aged & Disabled and Developmental Disability waivers. The benefit limit will remain the same, with participants having access to up to $2000 towards costs associated with setting up a household
• **Please note:** Transition Service funds will only be accessible once waiver services have gone in to effect. Funds cannot be reimbursed for purchases made prior to the waiver coverage effective date.

For more information regarding the Idaho Home Choice Sustainability Plan, visit the program website at http://healthandwelfare.idaho.gov/Medical/Medicaid/IdahoHomeChoice/tabid/1621/Default.aspx or contact IHC staff at (208) 364-1889.

## Preadmission Screening and Resident Review (PASRR): 30-Day Exemptions, Nursing Facility Readmissions and Significant Changes

There has been a recent increase in questions regarding when a PASRR Level I (87) requires submission to the Bureau of Long Term Care (BLTC). Most of these questions involve the 30-Day Exemption and readmissions to the nursing facility after a hospital stay. The purpose of this article is to clarify existing policies for 30-Day Exemptions and Nursing Facility Readmissions.

### *30-Day Exemption*

A Level I (87) is required for all admissions to a Medicaid certified nursing facility **regardless of the anticipated length of stay**. If the Level I (87) 'triggers' positive, the Level I (87) and supporting documentation must be sent to BLTC for further review.

- If the discharge and/or admission orders indicate the anticipated nursing facility stay is less than 30 days, the nurse reviewer will provide a 30-Day Exemption on the Abbreviated Level II (90). This 'exempts' the PASRR from further review by the Division of Behavioral Health and the Bureau of Developmental Disabilities during that 30-day period.
- If the individual's length of stay exceeds 30 days, the PASRR is then sent for further review by the Division of Behavioral Health or the Bureau of Developmental Disability Services.

### *Nursing Facility Readmissions*

- **Readmission with no changes:** If an Individual readmits to a nursing facility with an accurate previous PASRR (meaning no new diagnoses or changes to medications), the

previous Level I (87) can be submitted to the BLTC with supporting documentation. A new Abbreviated Level II (90) will then be issued indicating that there have been no changes and the Level I is current and accurate.

- **Readmission with changes:** If an Individual readmits to a nursing facility with a previous PASRR that is **not** accurate (e.g. there is a new diagnosis or change in medication), a new Level I (87) must be completed and submitted to the BLTC with supporting documentation. The PASRR will be reviewed by the BLTC and, if needed, by the Division of Behavioral Health or the Bureau of Developmental Disability Services. An Abbreviated Level II (90) and, if needed, a Level II (88 or 89) will be issued.

In either of the above situations, the Level I (87) will require review by BLTC and, at least, a new Abbreviated Level II (90) will be issued.

**Leave of Absence:** Nursing facilities can utilize a Leave of Absence (LOA) for individuals that are temporarily out of the facility for **3 days or less** due to a home visit or hospital stay. If a nursing facility exercises this option for an individual, a PASRR does not need to be completed. The determining factor is whether the individual is admitting to or returning to the nursing facility.

- **Admitting:** If the nursing facility will be submitting a long-term case file, the nursing facility is admitting the individual and a PASRR is required.
- **Returning:** If the nursing facility is not submitting a long-term case file **and** will beindicating an LOA on the monthly claim, a PASRR is **not** required.

### *Significant Changes*

Nursing facilities should submit an updated Level I (87) for significant changes. Current and accurate Level I (87) will expedite the readmission process if the individual were to become hospitalized. A significant change is considered as any of the following:

- any medication changes from those listed on the Level I to a different drug class, such as antidepressants to an anxiolytic
- a dosage increase of double or more of medication(s) listed on previous Level I
- a decline in condition (such as the onset or progression of dementia) that indicates specialized services are no longer beneficial for the individual
- an improvement in condition that indicates the individual may benefit from specialized services
- a new mental health or developmental/intellectual disability diagnosis

Any questions or concerns can be directed to Alex Childers-Scott at 208-364-1891 or Alexandria.Childers-Scott@dhw.idaho.gov.

## Hourly Supporteded Living (SL) and Participant Support Wh Sleeping

IDAPA 16.03.10.514.02.c. states hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) hour per day support.

If an hourly support plan is submitted requesting a total number of hours per day of Hourly SL services that indicates the participant will receive support during the participant's typical sleeping time, the BDDS Care Manager will need to clinically assess whether the number of hours of support being requested is appropriate.

In order to make this determination, the initial/annual service plan or addendum must include documentation that demonstrates what specific supports and services are being provided during the time the participant would typically be sleeping. Documentation must support the number of hours being requested and why a service provider needs to be available during the time a participant is sleeping. This may include information or documentation such as:

- Nighttime assessments;
- Medical conditions that require regular and routine monitoring, assistance or intervention;
- Toileting needs; and/or
- Behavior management.

Prior to making a request for services during a participant's typical sleeping time, the person-centered planning team should also explore whether the agency staffing schedule could be adjusted to allow for coverage during times the participant isn't sleeping. This will ensure the agency is present during times the participant is awake and service provision is necessary to meet the participant's desired goals and outcomes.

In some instances, a participant and their person-centered planning team may believe a person requires twenty-four (24) hour per day care but the current assessments do not allow for High or Intense Supported Living services to be approved. If the participant and their person-centered planning team believe the participant's health and safety is dependent on support being present for the majority of the day and night, to include time the participant is sleeping, the team may need to review the most current eligibility assessments to determine whether they accurately reflect the participant's current functional, behavioral or medical needs. The Change in Condition or Appeal processes may be used to request assessment(s) be updated based on relevant documentation and/or information.

Hourly SL services should not be requested for the sole purpose of ensuring support will be available to the participant should a crisis arise. If the participant is living with roommates who are receiving supports and supervision through a 24-hour supported living arrangement (e.g. High or Intense SL services), the SL agency is able to request community crisis hours to reimburse them for any support provided by the SL agency staff in the participant's home during the time the crisis occurred. For specific information about when an agency may bill community crisis supports, please see IDAPA 16.03.10.646.—648. Community Crisis Worksheets may also be found at: https://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/AdultDDInformationforProviders/tabid/2310/Default.aspx

If a participant is living alone in their own home, rather than require the participant to have direct care staff for the sole purpose of ensuring support should a crisis arise, other means of support may be explored (e.g. Personal Emergency Response system, natural supports, DME/SME, etc.). The participant may also include goals on their service plan specific to developing or maintaining skills to access support in the event of a crisis or during those times direct care staff or natural supports are not available.

## Anesthesia for Obstetrical/Maternity Services

This MedicAide article does not include all applicable guidance nor address all issues that may affect reimbursement, including but not limited to, correct coding and national guidance restrictions which may apply to obstetrical and maternity services than are covered in this article.

Time for epidural anesthesia services rendered during labor is counted differently from other anesthesia services. Obstetrical neuraxial anesthesia/epidural, CPT 01967 for vaginal delivery time is not counted like general anesthesia time. Obstetrical epidural time is counted in minutes from beginning to end even if the anesthesiologist is not physically in the room. This is allowed because the anesthesiologist may attend more than one patient concurrently under continuous epidural analgesia for obstetrical deliveries.

Medications for pain relief given during the time of the epidural anesthesia are included and must not be billed as a separate procedure. Medicaid does not pay for supervision of anesthesia services. Only one provider will be paid for epidural services. The provider who administers the anesthesia, either a physician or Certified Registered Nurse Anesthetist (CRNA), is paid 100 percent of the allowed amount for the epidural procedure.

When billing obstetrical anesthesia, indicate total time in minutes for CPT 01967. The Idaho Medicaid Management Information System (MMIS) will calculate the claim payment based on minutes. All anesthesia services must be billed with the appropriate diagnosis code, including for legal or therapeutic abortions, dilation and curettage (D & C) procedures, hysterectomies and elective sterilizations. All restricted services may have consent and documentation requirements which must be met (for more information, see the ***Idaho Medicaid Provider Handbook, Physician and Non-Physician Practitioner***, at idmedicaid.com).

CPT codes for Obstetric and Maternity Anesthesia services,

- **01960** Anesthesia for vaginal delivery only. [Note: Anesthesia via epidural catheter should be billed using CPT code 01967.]
- **01961** Anesthesia for cesarean delivery only.
- **01967** Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor).
- **01968** Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia. (List separately in addition to code for primary procedure.) Add-on code.
- **01969** Anesthesia for cesarean hysterectomy delivery following neuraxial labor analgesia/anesthesia. (List separately in addition to code for primary procedure.) Add-on code.

**Anesthesia for Cesarean Delivery Following a Planned Vaginal Birth**

Coding for scheduled cesarean deliveries can be done on a single claim line. When a delivery is planned as a vaginal delivery, but concludes as a cesarean delivery, two claim lines are required to fully describe the services.

CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. When an appropriately licensed and enrolled rendering/performing provider starts a planned vaginal delivery (CPT code 01967) which results in a cesarean delivery (CPT code 01968), both procedures may be billed. The date of delivery must be the date of service for both the primary and add-on code.

Do not report CPT 01968 for "standing-by" if the patient elects natural childbirth and the physician/provider doesn't perform an epidural.

**Anesthesia for Sterilization at the Time of Delivery**

Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately. All sterilization consent and documentation requirements must be met.



# Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT

This MedicAide article does not include all applicable guidance nor address all issues that may affect reimbursement, including but not limited to, correct coding and national guidance restrictions which may apply to obstetrical and maternity services than are covered in this article.

### When to Submit Global Obstetrical CPT

Global obstetrical (OB) billing consists of antepartum care, delivery (cesarean section or vaginal delivery, with or without episiotomy, with or without forceps, or breech delivery-intrapartum), and postpartum care. When the same practitioner or group of providers renders antepartum, delivery and postpartum care, claims submitted with separate reporting of codes included in a global service is unbundling and incorrect coding of services. Claims must be submitted using the date of delivery as the from and to date. Billing the global service is required regardless of the start date of the participant's eligibility. When the Medicaid participant has active eligibility that begins on the date of delivery or any point prior, the global CPT must be billed to Idaho Medicaid.

### When Not to Submit Global Obstetrical CPT

Global surgery CPT codes must not be submitted to Idaho Medicaid unless the appropriately licensed and enrolled rendering/performing provider or group of providers renders all services and supplies as included in and/or bundled into the standard global package. The medial record must fully document and substantiate the service/supplies as rendered by the enrolled provider. If the rendering/performing provider did not perform the full global surgical package, the service must be appropriately documented in the medical record and submitted with correct CPT codes reflecting the actual service rendered.

### Billing for Incomplete Intrapartum Care, Delivery of Placenta Only, CPT 59414

When delivery has occurred without the direct physical assistance of the appropriately licensed and enrolled rendering/performing provider, the provider may have still been present to deliver the placenta (as documented in the medical record). CPT code 59414 delivery of placenta (separate procedure) should be submitted with the appropriate CPT codes for antepartum and/or postpartum care, rather than a global CPT which includes labor and delivery.

### Billing for Incomplete Antepartum Care

Antepartum care includes the following usual prenatal services:

- Recording weight, blood pressure, and fetal heart tones
- Routine dipstick urinalyses
- Maternity counseling

If the performing provider sees the participant for part of the prenatal care but does not deliver, submit charges only for the services rendered. When billing for the initial physical examination and the second or third follow up visit, use the appropriate E/M CPT code.

Do not bill for lab charges sent to an outside laboratory. Bill only for the services rendered. When billing for four to six prenatal visits, use CPT code 59425 with the total charge for all visits on one line. Do not split out each visit. Enter the first date the participant was seen in both the **from** and **to** date fields on the CMS-1500 claim form. If billing a paper CMS-1500 claim form, note the date for each additional visit in field 19.

When billing for seven or more prenatal visits with or without an initial visit, use CPT code 59426 with the total charge and the description, Antepartum Care Only, on one line with one charge. Do not split out each visit. Enter the first date the participant was seen in both the **from** and **to** date fields on the CMS-1500 claim form. If billing a paper CMS-1500 claim, note the date for each additional visit in field 19.

**Billing for Incomplete Postpartum Care**

Postpartum care following delivery includes contraceptive counseling.

If the performing provider sees the participant for postpartum care, but does not deliver, bill CPT code 59430, postpartum care only. This code is to be billed once regardless of the number of visits. Enter the first date the participant was seen for postpartum care in both the **from** and **to** date fields. Do not bill E&M codes for postpartum visits.

**Intrapartum Care**

Intrapartum care includes the face to face time monitoring labor.

**Billing for Incomplete Intrapartum Care, Referred to Another Medicaid Provider for Delivery**

When the performing provider renders Intrapartum care, but must refer to another provider for delivery, bill CPT code 59899 and provide documentation that identifies the activities and time services were provided with the billing. If documentation is not provided, the claim may be denied.

***Idaho MMIS CMS 1500 Instructions, Appendix I. Licensed Midwives***

The Idaho MMIS CMS 1500 Instructions, **Appendix I. Licensed Midwives**, located in the Provider Handbook at idmedicaid.com, will be corrected to include CPT code 59414 delivery of placenta (separate procedure).

For more information on global surgical packages and billing, please see the Medicare Learning Network Booklet, Global Surgery Booklet, ICN 907166, updated September 2018, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

# Attention Occupational Therapists and Speech Language Pathologists: Feeding Therapy

Medicaid will cover medically necessary therapy to treat dysphagia and feeding disorders diagnosed by a physician or non-physician practitioner. Feeding disorders including problems gathering food and getting ready to suck, chew, or swallow. A child unable to pick up food and deliver it to their mouth, or one who cannot completely close their lips to keep food from falling out of their mouth, may have a feeding disorder. Therapy services are not covered for diagnosis or screening of dysphagia and feeding disorders. Feeding therapy services must be provided by a licensed speech language pathologist with training specific to feeding therapy, or an occupational therapist with a Specialty Certification in Feeding, Eating and Swallowing to receive reimbursement for these services.

| Eligible Codes for Feeding Therapy | |
|---|---|
| 92610 | the evaluation of oral and pharyngeal swallowing function, per visit |
| 92526 | the treatment of swallowing dysfunction and/or oral function for feeding, per visit |

The Department considers services for feeding therapy to be medically necessary when all of the following conditions are met:

- Medical causes have been treated without resolution of the feeding problem;
- Neurological or oral-motor problems exist;
- Behavior problems are interfering with feeding;
- Normal feeding milestones have not been met;
- Physician has ordered the treatment; and
- Patient demonstrates inadequate physical growth as evidence by any of the following:
    - Weight below the third or fifth percentile for gestation-corrected age and sex as outlined in standard growth charts. Children growing along a curve with a normal interval growth rate, even if their weight is less than the fifth percentile, do not meet this criteria.
    - Patient's linear growth is below the fifth percentile as outlined in standard growth charts.
    - Patient has dropped two major growth percentiles (i.e. from above the 75th percentile to below the 25th) within a month's time as outlined in standard growth charts.

# Attention Hospitals: Cesarean Diagnoses for Inpatient Stays

The list of preapproved medically necessary diagnoses for participants to receive a cesarean section will be updated to the below list of codes with an effective date of 10/01/2015. Codes that have been added appear in red. Previously approved codes not on the list below will be terminated 10/31/2018. Claims for non-approved diagnoses will need to go through the claim review and pre-appeal process for a review of medical necessity. Please, ensure documentation is attached to demonstrate medical necessity for a cesarean section. If an inpatient stay exceeds four days, providers should submit a prior authorization request to Telligen, Inc.

| ICD-10 Code | Description |
|---|---|
| A60.03 | Herpesviral cervicitis |
| A60.04 | Herpesviral vulvovaginitis |
| A60.9 | Anogenital herpesviral infection, unspecified |
| O10.02 | Pre-existing essential hypertension complicating childbirth |
| O10.12 | Pre-existing hypertensive heart disease complicating childbirth |
| O10.22 | Pre-existing hypertensive chronic kidney disease complicating childbirth |
| O10.32 | Pre-existing hypertensive heart and chronic kidney disease complicating childbirth |
| O10.42 | Pre-existing secondary hypertension complicating childbirth |
| O11.4 | Pre-existing hypertension with pre-eclampsia, complicating childbirth |
| O12.04 | Gestational edema, complicating childbirth |
| O12.24 | Gestational edema with proteinuria, complicating childbirth |
| O13.4 | Gestational (pregnancy-induced) hypertension without significant proteinuria, complicating childbirth |
| O14.04 | Mild to moderate pre-eclampsia, complicating childbirth |
| O14.14 | Severe pre-eclampsia complicating childbirth |
| O14.24 | HELLP syndrome, complicating childbirth |
| O15.1 | Eclampsia in labor |
| O26.72 | Subluxation of symphysis (pubis) in childbirth |
| O28.0 | Abnormal hematological finding on antenatal screening of mother |
| O30.002 – O30.003 | Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester |
| O30.012 – O30.013 | Twin pregnancy, monochorionic/monoamniotic, second or third trimester |
| O30.022 – O30.023 | Conjoined twin pregnancy, second or third trimester |
| O30.032 – O30.033 | Twin pregnancy, monochorionic/diamniotic, second or third trimester |
| O30.042 – O30.043 | Twin pregnancy, dichorionic/diamniotic, second or third trimester |
| O30.092 – O30.093 | Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester |
| O30.102 – O30.103 | Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester |
| O30.112 – O30.113 | Triplet pregnancy with two or more monochorionic fetuses, second or third trimester |
| O30.122 – O30.123 | Triplet pregnancy with two or more monoamniotic fetuses, second or third trimester |
| O30.132 – O30.133 | Triplet pregnancy, trichorionic/triamniotic, second or third trimester |
| O30.192 – O30.193 | Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester |

| ICD-10 Code | Description |
|---|---|
| O30.202 – O30.203 | Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester |
| O30.212 – O30.213 | Quadruplet pregnancy with two or more monochorionic fetuses, second or third trimester |
| O30.222 – O30.223 | Quadruplet pregnancy with two or more monoamniotic fetuses, second or third trimester |
| O30.232 – O30.233 | Quadruplet pregnancy, quadrachorionic/quadra-amniotic, second or third trimester |
| O30.292 – O30.293 | Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester |
| O30.802 – O30.803 | Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester |
| O30.812 – O30.813 | Other specified multiple gestation with two or more monochorionic fetuses, second or third trimester |
| O30.822 – O30.823 | Other specified multiple gestation with two or more monoamniotic fetuses, second or third trimester |
| O30.832 – O30.833 | Other specified multiple gestation, number of chorions and amnions are both equal to the number of fetuses, second or third trimester |
| O30.892 – O30.893 | Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, second or third trimester |
| O32.0XX0 – O32.0XX9 | Maternal care for unstable lie |
| O32.1XX0 – O32.1XX9 | Maternal care for breech presentation |
| O32.2XX0 – O32.2XX9 | Maternal care for transverse and oblique lie |
| O32.3XX0 – O32.3XX9 | Maternal care for face, brow and chin presentation |
| O32.4XX0 – O32.4XX9 | Maternal care for high head at term |
| O32.6XX0 – O32.6XX9 | Maternal care for compound presentation |
| O32.8XX0 – O32.8XX9 | Maternal care for other malpresentation of fetus |
| O33.0 | Maternal care for disproportion due to deformity of maternal pelvic bones |
| O33.1 | Maternal care for disproportion due to generally contracted pelvis |
| O33.2 | Maternal care for disproportion due to inlet contraction of pelvis |
| O33.3XX0 – O33.3XX9 | Maternal care for disproportion due to outlet contraction of pelvis |
| O33.4XX0 – O33.4XX9 | Maternal care for disproportion of mixed maternal and fetal origin |
| O33.5XX0 – O33.5XX9 | Maternal care for disproportion due to unusually large fetus |
| O33.6XX0 – O33.6XX9 | Maternal care for disproportion due to hydrocephalic fetus |

| ICD-10 Code | Description |
|---|---|
| O33.7XX0 – O33.7XX9 | Maternal care for disproportion due to other fetal deformities |
| O33.8 | Maternal care for disproportion of other origin |
| O34.12 – O34.13 | Maternal care for benign tumor of corpus uteri |
| O34.211 | Maternal care for low transverse scar from previous cesarean delivery |
| O34.212 | Maternal care for vertical scar from previous cesarean delivery |
| O34.29 | Maternal care due to uterine scar from other previous surgery |
| O34.32 – O34.33 | Maternal care for cervical incompetence |
| O34.42 – O34.43 | Maternal care for other abnormalities of cervix |
| O34.512 – O34.513 | Maternal care for incarceration of gravid uterus |
| O34.522 – O34.523 | Maternal care for prolapse of gravid uterus |
| O34.532 – O34.533 | Maternal care for retroversion of gravid uterus |
| O34.592 – O34.593 | Maternal care for other abnormalities of gravid uterus |
| O34.62 – O34.63 | Maternal care for abnormality of vagina |
| O34.72 – O34.73 | Maternal care for abnormality of vulva and perineum |
| O34.82 – O34.83 | Maternal care for other abnormalities of pelvic organs |
| O40.2XX0 – O40.3XX9 | Polyhydramnios |
| O41.02X0 – O41.03X9 | Oligohydramnios |
| O41.1220 – O41.1239 | Chorioamnionitis |
| O41.1420 – O41.1439 | Placentitis |
| O41.8X20 – O41.8X39 | Other specified disorders of amniotic fluid and membranes |
| O42.012 – O42.013 | Preterm premature rupture of membranes, onset of labor within 24 hours of rupture |
| O42.112 – O42.113 | Premature rupture of membranes, onset of labor more than 24 hours following rupture |
| O43.012 – O43.013 | Fetomaternal placental transfusion syndrome |
| O43.022 – O43.023 | Fetus-to-fetus placental transfusion syndrome |
| O43.112 – O43.113 | Circumvallate placenta |

| ICD-10 Code | Description |
|---|---|
| O43.122 – O43.123 | Velamentous insertion of umbilical cord |
| O43.192 – O43.193 | Other malformation of placenta |
| O43.212 – O43.213 | Placenta accreta |
| O43.222 – O43.223 | Placenta increta |
| O43.232 – O43.233 | Placenta percreta |
| O43.812 – O43.813 | Placental infarction |
| O43.892 – O43.893 | Other placental disorders |
| O44.02 – O44.03 | Placenta previa specified as without hemorrhage |
| O44.12 – O44.13 | Placenta previa with hemorrhage |
| O44.22 – O44.23 | Partial placenta previa NOS or without hemorrhage |
| O44.32 – O44.33 | Partial placenta previa with hemorrhage |
| O44.42 – O44.43 | Low lying placenta NOS or without hemorrhage |
| O44.52 – O44.53 | Low lying placenta with hemorrhage |
| O45.012 – O45.013 | Premature separation of placenta with afibrinogenemia |
| O45.022 – O45.023 | Premature separation of placenta with disseminated intravascular coagulation |
| O45.092 – O45.093 | Premature separation of placenta with other coagulation defect |
| O45.8X2 – O45.8X3 | Other premature separation of placenta |
| O46.012 – O46.013 | Antepartum hemorrhage with afibrinogenemia |
| O46.022 – O46.023 | Antepartum hemorrhage with disseminated intravascular coagulation |
| O46.092 – O46.093 | Antepartum hemorrhage with other coagulation defect |
| O46.8X2 – O46.8X3 | Other antepartum hemorrhage |
| O61.0 – O61.8 | Failed induction of labor |
| O62.0 – O62.2 | Abnormalities of forces of labor |

| ICD-10 Code | Description |
|---|---|
| O62.4 – O62.8 | Abnormalities of forces of labor |
| O64.0XX0 – O64.0XX9 | Obstructed labor due to incomplete rotation of fetal head |
| O64.1XX0 – O64.1XX9 | Obstructed labor due to breech presentation |
| O64.2XX0 – O64.2XX9 | Obstructed labor due to face presentation |
| O64.3XX0 – O64.3XX9 | Obstructed labor due to brow presentation |
| O64.4XX0 – O64.4XX9 | Obstructed labor due to shoulder presentation |
| O64.5XX0 – O64.5XX9 | Obstructed labor due to compound presentation |
| O64.8XX0 – O64.8XX9 | Obstructed labor due to other malposition and malpresentation, not applicable or unspecified |
| O65.0 – O65.8 | Obstructed labor due to maternal pelvic abnormality |
| O66.0 – O66.3 | Other obstructed labor |
| O66.41 – O66.8 | Other obstructed labor |
| O67.0 – O67.8 | Labor and delivery complicated by intrapartum hemorrhage, not elsewhere classified |
| O68 | Labor and delivery complicated by abnormality of fetal acid-base balance |
| O69.0XX0 -- O69.89X9 | Labor and delivery complicated by umbilical cord complications |
| O71.02 – O71.1 | Rupture of uterus before or during labor |
| O75.1 | Shock during or following labor and delivery |
| O75.3 | Other infection during labor including sepsis |
| O75.81 | Maternal exhaustion complicating labor and delivery |
| O76 | Abnormality in fetal heart rate and rhythm complicating labor and delivery |
| O77.0 – O77.8 | Other fetal stress complicating labor and delivery |
| O88.02 | Air embolism in childbirth |
| O88.12 | Amniotic fluid embolism in childbirth |
| O88.22 | Thromboembolism in childbirth |
| O88.32 | Pyemic and septic embolism in childbirth |
| O88.82 | Other embolism in childbirth |
| O98.72 | Human immunodeficiency virus [HIV] disease complicating childbirth |
| O99.354 | Diseases of the nervous system complicating childbirth |
| O99.42 | Diseases of the circulatory system complicating childbirth |

| ICD-10 Code | Description |
|---|---|
| O99.52 | Diseases of the respiratory system complicating childbirth |
| O99.824 | Streptococcus B carrier state complicating childbirth |
| O9A.12 | Malignant neoplasm complicating childbirth |

# Pharmacist Prescribing Authority

The 2018 Idaho Legislature passed updates to the practice of pharmacy to allow pharmacists additional prescriptive authority. Pharmacists should bill medical/DME codes under their DME supplier NPI. DXC Technology's claims processing system will be updated to allow claims from 7/1/2018 forward. Please, allow time for the system update to be implemented. The following codes may be prescribed by pharmacists when medically necessary within the scope of their licensure. Pharmacy claims can continue to be billed through the Magellan POS system with the pharmacist NPI entered as prescriber and the pharmacy NPI as the paid to entity.

| Codes | Description |
|---|---|
| 86580 | Skin test; tuberculosis, intradermal |
| 87502 | Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, first 2 types or sub-types |
| 87651 | iadna streptococcus group a amplified probe tq |
| 87804 | Infectious agent antigen detection by immunoassay with direct optical observation; Influenza |
| 90460 | Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered |
| 90461 | im adm thru 18yr any rte addl vac/tox compt |
| 90471 | imadm prq id subq/im njxs 1 vaccine |
| 90472 | imadm prq id subq/im njxs ea vaccine |
| 90473 | imadm intransl/oral 1 vaccine |
| 90474 | imadm intransl/oral ea vaccine |
| 90476 | adenovirus vaccine type 4 live oral |
| 90477 | adenovirus vaccine type 7 live for oral |
| 90581 | anthrax vaccine subcutaneous/im use |
| 90585 | bacillus calmette-guerin vacc for tb live perq |
| 90586 | bacillus calmette-guerin vaccine intravesical |
| 90620 | menb-4c recombnt prot & outer memb vesic vacc im |
| 90621 | menb-fhbp recombnt lipoprotein vacc 2/3 dose im |
| 90625 | cholera vaccine adult 1 dose live for oral use |
| 90630 | influenza vacc iiv4 split virus prsrv free id |
| 90632 | hepa vaccine adult dose for intramuscular use |
| 90633 | hepa vaccine 2 dose schedule ped/adolesc im use |
| 90634 | hepa vaccine 3 dose schedule ped/adolesc im use |

| Codes | Description |
|---|---|
| 90636 | hepatitis a & b vaccine hepa-hepb adult im |
| 90647 | hib prp-omp vaccine 3 dose schedule im use |
| 90648 | hib prp-t vaccine 4 dose schedule im use |
| 90649 | 4vhpv vaccine 3 dose schedule for im use |
| 90650 | 2vhpv vaccine 3 dose schedule for im use |
| 90651 | 9vhpv vacc 2/3 dose sched im use |
| 90653 | iiv adjuvanted vaccine for intramuscular use |
| 90654 | influenza vacc iiv3 split virus prsrv free id |
| 90655 | iiv3 vacc presrv free 0.25 ml dosage im use |
| 90656 | iiv3 vacc preservative free 0.5 ml dosage im use |
| 90657 | iiv3 vaccine split virus 0.25 ml dosage im use |
| 90658 | iiv3 vaccine split virus 0.5 ml dosage im use |
| 90660 | laiv3 vaccine live for intranasal use |
| 90661 | cciiv3 vaccine preservative free 0.5 ml im use |
| 90662 | iiv vaccine preserv free increased ag content im |
| 90664 | laiv vaccine pandemic formula for intranasal use |
| 90666 | influenza vaccine pandemic splt prsrv free im |
| 90667 | iiv vaccine pandemic adjuvant for im use |
| 90668 | iiv vaccine pandemic for intramuscular use |
| 90670 | pcv13 vaccine for intramuscular use |
| 90672 | laiv4 vaccine for intranasal use |
| 90673 | riv3 vaccine preservative free for im use |
| 90674 | cciiv4 vaccine preservative free 0.5 ml im use |
| 90675 | rabies vaccine intramuscular |
| 90676 | rabies vaccine intradermal |
| 90680 | rv5 vaccine 3 dose schedule live for oral use |
| 90681 | rv1 vaccine 2 dose schedule live for oral use |
| 90682 | riv4 vacc recombinant dna prsrv antibio free im |
| 90685 | iiv4 vacc prsrv free 0.25 ml dos for im use |
| 90686 | iiv4 vacc presrv free 0.5 ml dos for im use |
| 90687 | iiv4 vacc split virus 0.25 ml dos for im use |
| 90688 | iiv4 vacc split virus 0.5 ml dos for im use |
| 90690 | typhoid vaccine live oral |
| 90691 | typhoid vaccine vi capsular polysaccharide im |
| 90698 | dtap-ipv/hib vaccine for intramuscular use |
| 90700 | diphth tetanus tox acell pertussis vacc<7 yr im |
| 90702 | dt vaccine younger than 7 yrs for im use |
| 90707 | measles mumps rubella virus vaccine live subq |
| 90710 | measles mumps rubella varicella vacc live subq |
| 90713 | poliovirus vaccine inactivated subq/im |

| Codes | Description |
|---|---|
| 90714 | td vaccine prsrv free 7 yrs or older for im use |
| 90715 | tdap vaccine 7 yrs/> im |
| 90716 | var vaccine live for subcutaneous use |
| 90717 | yellow fever vaccine live subq |
| 90723 | dtap-hepb-ipv vaccine intramuscular |
| 90732 | ppsv23 vaccine 2 yrs or older for subq/im use |
| 90733 | mpsv4 vaccine groups acyw-135 subq use |
| 90734 | mcv4/menacwy conj vacc grps acyw-135 im use |
| 90736 | zoster vaccine hzv live for subcutaneous use |
| 90738 | japanese encephalitis vaccine inactivated im |
| 90739 | hepb vaccine adult 2 dose schedule for im use |
| 90740 | hepb vaccine dialysis/immunsup pat 3 dose im |
| 90743 | hepb vaccine adolescent 2 dose schedule im |
| 90744 | hepb vaccine ped/adolesc 3 dose schedule im |
| 90746 | hepb vaccine adult 3 dose schedule for im use |
| 90747 | hepb vaccine dialysis/immunsup pat 4 dose im |
| 90748 | hib-hepb vaccine for intramuscular use |
| 90756 | cciiv4 vaccine antibiotic free 0.5 ml dos im use |
| A4206 | 1 CC sterile syringe & needle, each |
| A4207 | 2 CC sterile syringe & needle, each |
| A4208 | 3 CC sterile syringe & needle, each |
| A4209 | 5+ CC sterile syringe & needle, each |
| A4211 | Supplies for self-administered injections |
| A4212 | Non coring needle or stylet w/o catheter |
| A4213 | 20+ CC syringe only, each |
| A4215 | Sterile needle, any size, each |
| A4220 | Infusion pump refill kit, implantable pump |
| A4221 | Supplies maint drug infusion catheter per wk |
| A4222 | External drug infusion pump supplies, per bag |
| A4223 | Infusion supplies w/o pump |
| A4224 | Supplies insulin infusion cath, per week |
| A4225 | Supplies external insulin infusion pump syr |
| A4232 | Syringe w/needle external insulin 3cc |
| A4233 | Alkaline battery for glucose monitor |
| A4234 | J-cell battery for glucose monitor |
| A4235 | Lithium battery for glucose monitor |
| A4236 | Silver oxide battery glucose monitor |
| A4244 | Alcohol or peroxide, per pint |
| A4245 | Alcohol wipes, per box |
| A4246 | Betadine/phisohex solution, per pint |

| Codes | Description |
|---|---|
| A4247 | Betadine/iodine swabs/wipes, per box |
| A4250 | Urine reagent strips/tablets 100 tabs/strips |
| A4252 | Blood ketone test or strip, each |
| A4253 | Blood glucose/reagent strips, per 50 strips |
| A4256 | Calibrator solution/chips normal high low |
| A4258 | Spring- powered lancet device ,each |
| A4259 | Lancets per box of 100 |
| A7004 | Disposable nebulizer small volume nonfiltered |
| A7005 | Nondisposable pneumtc nebulizer set admin set |
| A7006 | Filtered sm vol nebulizer administration set |
| A7007 | Lg volume nebulizer disposable use w aerosol |
| A7008 | Disposable nebulizer prefill, use w aerosol |
| A7009 | Lg vol nebulizer reserv bottle, non-disposable |
| A7010 | Disp corrugate tubng used w/lg vol neb, 100ft |
| A7012 | Large vol nebulizer water collection device |
| A7013 | Disposable aerosol compressor filter |
| A7014 | Non-disposable aerosol compressor filter |
| A7015 | Aerosol mask used with DME nebulizer |
| A7016 | Nebulizer dome & mouthpiece use w sml neb |
| A7017 | Nebulizer , durable, glass not used w oxygen |
| A7018 | Water distilled w/nebulizer, not used w oxygn |
| A9275 | Disposable home glucose monitor |
| A9276 | Disposable sensor, CGM system |
| A9277 | External transmitter, CGM system |
| A9278 | External receiver, CGM system |
| G0008 | Administration of influenza virus vaccine |
| G0009 | Administration of pneumococcal vaccine |
| G0010 | Administration of hepatitis B vaccine |
| J0171 | Injection, Adrenalin, epinephrine, 0.1 mg |
| J2310 | Injection, naloxone HCl, per 1 mg |
| J7611 | Albuterol non-compounded concentrated, 1MG |
| J7612 | Levalbuterol non-compounded concentrated, 0.5MG |
| J7613 | Albuterol non-compounded unit, 1MG |
| J7614 | Levalbuterol non-compounded unit, 0.5MG |
| J7620 | Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, noncompounded, administered through DME |
| S8100 | Holdng chmbr/spacer for use w inhaler wo mask |
| S8101 | Holdng chambr/spacer for use w inhaler w mask |

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

September 27, 2018

**MEDICAID INFORMATION RELEASE MA 18-14**

To: All Hospice Providers

From: Matt Wimmer, Administrator MW by G.G.
Division of Medicaid

Subject: Medicaid Hospice Rates Update ***(*This is an amended IR due to a date change on page two for hospice cap run dates.)***

Section 3004 of the Affordable Care Act amended the Social Security Act to authorize a Medicare quality reporting program for hospice services. Section 1814(i)(5)(A)(i) of the Social Security Act requires that beginning with FY 2014 and for each subsequent fiscal year, the Secretary shall reduce the market basket update by 2 percent (2%) for any hospice provider that does not comply with the quality data submission requirements with respect to that fiscal year. Medicaid minimum rates are reduced by the amount of any penalty due to non-reporting.

Based on these requirements, the two tables below include Medicaid hospice rates for FY 2019. Table 1 includes the Medicaid hospice rates for those providers that have complied with the quality reporting requirements. Table 2 provides rates for those providers that have not complied with the reporting requirements.

Effective for dates of service on and after October 1, 2018 through September 30, 2019, Medicaid hospice rates are as follows:

**Table 1 – Hospice Providers that Have Submitted Medicare Required Quality Data**

| County | Revenue Code | | | | | |
|---|---|---|---|---|---|---|
| | 651 | | SIA | 652 | 655 | 656 |
| | *Days 1-60* | *Days 61-∞* | *Up To* | *All Days* | | |
| Franklin | $179.27 | $140.87 | $151.68 | $9.48 | $172.47 | $696.15 |
| Kootenai | $182.85 | $143.68 | $154.72 | $9.67 | $175.13 | $709.01 |
| Nez Perce | $180.30 | $141.68 | $152.64 | $9.54 | $173.24 | $699.84 |
| Bannock | $180.11 | $141.53 | $152.48 | $9.53 | $173.09 | $699.16 |
| Bonneville, Butte, and Jefferson | $182.98 | $143.79 | $154.88 | $9.68 | $175.23 | $709.50 |
| Ada, Boise, Canyon, Gem, and Owyhee | $181.30 | $142.46 | $153.44 | $9.59 | $173.98 | $703.43 |
| RURAL (*all others*) | $169.50 | $133.19 | $143.52 | $8.97 | $165.21 | $661.02 |

**Table 2 – Hospice Providers that Have Not Submitted Medicare Required Quality Data**

| County | Revenue Code | | | | | |
|---|---|---|---|---|---|---|
| | 651 | | SIA | 652 | 655 | 656 |
| | *Days 1-60* | *Days 61-∞* | *Up To* | *All Days* | | |
| Franklin | $175.69 | $138.05 | $148.65 | $9.29 | $169.02 | $682.23 |
| Kootenai | $179.19 | $140.81 | $151.63 | $9.48 | $171.63 | $694.83 |
| Nez Perce | $176.69 | $138.84 | $149.59 | $9.35 | $169.77 | $685.84 |
| Bannock | $176.51 | $138.70 | $149.43 | $9.34 | $169.63 | $685.18 |
| Bonneville, Butte, and Jefferson | $179.32 | $140.91 | $151.78 | $9.49 | $171.73 | $695.31 |
| Ada, Boise, Canyon, Gem, and Owyhee | $177.67 | $139.61 | $150.37 | $9.40 | $170.50 | $689.36 |
| RURAL (*all others*) | $166.11 | $130.53 | $140.65 | $8.79 | $161.91 | $647.80 |

Counties not specifically stated above fall into the "RURAL (all others)" category.

Section 1814(i)(2)(B) of the Social Security Act also provides for an annual increase in the hospice cap amounts. The hospice cap runs from October 1st of each year through September 30th of the following year. The hospice cap amount for the cap year ending September 30, 2019, is $29,205.44.

If you have any questions regarding these rates please contact Alan Brewington, Office of Reimbursement, Idaho Division of Medicaid, at (208) 364-1994.

Thank you for your continued participation in the Idaho Medicaid Program.

MW/ab/as

# Provider Training Opportunities in 2018

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

**November: Home Health Hospice**
This training will walk Home Health and Hospice 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.

| | November | December | January |
|---|---|---|---|
| | **Home Health Hospice** | **Personal Care Service** | **Eligibility** |
| 10:00 - 11:00 AM MT | 11/15/2018 | 12/18/2018 | 1/15/2019 |
| | 11/19/2018 | 12/19/2018 | 1/16/2019 |
| | 11/21/2018 | 12/20/2018 | 1/17/2018 |
| | | | |
| 2:00 - 3:00 PM MT | 11/8/2018 | 12/12/2018 | 1/9/2019 |
| | 11/14/2018 | 12/13/2018 | 1/10/2019 |
| | 11/15/2018 | 12/18/2018 | 1/15/2019 |
| | 11/19/2018 | 12/20/2018 | 1/17/2019 |

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 DXC Technology representative can provide the medical reviewer's reason captured in the participant's non-clinical notes. If you are unable to view the authorization status, please review the Trading Partner Account (TPA) User Guide located under **User Guides** on www.idmedicaid.com. To speak to a DXC Technology representative, call 1 (866) 686-4272, option 3.

**MCU Medical Review Decisions**
If you have any questions about medical review decisions, please refer to the following contact numbers or e-mail MedicalCareUnit@dhw.idaho.gov.

For DMEPOS PA policy, please see the DMEPOS PA Policy and Medical Criteria under the **Resources** tab on the DME page. Please review the DMEPOS PA Policy and Medical Criteria to obtain important information, policy, and guidance relating to requesting PAs for DMEPOS items. This document also includes the medical criteria used by the Department in most circumstances related to DMEPOS requests.

| | Fax Number | Phone Number |
|---|---|---|
| Administratively Necessary Days | 1 (877) 314-8779 | 1 (866) 205-7403 |
| Ambulance* | 1 (877) 314-8781 | 1 (800) 362-7648 |
| Breast & Cervical Cancer | 1 (877) 314-8779 | 1 (208) 364-1826 |
| Durable Medical Equipment | 1 (877) 314-8782 | 1 (866) 205-7403 |
| Hospice | 1 (877) 314-8779 | 1 (866) 205-7403 |
| Preventive Health Assistance | 1 (877) 845-3956 | 1 (208) 364-1843 |
| Service Coordination | 1 (877) 314-8779 | 1 (866) 205-7403 |
| Surgery-Procedure-Lab | 1 (877) 314-8779 | 1 (866) 205-7403 |
| Therapy: OT, PT, SLP | 1 (877) 314-8779 | 1 (866) 205-7403 |
| Vision | 1 (877) 314-8779 | 1 (866) 205-7403 |

*Idaho Medicaid contracts with Medical Transportation Management (MTM) for all non-emergency medical transportation services. Please go to http://www.mtm-inc.net/idaho/ or call 1 (877) 503-1261 for more information.

# DHW Resource and Contact Information

| | |
|---|---|
| **DHW Website** | www.healthandwelfare.idaho.gov |
| **Idaho CareLine** | 2-1-1<br>1 (800) 926-2588 |
| **Medicaid Program Integrity Unit** | P.O. Box 83720<br>Boise, ID 83720-0036<br>prvfraud@dhw.idaho.gov<br>Fax: 1 (208) 334-2026 |
| **Telligen** | 1 (866) 538-9510<br>Fax: 1 (866) 539-0365<br>http://IDMedicaid.Telligen.com |
| **Healthy Connections Regional Health Resource Coordinators** | |
| **Region I**<br>**Coeur d'Alene** | 1 (208) 666-6766<br>1 (800) 299-6766 |
| **Region II**<br>**Lewiston** | 1 (208) 799-5088<br>1 (800) 799-5088 |
| **Region III**<br>**Caldwell** | 1 (208) 455-7244<br>1 (208) 642-7006<br>1 (800) 494-4133 |
| **Region IV**<br>**Boise** | 1 (208) 334-0717<br>1 (208) 334-0718<br>1 (800) 354-2574 |
| **Region V**<br>**Twin Falls** | 1 (208) 736-4793<br>1 (800) 897-4929 |
| **Region VI**<br>**Pocatello** | 1 (208) 235-2927<br>1 (800) 284-7857 |
| **Region VII**<br>**Idaho Falls** | 1 (208) 528-5786<br>1 (800) 919-9945 |
| **In Spanish**<br>**(en Español)** | 1 (800) 378-3385 |

# Insurance Verification

| | |
|---|---|
| **HMS**<br>PO Box 2894<br>Boise, ID 83701 | 1 (800) 873-5875<br>1 (208) 375-1132<br>Fax: 1 (208) 375-1134 |

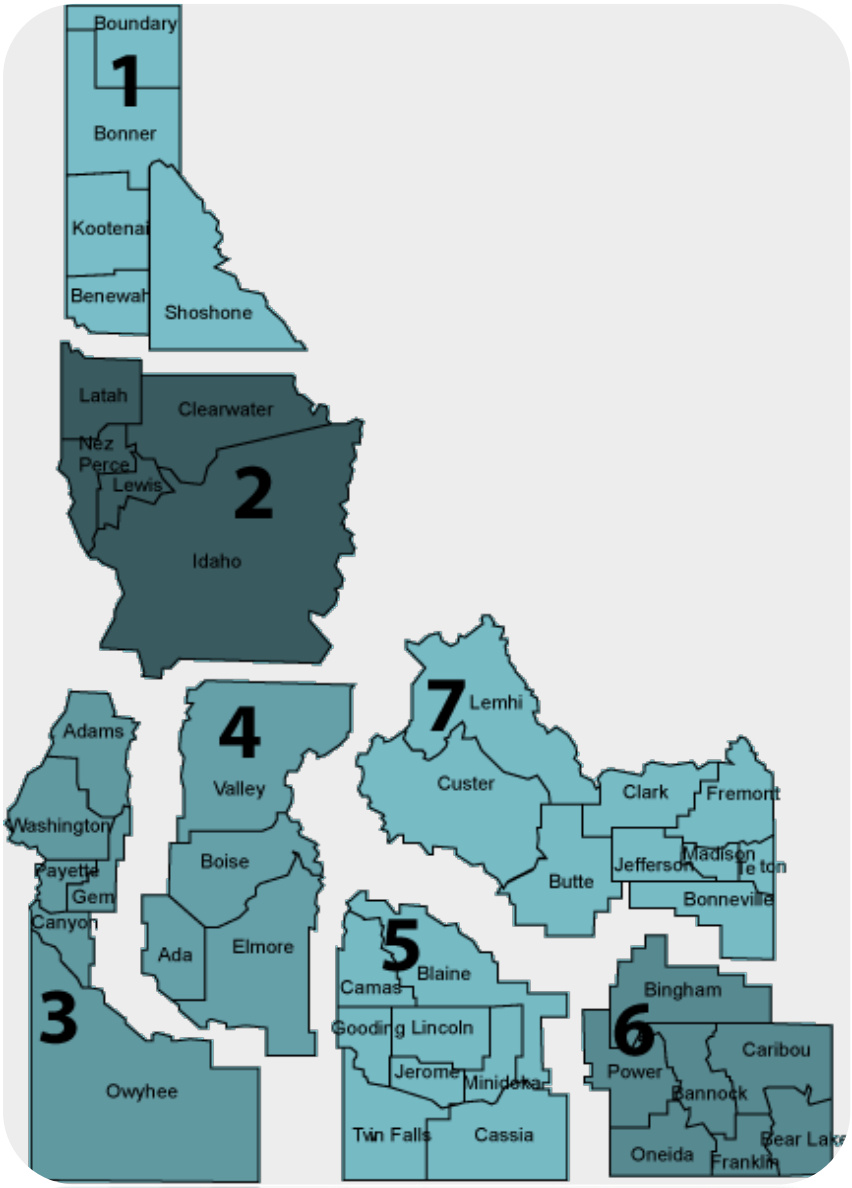
# DXC Technology Provider and Participant Services Contact Information

| | |
|---|---|
| **Provider Services** | |
| **MACS (Medicaid Automated Customer Service)** | 1 (866) 686-4272<br>1 (208) 373-1424 |
| **Provider Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT** | 1 (866) 686-4272<br>1 (208) 373-1424 |
| **E-mail** | idproviderservices@molinahealthcare.com<br>idproviderenrollment@molinahealthcare.com |
| **Mail** | P.O. Box 70082<br>Boise, ID 83707 |
| **Participant Services** | |
| **MACS (Medicaid Automated Customer Service)** | 1 (866) 686-4752<br>1 (208) 373-1432 |
| **Participant Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT** | 1 (866) 686-4752<br>1 (208) 373-1424 |
| **E-mail** | idparticipantservices@molinahealthcare.com |
| **Mail – Participant Correspondence** | P.O. Box 70081<br>Boise, ID 83707 |
| **Medicaid Claims** | |
| **Utilization Management/Case Management** | P.O. Box 70084<br>Boise, ID 83707 |
| **CMS 1500 Professional** | P.O. Box 70084<br>Boise, ID 83707 |
| **UB-04 Institutional** | P.O. Box 70084<br>Boise, ID 83707 |
| **UB-04 Institutional Crossover/CMS 1500/Third-Party Recovery (TPR)** | P.O. Box 70084<br>Boise, ID 83707 |
| **Financial/ADA 2006 Dental** | P.O. Box 70087<br>Boise, ID 83707 |

# DXC Technology Provider Services Fax Numbers

| | |
|---|---|
| **Provider Enrollment** | 1 (877) 517-2041 |
| **Provider and Participant Services** | 1 (877) 661-0974 |

# Provider Relations Consultant (PRC) Information




**Region 1 and the state of Washington**
1 (208) 559-4793
Region.1@MolinaHealthCare.com

**Region 2 and the state of Montana**
1 (208) 991-7138
Region.2@MolinaHealthCare.com

**Region 3 and the state of Oregon**
1 (208) 860-4682
Region.3@MolinaHealthCare.com

**Region 4 and all other states**
1 (208) 912-3970
Region.4@MolinaHealthCare.com

**Region 5 and the state of Nevada**
1 (208) 484-6323
Region.5@MolinaHealthCare.com

**Region 6 and the state of Utah**
1 (208) 870-3997
Region.6@MolinaHealthCare.com

**Region 7 and the state of Wyoming**
1 (208) 991-7149
Region.7@MolinaHealthCare.com

**DXC Technology**
**PO Box 70082**
**Boise, Idaho 83707**

IDAHO DEPARTMENT OF HEALTH & WELFARE

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**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