# MedicAide

An Informational Newsletter for Idaho Medicaid Providers

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

## In This Issue



## Information Releases

# DXC Technology Purchased Molina Medicaid Solutions

Effective October 1st, 2018, DXC Technology has purchased Molina Medicaid Solutions. We are excited about the opportunity for our company to forge new pathways to healthcare innovation and improve the quality of services to individuals and providers. DXC Technology will work closely with Molina Medicaid Solutions and IDHW to ensure daily operations will not be impacted due to this transaction. For more information, please see the related press release or refer to the FAQ's.

# Medicaid Program Integrity Unit

### *Use of Previously Issued Criminal History Checks*

The Medicaid Program Integrity Unit has found instances where employers have not complied with the requirements when using a previously issued criminal history background check. Employers may use a previously issued Department criminal history and background check clearance by obtaining access to the individual's clearance, as long as the clearance was issued within three years from the date of their employment. The employer must also complete a state-only background check through the Idaho State Police within thirty days of obtaining access to the individual's clearance.

An individual cannot provide services until the employer has obtained access to the background check and added the employer's identification number to the individual's clearance through the Department's criminal history website.

If the individual's last Department criminal history and background check clearance was completed more than three years prior to his employment with the new employer, the individual must complete a new application, including fingerprints.

IDAPA 16.05.06.300.02 outlines when an employer may use a previous Department criminal history and background check clearance, and states:

> 02. Use of Criminal History Check Within Three Years of Completion. Any employer may use a Department criminal history and background check clearance obtained under these rules if:
>
> a. The individual has received a Department's criminal history and background check clearance within three (3) years from the date of employment;
>
> b. Prior to allowing the individual to provide services, the employer must obtain access to the individual's background check results and clearance through the Department's website by having the employer's identification number added to the individual's background check results, and
>
> c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and no disqualifying crimes are found.
>
> > i. The action must be initiated by the employer within thirty (30) calendar days of obtaining access to the individual's criminal history and background check clearance issued by the Department; and
> >
> > ii. The employer must be able to provide proof of this action by maintaining a copy of the records required in Subsections 300.02.a. and 300.02.c. of this rule for a

period consistent with the employer's own personnel documentation retention schedule.

d. An employer not listed in Section 126 of these rules, may use an individual's Department clearance or enhanced clearance that was obtained within three (3) years from date of employment.

e. An individual with a current clearance that is within three (3) years from date of employment, who applies to a new agency or employer identified in Section 126 of these rules, must submit an application for a new criminal history and background check to obtain an enhanced clearance.

The Department may assess civil monetary penalties if providers are not in compliance with the Department's criminal history and background check rules in accordance with IDAPA 16.05.07.237, which states:

237. CIVIL MONETARY PENALTIES FOR CRIMINAL HISTORY BACKGROUND CHECK VIOLATIONS.

The Department may assess civil monetary penalties against a provider, any officer, director, owner, or managing employee for failing to perform required background checks or failing to meet required time lines for completion of background checks as required by rule. The amount of the penalty is five hundred dollars ($500) for each month worked for each staff person or contractor for whom the background check was not performed or not performed timely. The maximum amount that may be assessed for criminal history background check violations is five thousand dollars ($5,000) per month. A partial month is considered a full month for purposes of determining the amount of the penalty.

## Attention: Home Health Providers – Homebound Not Required

Although Medicaid follows many of Medicare's guidelines, Idaho Medicaid will not require participants to be homebound to receive home health services.

## Provider Handbook Updates

- The Glossary was updated to add Lifetime Procedures.
- The TPR Carrier Codes were updated to include a significant number of carriers.

## Attention Medicaid CGM Suppliers

The Medical Care Unit has implemented a new CGM Prior Authorization form to use when submitting requests for CGM supplies. The "Idaho Medicaid Continuous Glucose Monitoring (CGM) / Supply Prior Authorization Form" is currently online and available at www.DME.Idaho.gov. Please start utilizing this form as soon as possible.

As of October 1, 2018, the utilization of this form will be required when submitting requests for CGM supplies. This form takes the place of the standard DME PA request PA for when requesting CGM's and their related supplies.

Please note: the "Idaho Medicaid Continuous Glucose Monitoring (CGM) / Supply Prior Authorization Form" must be used starting October 1st, 2018. In order to prevent a denial based on incorrect documentation; the form must be filled out completely and be submitted with all supporting documentation required as indicated in the Idaho Medicaid DMEPOS PA Policy and Medical Criteria handbook. If you have questions, you can contact the Medical Care Unit at (866) 205-7403 or at MedicalCareUnit@dhw.idaho.gov.

# Idaho Medicaid Continuous Glucose Monitoring (CGM) / Supply Prior Authorization Form

**Idaho Medicaid Continuous Glucose Monitoring (CGM) / Supply Prior Authorization Form**

***Please complete entire form and submit all required documentation to (877) 314-8782***

| **Medicaid Participant Information** | | |
|---|---|---|
| Last Name: | First Name: | Intl: |
| Medicaid ID: | Date of Birth: | |
| Diagnosis: | | |
| **Medicaid Supplier Information** | | |
| Supplier Name: | NPI: | |
| Contact Name: | Email: | |
| Phone: | Fax: | |
| **Physician Information** | | |
| Physicians Name: | Phone: | |
| **Equipment Requested** | | |
| **CGM Model:** | | |
| ☐ Non-Therapeutic Receiver A9278<br>☐ Non-Therapeutic Transmitter A9277<br>☐ Non-Therapeutic Sensors A9276 | ☐ Therapeutic Receiver K0554<br>☐ Therapeutic Supplies K0553 | |

| HCPCS | Description | Quantity | Price Each | Start Date | Length of Need |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Medicaid Supplier Requirements**

☐ Current signed and dated physician order with identification of specific equipment including brand and model of CGM, patient diagnosis, and length of need are included in this PA submission.

☐ All other documentation requirements as indicated in the Idaho Medicaid DMEPOS PA Policy and Medical Criteria.

**Notes**

The status of a prior authorization request may be checked online at the www.idmedicaid.com under "Authorization Status", using your NPI, or by contacting Molina at (866) 686-4272.

**Fax: (877) 314-8782 Email: MedicalCareUnit@dhw.idaho.gov**

*More information is available at* www.dme.idaho.gov and www.idmedicaid.com

Rev 8/2018

# Prior Authorization (PA) requests for Therapeutic Glucose Monitors

Idaho Medicaid's medical necessity criteria for continuous glucose monitors (CGM) is set forth by the CMS/Medicare Jurisdiction D Manual. Medicaid will continue to only cover the DeXcom G5 CGM's that are defined as therapeutic as per the guidance of CMS ruling CMS-1682-R. Currently the DeXcom G6 CGM model is not covered per CMS/Medicare and will not be authorized by the Medical Care Unit at this time.

Effective October 1st, 2018 requests for CGM's must be submitted on the Idaho Medicaid Continuous Glucose Monitoring (CGM)/Supply Prior Authorization Form. This form is currently online under the forms section for Durable Medical Equipment.

To ensure Idaho Medicaid is aligned with CMS guidelines and federal coding requirements, therapeutic models must have the K0553 and K0554 HCPCS codes submitted on PA requests. Non-therapeutic models must be submitted with the A9276, A9277, A9278 HCPCS codes.

# Attention EMS Providers

As a reminder, claims from ambulance providers who are billing for emergency ground transportation for dates of service of February 1, 2017 and forward are being processed by Molina. These services no longer require a prior authorization prior to claim submission. Some providers are still submitting PA requests for these codes. Idaho Medicad will not prior authorize a service code if the code does not require a PA. Providers should follow the correct process to receive payment in a timely manner. Please follow these instructions to receive your payment more timely.

Emergency 911 Ground Transport Claims should be submitted directly to Molina:

- A0433-Advanced Life Support 2
- A0427-Advanced Life Support 1
- A0429- Basic Life Support
- A0425-Mileage

These codes are to be billed as a claim, through the Molina portal with supporting documentation (Pt. care report & EOB). The claim must be in "open" status in order to attach documents to the claim. For additional guidance on how to submit a claim through the Molina portal, please contact your regional PRC or call 1 (866) 686-4272 to speak to someone in provider services.
This approach has allowed providers to get paid in a more timely and efficient manner. Please assure when billing that all CMS/IDAPA rules are being utilized, as well as your Provider Handbook.

The Department understands that EMS providers are legally required to respond when dispatched by 911. In the incidents where the provider responded, evaluated, and released without transportation, they may submit a claim utilizing HCPCS A0988 with II(ii) modifier, Ambulance response and treatment, no transport. In these instances, these claims will pay through the system with no manual intervention. This code pays a flat fee and is updated annually by CMS for reimbursement. If the participant was transported and the transport does not meet the CMS/ IDAPA Medicaid Necessity Criteria, you may bill using the A0998 with II modifier, HCPCS code and receive the flat fee rate.

Please note that all Non-Emergency Transfers, CCT, Rotary/Fixed Wing, and all Revenue Codes, still require a prior authorization by the MCU for medical necessity determination.

If you have questions about the status of your claims, please contact Molina directly at 1 (866) 686-4272.

## Attention Therapy Providers – Group Therapy

IDAPA 16.03.09.732.3.g, "Idaho Medicaid Basic Plan Benefits" excludes group therapy except for school-based services and the Infant Toddler Program (ITP). ITP no longer provides this service due to changes in their contract effective 7/1/18Therefore, only school-based services are currently allowed to provide group therapy. Providers outside of school-based services will not be reimbursed for these services. Providers submitting claims for group therapy services under general therapy codes to circumvent system edits are committing fraud. If ineligible providers have previously billed Medicaid they are subject to recoupment.See your therapy provider handbook for additional information on allowed services.

## Prolonged Services Before or After Direct Patient Care – CPT® 99358 and 99359

In January of 2017, Medicare decided to unbundle 99358 and 99359 from the evaluation and management codes and began reimbursing for them separately. Idaho Medicaid did not opt to unbundle these codes, and still considers the payment for the primary services to include 99358 and 99359.

## Documentation of Services Provided - Signature Required

Idaho Code Section 56-209h and IDAPA 16.05.07.101.01, "Investigation & Enforcement of Fraud, Abuse, & Misconduct" require providers to generate records at the time service is delivered and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years after the date of service.

The provider delivering services must sign and date the documentation to attest that the records are a true and accurate account of the services delivered. Electronic signatures, that meet these requirements, are acceptable. Stamped signatures are unacceptable unless a disability prevents the provider from signing. Records should be signed shortly after the service is provided with only a short delay allowed for transcription. Additional information on medical documentation signature requirements may be found at Medicare's contractor Noridian's webpage.

## Adult Developmental Disability (DD) Services—Safety Plans

It has come to the attention of the Bureau of Developmental Disability Services (BDDS) that Safety Plans are being submitted that include information outside of what is required by the Individual Service Plan (ISP) Instruction Manual.

A Safety Plan should only be submitted with an initial/annual service plan or with an Addendum adding a new service or requesting a change in provider when the new provider will be

responsible for implementing the Safety Plan. Safety Plans should not be submitted as stand-alone documents or with an Addendum that does not comply with IDAPA 16.03.10.513.11.

Effective immediately, if a Safety Plan is submitted that contains information that is not specific to the guidance identified in the ISP Instruction Manual for Safety Plans, the BDDS Care Manager (CM) will line out the non-applicable language. If none of the information in the Safety Plan aligns with the guidance identified in the ISP Instruction Manual, instead of lining out all of the language in the document, the CM will remove that document so it is not included as a part of the participant's service plan.

Additionally, if language is included on the Supports and Services page of a traditional DD service plan that is not consistent with the instructions identified on page 23 of the ISP Instruction Manual for the Supports and Services column or page 24 for the Goals to be Addressed Within the Plan Year column, the CM will line-out the non-applicable language as well.

Information on developing Safety Plans is identified on page 15 of the Individual Support Plan (ISP) Instruction Manual. The manual states: A Safety Plan 'should be in place in the event that the participant requires immediate help at a time when a paid support is not available. A safety plan is needed when any of the following criteria are met:

- A 'YES' answer for the following Safety Concern question is identified and the participant lives in a supported living environment: 'Within the last plan year have there been any situations that could re-occur that would put the participant or others in danger?' If a 'yes' response, a safety plan is required.
- Any requests for home alone time on an ISP for participants accessing High Supported Living services.
  Note:Care Managers may deny requests for alone time if there are contradictions between assessed needs, goals and an alone time request.
- There is a transition to fewer paid supports indicated by a 'yes' for either situation on the transition section of the ISP (i.e. a participant moving from 'Intense' or 'Hourly').

A safety plan generally includes the participant's own knowledge of what to do in emergency situations and the availability of natural supports and/or other paid supports or devices such as:

- Co-workers at a job site;
- Roommate or neighbors at home;
- Family, friends and community acquaintances; and
- A Personal Emergency Response System (PERS).

A safety plan would need to include the following information:

- What support is in the plan to reduce risk?
- What will be done to resolve a risk due to loss of support?
- How has the participant demonstrated their ability to implement any part of the identified safety plan?
- How would the participant evacuate their residence?
- What mobility, functional and communication skills does the participant have to protect themselves?
- What back-up supports are in place?
- What ability does the participant have to recognize the need for and seek emergency help?

# Vision Benefits Administrator

As of October 1, 2018, National Vision Administrators, LLC (NVA) is the new vision benefits administrator for Idaho Medicaid vision services. NVA has partnered with Classic Optical, the laboratory that has served Idaho Medicaid members' optical needs for the last five years, as our new contractor to administer vision benefits and provide the same great quality products that Idaho Medicaid providers and members are used to. While member benefits remain the same, some of the administrative processes will change effective October 1, 2018. NVA has worked hard along with the Department to streamline many of these processes and will be better able to assist eye care professionals in Idaho. NVA will offer:

- Website services: Verify eligibility and submit lab orders
- Dedicated toll-free line for use by participating eye care professionals
- Specially trained Eye Care Professional Service Representatives devoted to assisting our participating eye care professionals
- Use of the same dedicated laboratory – Classic Optical

You may continue to follow the same process as you do today to obtain eligibility and submit claims for exams. NVA's Provider Service line is 1-877-626-2969.Their website is www.e-nva.com. Please contact Cody Cockrum (cody.cockrum@dhw.idaho.gov) or Sara Stith (sara.stith@dhw.idaho.gov) with any questions.

# Residential Habilitation—Supported Living: Participant Choice and Plan Flexibility

In response to recent questions regarding the provision of individual and group supports, the Bureau of Developmental Disability Services (BDDS) is providing the following guidance regarding implementation of supported living services consistent with what is authorized on a participant's service plan.

For *High Supported Living* services, the Department requires a participant's service plan to identify the weekly distribution of individual and group supported living services. The request for this level of detail is supported by IDAPA 16.03.10.000.03.b., which empowers the Department to identify the amount, duration, scope of care and services to be purchased on behalf of individuals eligible to receive benefits under the Medical Assistance program.

For *Hourly Supported Living* services, the Department requires a service plan to include separate requests for Individual and Group Hourly Supported Living services. The total number of units requested for Individual and Group Hourly Supported Living should be based on the weekly frequency each of these services will be provided.

The distribution of Individual and Group hours assists a Care Manager in their clinical review of a Supported Living plan to determine whether the plan allows the participant to meet their goals, desired outcomes and needs.

In addition, according to IDAPA 16.03.10.513.09. Residential Habilitation—Supported Living providers must develop an implementation plan that identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service.

The Department does recognize that a participant's life may result in a need for either more or less hours of individual or group supports than what is identified on the authorized service plan.

If a participant intermittently makes choices or encounters life events that results in the number of hours per week of individual and group supported living services to be provided differently than what was approved on the plan, the Residential Habilitation Agency provider must document the specific reason(s) why. Justification for the change must include a level of detail that demonstrates the change was participant driven, consistent with home and community-based services (HCBS) requirements identified in IDAPA 16.03.10.313

If participant need or choice results in a need for regular and routine changes to the distribution of individual and group supported living services from what was initially approved on the plan, the provider must revise the participant's Implementation Plan. According to IDAPA 16.03.10.513.09.b.ii. and c. Implementation Plan revision must be based on changes to the needs of the participant. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title.

For participants accessing Hourly Supported Living services, this change may also require the submission of an Addendum to discontinue and/or add units of Individual or Group Hourly Supported Living services.

In some instances, a participant approved for supported living services may decline service delivery as approved on their service plan. This may result in the participant being without residential habilitation services for a portion of the day. If this occurs, the Residential Habilitation Agency must document the specific reason(s) why service delivery did not occur as approved. Justification for the participant being without Residential Habilitation services as approved on the plan must include a level of detail that demonstrates the reason was participant driven, consistent with the HCBS quality requirements identified in IDAPA 16.03.10.313.

According to IDAPA 16.03.10.317.07 the person-centered service plan must identify risk factors to the participant as well as people around the participant and measures in place to minimize risks, including individualized back-up plans and strategies when needed.

If the participant's choice to not receive services is related to a HCBS setting quality requirement, and the participant's choice(s) related to that setting requirement present a health or safety risk to the participant or those around the participant, providers must develop goals and strategies to mitigate the risk prior to imposing any restrictions. The goals and strategies to mitigate risk must be agreed to through the person-centered planning process.

## Monthly Children's DD Enhancement Rule Collaboration Meetings!

Based on feedback the Department received from parents, providers and other advocates regarding the proposed changes to the Children's Enhancement rules, the Department has made the decision to withdraw the proposed changes to the Children's Enhancement rules to allow for more collaboration with stakeholders. Monthly collaboration meetings have been scheduled in each region for both providers and families. Please join us to discuss rule content and comment on the recommendations. For a complete list of scheduled meetings please visit the Children's Enhancement Project webpage at enhancement.dhw.idaho.gov to review.

# Types of Non-Covered Genetic Laboratory Tests

Idaho Medicaid coverage includes genetic testing or molecular pathology services performed in a credentialed lab, but only when such testing is considered under current standards to be reasonable and necessary for the diagnosis and potential treatment of an illness, disease, or condition.

The following types of genetic testing are not covered by Idaho Medicaid:

- Tests performed for screening purposes only, in the absence of signs, symptoms, or personal history of disease or injury
- Tests that are done solely to diagnose a patient, and will not impact medical decision-making for the patient or the patient's treatment plan
- Tests performed for the purposes of genetic counseling or family planning
- Tests that do not meet the definition of medical necessity as set forth in IDAPA 16.03.09.011.16

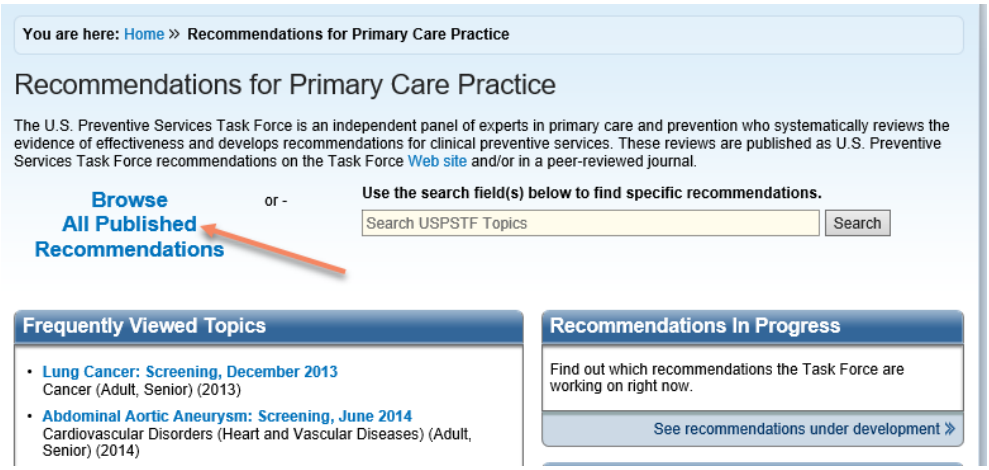
Assistance for Providers
The Medicaid Fee Schedule shows which labs always require a prior authorization, and which organization will review your request.
Additional information is available on the following Medicaid services at the Medical Care Unit home page:
https://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/tabid/217/Default.aspx

- Durable Medical Equipment
- Therapy Services
- Lead Testing Program
- Surgery
- Vision
- Breast and Cervical Cancer
- Dental Services
- Hospice Services
- Ambulance Services
- Medical Transportation
- Service Coordination
- Chiropractic Services
- Home Health
- Administratively Necessary Days
- Genetic Laboratory Testing

# Idaho Medicaid Covers Screening Services per the Affordable Care Act and USPSTF Recommendations

For information about the U.S. Preventive Services Task Force (USPSTF) recommendations with an A or B grade, please see the USPSTF web site and the page Recommendations for Primary Care Practice. On the Task Force page, click the text **"Browse All Published Recommendations"** and the following page will begin the list of all **99** current published recommendation titles. Each recommendation can be clicked again to find a summary page including the population, recommendation, grade, clinical summary, and supporting documents for the recommendation. Also included is access to the full Recommendation Statement. Providers must be informed of all limits and restrictions included with these recommendations. Screening outside the recommendation guidance is non-covered.

https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations




Only those screenings, as approved and recommended by the USPSTF are covered by Idaho Medicaid. All other tests or procedures rendered for screening purposes are excluded by federal and state law and rule for lack of medical necessity. A billing CPT or HCPCS code found on an Idaho Medicaid Fee schedule, is non-covered when rendered for a screening purpose, subclinical or unapproved diagnosis.

Testing or screening is considered not medically necessary when:

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

**Predictive Screening:** Idaho Medicaid coverage of screening services is limited to those tests/screening recommended by; the U.S. Preventive Services Task Force (USPSTF) A and B Recommendations. Please see Idaho Administrative Code IDAPA 16.03.09, Sub Area: Prevention Services, (Sections 580 - 649) For more information about screening services, please see the MedicAide newsletter, March 2018, Page 12 to 14 of 29.

## Free Training and Guidance from CMS.gov for Medicaid Providers and Staff: Documentation Resources

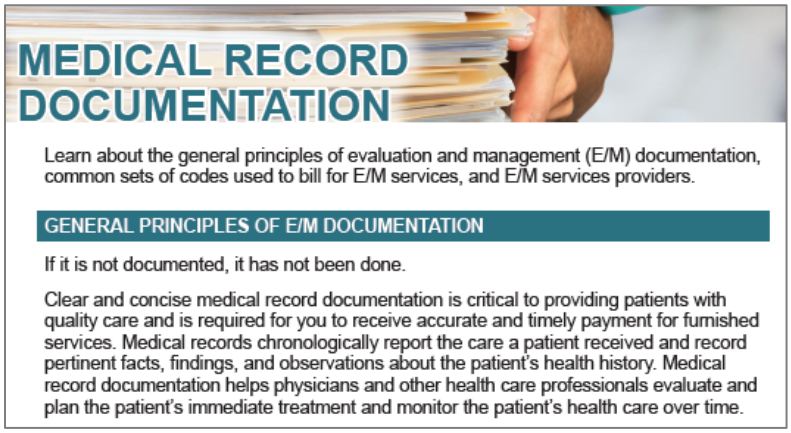
What medical record documentation standards would you chose for your own health care? What would you want a new/future medical provider to know about your care? How much accuracy would you expect on record about who physically performed a procedure while you were in a surgery suite, or an emergency department?

The same documentation standards apply to ordinary office visits, therapy services, mental health care etc., as apply to immunotherapy, cardiac surgeries, and genetic testing. Less 'emergent' services do not have any less importance in through, accurate and complete documentation of health care. Medical record documentation is written for the future, and for the next medical provider, as much tracking of services performed now. Medical documentation is

translated into standard coding and generates data on causes and conditions affecting health and outcomes for medical care in the United States.

Medicaid staff observes many incomplete, vague medical records when reviewing claims for both pre-payment and post-payment review. Medical records which are required to substantiate the service as billed to Medicaid, sometimes readmore as taking brief notes to oneself rather than a clear explanation of medical necessity and of what does and does not work well for an individual participant. This month's MedicAide includes some of many national resources on minimum documentation standards when submitting claims to federal and state funded healthcare programs.

## If it is not documented, it has not been done, CMS.gov




The screen shot above is from the Medicare Learning Network document titled, ***Evaluation and Management Services Guide, 2016***. *ICN 006764 August 2017, The content remains current. (available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf)

From ***Evaluation and Management Services Guide, 2016,*** pages 1 and 2 of 90:

> **MEDICAL RECORD DOCUMENTATION**
> Learn about the general principles of evaluation and management (E/M) documentation, common sets of codes used to bill for E/M services, and E/M services providers.
>
> **GENERAL PRINCIPLES OF E/M DOCUMENTATION If it is not documented, it has not been done.**

Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history. Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.

Health care payers may require reasonable documentation to ensure that a service is consistent with the patient's insurance coverage and to validate:

- The site of service
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided

- That services furnished were accurately reported

General principles of medical record documentation apply to all types of medical and surgical services in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, these general principles help ensure that medical record documentation for all E/M services is appropriate:

- The medical record should be complete and legible
- The documentation of each patient encounter should include:
- Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
- Assessment, clinical impression, or diagnosis
- Medical plan of care
- Date and legible identity of the observer
- If the rationale for ordering diagnostic and other ancillary services is not documented, it should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk factors should be identified
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record
- To maintain an accurate medical record, document services during the encounter or as soon as practicable after the encounter.

**All Providers Must Document Who, What, Why, When, Where, How and by Whom**

Multiple auditing bodies review Medicaid claims based on the claim's coding and the provider's documentation as found in a participant's medical record.
Some benefits of well prepared documentation are:

- protects the current provider of services from trying to substantiate a Medicaid claim and prove something not found in documentation
- protects the participant who needs a record of conditions and treatment rendered, including the response at the time of service, as well as the outcome of services which did or did not work well for the individual participant
- protects the participant because incomplete medical records may result in delayed treatment, wastefully repeated treatment, a unknown record of ineffective treatment or even harmful treatment.
- allows and protects coordination of care and helps future providers develop fully informed evaluation, assessment, response and planning for care
- protects the payor and taxpayers from duplication of services and repeated payment of services, items and testing already rendered and paid, yet repeated because of incomplete documentation.
- creates research benefits when correctly coded claims and effective documentation, are assessed across populations.

# All Idaho Medicaid Providers and Staff: Documentation and Record Keeping Tools and Guidance

*Below is web page text from CMS.gov. CMS has free education and tools as guidance for Medicaid providers and staff.*

**CMS.gov Medicaid Education Free Learning and Compliance Tools**
**Medicaid Program Integrity Education**


- **Program Integrity: Medicaid Compliance for the Dental Professional**
- **Program Integrity: Non Emergency Medical Transportation Toolkit**
- **Program Integrity: Nursing Home Toolkit**
- **Program Integrity: Off Label Pharmaceutical Marketing**
- **Program Integrity: Personal Care Services (PCS)**
- **Program Integrity: Pharmacy Auditing and Dispensing Toolkit**
- **Program Integrity: Pharmacy Education Toolkit**

*The text below is from the CMS web page:*

The Center for Program Integrity provides educational resources for providers, beneficiaries and other stakeholders to promote best practices and increased awareness of Medicaid fraud, waste and abuse.
There are several resources available including print and electronic media, toolkits, train-the-trainer guides, webinars, videos, and other innovative strategies.

**Available tools and resources include:**
In an effort to further educate providers, beneficiaries and other stakeholders, the Medicaid Program Integrity Education (MPIE) will now include topic-based infographics to aid in furthering education efforts.
**New tools and resources now available include:**
E-Bulletins are now available
Key Messages & Tips for Providers and Beneficiaries
Podcasts

| | |
|---|---|
| Beneficiary Card Sharing Toolkit | Documentation Matters Toolkit |
| Hospice Care Toolkit | Medicaid Compliance for the Dental Professional |

| | |
|---|---|
| Non Emergency Medical Transportation | Nursing Home Toolkit |
| Off Label Pharmaceutical Marketing | Personal Care Services |
| Pharmacy Audit and Dispensing Toolkit | Pharmacy Education Toolkit |

*Find the text above at*, https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html

**Medicaid Program Integrity Education Key Messages and Tips for Both Providers and Participants**

Key Messages & Tips were provided in 2015 & 2016 and intended to further the education efforts of Medicaid Program Integrity Education.

- ***July 2015***
- Provider Key Message & Tips - Habilitation and Waiver Services
- Beneficiary Key Message & Tips - Habilitation and Waiver Services
- ***August 2015***
- Provider Key Message & Tips - Mental Health and Substance Use Services
- Beneficiary Key Message & Tips - Mental Health and Substance Use Disorder Services
- ***September 2015***
- Provider Key Message & Tips - Person-Centered Service Plans
- Beneficiary Key Message & Tips - Person-Centered Service Plans
- ***October 2015***
- Provider Key Message & Tips - Self-Directed Personal Assistance Services
- Beneficiary Key Message & Tips - Self-Directed Care
- ***November 2015***
- Provider Key Message & Tips - Personal Care and Support Services
- Beneficiary Key Message & Tips - Personal Care and Support Services
- ***December 2015***
- Provider Key Message & Tips - Durable Medical Equipment, Supplies, and Devices
- Beneficiary Key Message & Tips - Durable Medical Equipment
- ***January 2016***
- Provider Key Message & Tips - Hospice and Levels of Care
- Beneficiary Key Message & Tips - Hospice
- ***February 2016***
- Provider Key Message & Tips - Home and Community-Based Services
- Beneficiary Key Message & Tips - Home Health and Other Home and Community-Based Services
- ***March 2016***
- Provider Key Message & Tips - Institutional Long-Term Services and Supports
- Beneficiary Key Message & Tips - Long-Term Care
- ***April 2016***

- Provider Key Message & Tips - Adult Day Care
- Beneficiary Key Message & Tips - Adult Day Care
- ***May 2016***
- Provider Key Message & Tips - Common Types of Fraud and Abuse
- Beneficiary Key Message & Tips - Common Types of Fraud and Abuse
- ***June 2016***
- Provider Key Message & Tips - My Responsibilities
- Beneficiary Key Message & Tips - My Responsibilities

## CMS YouTube Channel Learning Videos

Free training videos for Medicaid and Medicare programs are available on YouTube. The Center for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS) have an official YouTube channel with video series for provider and patient education. These videos may be brief coding and billing tips, or longer reviews for compliance training and feature provider and service types across the spectrum of Medicaid and Medicare services.


## Medicaid Video Learning with CMS, Your Medical Documentation Matters

National implications result from incorrectly rendered and/or paid Medicaid services. In 2014, Medicaid accounted for 17.5 billon dollars or 14% of all government improper payments.

For new staff or a training refresher, Idaho Medicaid encourages all provider types and specialties and their staff to view this entire free training video titled ***Your Medical Documentation***

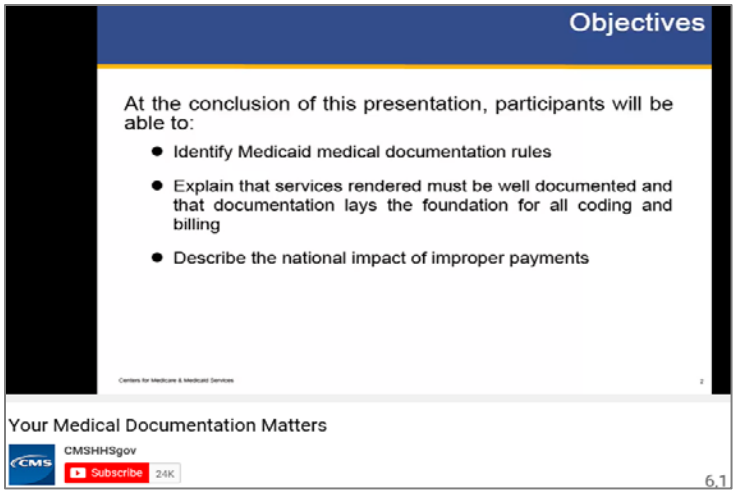
***Matters.*** This video is specific to Medicaid and designed to improve quality and compliance in record keeping. Complete and clearly developeddocumentation is required of all visits/services/items etc, furnished to Medicaid participants.Required must be present in the medical record by each provider of each service before submitting a claim to Idaho Medicaid.

This CMS video is available on YouTube, and follows a Medicaid patient through an entire episode of care from an ambulance ride to surgery to outpatient rehabilitation services. The video has a companion case study booklet posted at CMS.gov for full illustration of this valuable training and educational tool.

The video is available at, https://www.youtube.com/watch?v=WOrAvj-9LTI
The 20 page case study booklet is available at, https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-casestudy-guide.pdf.


The video and case study text cover the following types of care and treatment:

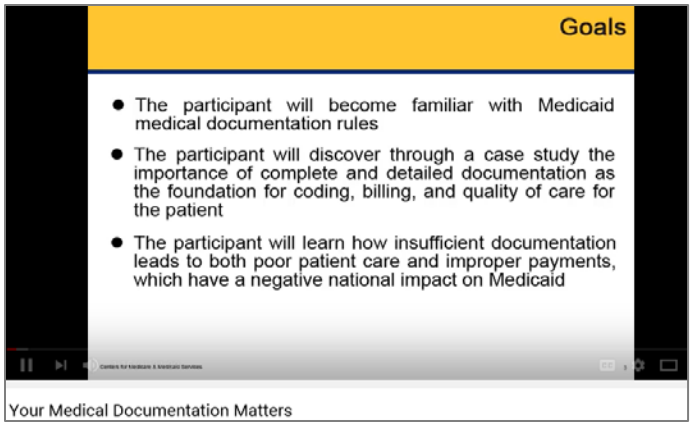
- Emergency Transport
- Emergency Department Physician
- Hospitalist Admits the Patient to Intensive Care Unit
- Orthopedic Surgeon Consult — Notes
- Surgeon Recommendation
- Coding the Consult
- Surgeon's Operation Notes
- Post-Surgery Documentation
- Global Billing
- Discharge Summary
- Rehabilitation
- Rehabilitation – Physical Therapy Treatment Plan
- Billing Rehabilitation/Therapy Services
- Discharge to Home – Case Management Services
- Patient Motivation
- Durable Medical Equipment Providers
- Billing Durable Medical Equipment Services
- Mental Health Services
- Billing Mental Health Services



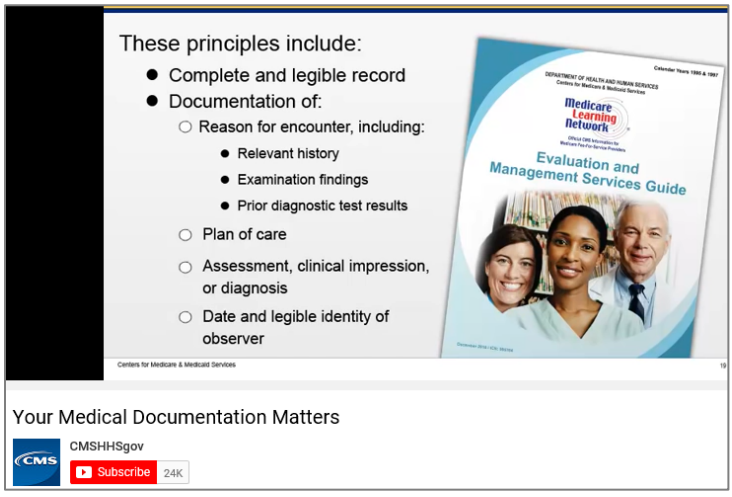

The text below is from the case study booklet companion to the video, ***Your Medical Documentation Matters*** presentation, page 2 of 20:

> This is the case study used during the "Your Medical Documentation Matters" presentation. It is a tool used for reviewing the details of the case during the presentation and the documentation requirements for the various provider types furnishing services. It highlights important Federal and State Medicaid documentation regulations and rules. To illustrate these points, the case study follows a patient's course of treatment through several medical services and the respective provider types furnishing the services. The case study begins with the patient's emergency transport and ends with his discharge from services.
>
> Medicaid is a unique program and is quite different from Medicare. Medicare has nationwide laws and standards that every provider in every State must follow. Medicaid programs and regulations, on the other hand, vary by State. In addition, each State has the option of developing and implementing Medicaid waiver programs. Waiver program rules can also vary from State to State and even within the same State's programs.
>
> Much of the general information for one provider type is the same as other provider types. As providers, you should be familiar with the nuances of the Medicaid program in the States where you furnish services. It is the provider's responsibility to know and follow all Medicaid rules in the States where they practice. If there are any questions regarding documentation, contact your State Medicaid agency (SMA). Visit that State's Medicaid website for contact information or look it up at http://medicaiddirectors.org[1] on the Internet.

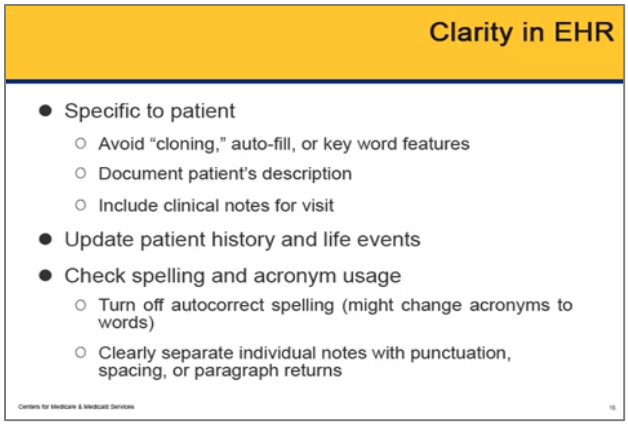
This CMS Medicaid training video guides provider types and specialties in national minimum documentation requirements shared by all Medicaid programs. Each Medicaid participating provider must also review each state Medicaid program rules, policy, and guidance for each service or item rendered/furnished to a Medicaid eligible participant. It is the provider's responsibility to be informed of and in compliance with national and state specific requirements in rendering and billing of Medicaid benefits.
The documentation requirements and guidance in this presentation and supplemental training materials are national standards shared by all Medicaid programs.



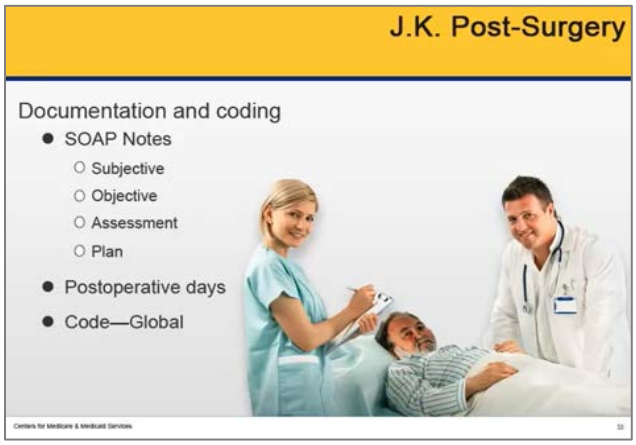





***Your Medical Documentation Matters*** YouTube video from CMS.gov.:




***Your Medical Documentation Matters*** YouTube video from CMS.gov.:




***Your Medical Documentation Matters*** YouTube video from CMS.gov.:

Idaho Medicaid again, encourages providers and staff to view this CMS video and the accompanying case study booklet.

# Notice Of Rulemaking – Proposed Rule For Swing Beds

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

**PUBLIC HEARING**

**Friday, October 26, 2018 -**

**Department of Health & Welfare Medicaid Central Office**
**3232 Elder Street**
**Conference Room D-**
**East Boise, ID 83705**

**TELECONFERENCE CALL-IN**

**Toll Free: 1-877-820-7831**
**Participant Code: 701700**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

**DESCRIPTIVE SUMMARY:** The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking

Some rural communities in Idaho do not have local skilled nursing facilities. When individuals from those communities need skilled nursing services, they are placed in skilled nursing facilities that are up to 50 miles away from where they and their families live, limiting access to support networks that significantly contribute to their recovery and quality of life. These rule changes will allow eligible Critical Access Hospitals to designate additional acute care beds as swings beds to provide necessary care for individuals, without having to place them in facilities outside of their community and away from their support system. These rules would only apply to those Critical Access Hospitals, who do not have a skilled nursing facility within 35 miles of their facility, and have been approved by Medicare to offer swing-beds.

**FISCAL IMPACT:** The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

The fiscal impact in SFY2020 of allowing Critical Access Hospitals who meet the special requirements to request additional swing-bed days from the Department would be a savings of $87 per person, per day. The savings to the state general fund would be $25 per person, per day, and the Federal savings would be $62 per person, per day. This rule change would only allow those Critical Access Hospitals who do not have nursing facilities in their communities to provide additional hospital swing beds that provide the level of care that individuals need to receive care in their local communities. A detailed breakdown can be found in Addendum A: Fiscal Impact for Docket No. 16-0309-1801.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was
conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 6, 2018, Idaho Administrative Bulletin, Volume 18-6, pages 55 and 56.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance
on technical questions concerning the proposed rule, contact William Deseron at (208) 287-1179.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Friday, October 26, 2018.

***THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1801***
***(Only Those Sections With Amendments Are Shown.)***

**405. INPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.**

Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of inpatient services in accordance with the procedures detailed under this Section of rule. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (3-30-07)

**01. Exemption of New Hospitals.** A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reasonable cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, in accordance with 42 CFR Section 413.64. (3-30-07)

**02. Medicaid Inpatient Operating Cost Limits.** The following describe the determination of inpatient operating cost limits. (3-30-07)

a. Medicaid Cost Limits for Dates of Service Prior to a Current Year. The reimbursable reasonable costs for services rendered prior to the beginning of the principal year, but included as prior period claims in a subsequent period's cost report, will be subject to the same operating cost limits as the claims under settlement. (3-30-07)

b. Application of the Medicaid Cost Limit. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of a principal year, a hospital inflation index, computed for each hospital's fiscal year end, will be applied to the operating costs, excluding capital costs and other allowable costs as defined for the principal year and adjusted on a per diem basis for each subsequent year under the hospital inflation index. (7-1-18)

i. Each inpatient routine service cost center, as reported in the finalized principal year end Medicare cost report, will be segregated in the Medicaid cost limit calculation and assigned a share of total Medicaid inpatient ancillary costs. The prorated ancillary costs will be determined by the ratio of each Medicaid routine cost center's reported costs to total Medicaid inpatient routine service costs in the principal year. (3-30-07)

ii. Each routine cost center's total Medicaid routine service costs plus the assigned share of Medicaid inpatient ancillary costs of the principal year will be divided by the related Medicaid patient days to identify the total costs per diem in the principal year. (3-30-07)

(1) The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 405.02.b.ii. of this rule to identify each inpatient routine service cost center per diem cost limit in the principal year. (3-30-07)

(2) If a provider did not have any Medicaid inpatient utilization or render any Medicaid inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the principal year, the principal year for only those routine cost centers without utilization in the provider's principal year will be appropriately calculated using the information available in the next subsequent year in which Medicaid utilization occurred. (3-30-07)

iii. Each routine cost center's cost per diem for the principal year will be multiplied by the hospital inflation index for each subsequent fiscal year. (7-1-18)

iv. The sum of the per diem cost limits for the Medicaid inpatient routine service cost centers of a hospital during the principal year, as adjusted by the hospital inflation index, will be the Medicaid cost limit for operating costs in the current year. (7-1-18)

(1) At the date of final settlement, reimbursement of the Medicaid current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the hospital inflation cost index. (7-1-18)

(2) Providers will be notified of the estimated inflation index periodically or hospital inflation index (CMS Market Basket Index) prior to final settlement only upon written request.(7-1-18)

**03. Adjustments to the Medicaid Cost Limit.** A hospital's request for review by the Department concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Section 405 of this chapter of rules, must be granted under the following circumstances: (3-30-07)

a. Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Medicaid limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (3-30-07)

b. Reimbursement to Public Hospitals. A public hospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. (7-1-18)

c. Adjustment to Cost Limits. A hospital is entitled to a reasonable increase in its Medicaid cost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case- mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the principal year. Any hospital making such showing is entitled to an increase commensurate with the increase in per diem costs. (7-1-18)

i. The Medicaid operating cost limit may be adjusted by multiplying cost limit by the ratio of the current year's case-mix index divided by the principal year's case-mix index. (7-1-18)

ii. The contested case procedure set forth in IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings,” is available to larger hospitals seeking such adjustments to their Medicaid cost limits. (7-1-18)

d. Adjustment to the Proration of Ancillary Costs in the principal year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Medicaid cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each participant for each type of patient day during each participant's stay during the principal year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (3-30-07)

**04. Payment Procedures.** The following procedures are applicable to in-patient hospitals: (3-30-07)

a. The participant's admission and length of stay is subject to prior authorization, concurrent review, continued stay review, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. If a review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely QIO review as required by Section 402 of this chapter of rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO review has determined that the hospital stay was medically necessary,

Medicaid will assess a late review penalty to the hospital as outlined in Section 405 of this rule. (7-1-18)

i. All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (3-30-07)

ii. Reimbursement for services originally identified as not medically necessary by the QIO will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)

iii. Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the participant. (3-30-07)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of semi-private rates for in-patient hospital care as set forth in this rule, unless an exception applies as stated in Section 402 of these rules. The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (3-30-07)

**05. Hospital Penalty Schedule.** (3-30-07)

a. A request for a preadmission and/or continued stay QIO review that is one (1) day late will result in a penalty of two hundred and sixty dollars ($260), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

b. A request for a preadmission and/or continued stay QIO review that is two (2) days late will result in a penalty of five hundred and twenty dollars ($520), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

c. A request for a preadmission and/or continued stay QIO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars ($780), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

d. A request for a preadmission and/or continued stay QIO review that is four (4) days late will result in a penalty of one thousand and forty dollars ($1,040), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

e. A request for a preadmission and/or continued stay QIO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars ($1,300), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

06. AND Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/ID rates are excluded from this calculation. (3-30-07)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (3-30-07)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (3-30-07)

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (3-30-07)

**07. Reimbursement for Services.** Routine services as addressed in Subsection 405.08 of this rule include all medical care, supplies, and services which are included in the calculation of nursing facility property and non-property costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)( )

**08. Hospital Swing-Bed Reimbursement.** The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital ("swing-beds") ~~beds~~ who require nursing facility level of care. (3-30-07)( )

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: (3-30-07)

i. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.58 "Special Requirements" for hospital providers of long-term care services ("swing- beds"), or 42 CFR 485.645 - Special requirements for CAH providers of long-term services ("swing-beds") as applicable; and ~~(3-30-07)~~( )

ii. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (3-30-07)

iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (3-30-07)

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (3-30-07)

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.58(a)(1) for swing-bed purposes; and (3-30-07)

vi. Nursing facility services in swing-beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. (3-30-07)

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (3-30-07)

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05,

"Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled"; and (3-30-07)

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 222.02. (3-30-07)

c. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (3-30-07)

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/ID facilities' rates are excluded from the calculations. (3-30-07)

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (3-30-07)

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (3-30-07)

iv. Routine services include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 225.01. (3-30-07)

v. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (3-30-07)

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules.(3-30-07)

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety-five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. The Department may authorize additional critical access hospital swing-bed days for participants residing in a community without a nursing facility within thirty-five (35) miles contingent on a review of medical necessity, cost-effectiveness, residency, and quality of care. (3-30-07)( )

d. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 224. (3-30-07)

09. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. (3-29-10)

a. DSH Survey Requirements. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. The DSH survey must be returned to the Department on or before May 31 of the same calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. No later than July 15 of each calendar year, the Department must notify each hospital of their calculated DSH payment and notify each hospital of its preliminary calculated distribution amount. A hospital may file an amended survey to complete, correct, or revise the original DSH survey by submitting the amended survey and supporting documentation to the Department no later than thirty (30) days after the notice of the preliminary DSH calculation is mailed to the hospital. The state's annual DSH allotment payment will be made by September 30 of the same calendar year based on the final DSH surveys and Department data. (3-30-07)

b. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals which: (3-30-07)

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (3-30-07)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (3-29-10)

(1) Subsection 405.09.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (3-30-07)
(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (3-30-07)

iii. The MUR will not be less than one percent (1%). (3-30-07)

iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection

400.13 of these rules, and the criteria of Subsections 405.09.b.ii. and 405.09.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.09.b.vi. through 405.09.b.x. of this rule. (3-29-10)

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

viii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation.(3-30-07)

c. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.09.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (3-29-10)

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (3-30-07)

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (3-30-07)

d. Insufficient DSH Allotment Amounts. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (3-30-07)

e. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (3-30-07)

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. (3-30-07)

ii. Claims of uninsured costs which increase the maximum amount which a hospital may receive as a DSH payment must be documented. (3-30-07)

f. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (3-30-07)

g. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (4-7-11)

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (4-7-11)

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (4-7-11)

iii. Beginning with FFY 2011, if based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: (4-7-11)

(1) Recover the overpayment from the provider; and (4-7-11)

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. (4-7-11)

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the Social Security Act. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (4-7-11)

**10. Out-of-State Hospitals.** (3-30-07)

a. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: (3-30-07)

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (3-30-07)

ii. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (3-30-07)

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (3-30-07)

**11. Audit Function.** Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (3-30-07)

**12. Adequacy of Cost Information.** Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (3-30-07)

**13. Availability of Records of Hospital Providers.** A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (3-30-07)

**14. Interim Cost Settlements.** The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (3-30-07)

a. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (3-30-07)

b. Hard Copy of Cost Report. Hospitals which request to undergo interim cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Department upon filing with the Intermediary. (3-30-07)

c. Limit or Recovery of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (3-30-07)

**15. Notice of Program Reimbursement.** Following receipt of the finalized Medicare cost report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount.
(3-30-07)

a. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report from the Medicare Intermediary. (3-30-07)

b. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the cost report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (3-30-07)

**16. Nonappealable Items.** The formula for the determination of the hospital inflation index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations

as supported by properly completed cost reports and audits must not be accepted as appealable items. (7-1-18)

**17. Interim Reimbursement Rates.** The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-30-07)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (3-30-07)

**18. Audits.** All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)

# Notice Of Rulemaking – Proposed Rule For Laboratory And Radiology

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

**PUBLIC HEARING**
**Friday, October 26, 2018 - 9:00 a.m.**

**Department of Health & Welfare Medicaid Central Office**
**3232 Elder Street**
**Conference Room D-**
**East Boise, ID 83705**

**TELECONFERENCE CALL-IN**
**Toll Free: 1-877-820-7831**
**Participant Code: 701700**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

**DESCRIPTIVE SUMMARY:** The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking

Laboratory rules in this chapter haven't been updated since 2007. Laboratory tests have rapidly changed in the past 11 years, and a foundation in rule is needed for Department coverage of these services. A minimum standard will be established with the following changes.

1. Ensure that Medicaid providers outside of Idaho maintain the same quality of work and documentation as providers within the state;
2. Prevent expenditure of tax payer funds for services that are inaccurate, or for genetic services that could be used for elective abortions;
3. Establish authority for prior authorizations to be required by the Department so that delivery of services is consistent with the Department's utilization management as required by CFR; and
4. Set minimum requirements for testing coverage.

**FISCAL IMPACT:** The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no anticipated fiscal impact to state general funds, or any other funds as a result of this rulemaking.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the July 4, 2018, Idaho Administrative Bulletin, Volume 18-7, pages 103 through 104.

***ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:*** *For assistance*

on technical questions concerning the proposed rule, contact William Deseron at (208) 287-1179.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Friday, October 26, 2018.

***THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1804***

**(Only Those Sections With Amendments Are Shown.)**

**650. LABORATORY AND RADIOLOGY SERVICES: DEFINITIONS.**

**01. Independent Laboratory**. A laboratory that is not located in a physician's office, and receives specimens from a source other than another laboratory. A physician is not an independent laboratory.

~~(3-30-07)~~( )

**02. Laboratory or Clinical Laboratory**. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. ( )

**03. Proficiency Testing**. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. ( )

**04. Quality-Control**. A day-to-day analysis of reference materials to ensure reproducibility and accuracy of laboratory results, and includes an acceptable system to assure proper functioning of instruments, equipment and reagents. ( )

0~~2~~5. **Reference Laboratory**. A laboratory that only accepts specimens from other laboratories ~~and does not receive specimens directly from patients~~. ~~(3-30-07)~~( )

***651. -- 65~~3~~2. (RESERVED)***

**653. LABORATORY AND RADIOLOGY SERVICES: COVERAGE AND LIMITATIONS.**

01. **Medical Necessity Criteria**. Services must meet the definition of Medical Necessity in Section 11 of these rules as detailed in the Idaho Medicaid Provider Handbook. ( )

02. **Prior Authorization of Services**. The Department may require prior authorization of any laboratory or radiology service as detailed in the Idaho Medicaid Provider Handbook. ( )

***654. LABORATORY AND RADIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.***

~~Laboratories in a physician's office or a physician's group practice association, except when physicians personally perform their own patients' laboratory tests, must be certified by the Idaho Bureau of Laboratories and be eligible for Medicare certification for participation. All other Idaho laboratories must fulfill these requirements.~~ ~~(3-30-07)~~

01. **Laboratory and Radiology Requirements**. Providers of laboratory and radiology services must be eligible for Medicare certification for these services. ( )

02. **Use of Reference Laboratories**. Laboratories using reference laboratories must ensure that all requirements of Sections 650 through 659 of these rules are met by the reference laboratory. ( )

## 655. LABORATORY AND RADIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. **Provider of Service**. Payment for laboratory tests can only be made to the actual provider of that service. An exception to the preceding is made in the case of: ( )

a. ~~a~~An independent laboratory that can bill for a reference laboratory.; ~~A physician is not an independent laboratory.~~ ~~(3-30-07)~~( )

b. A transplant facility that can bill for histocompatibility testing; and ( )

c. Healthcare professionals acting within the licensure and scope of their practice to comply with IDAPA 16.02.12, "Procedures and Testing to be Performed on Newborn Infants." ( )

0~~1~~2. **Tests Performed by or Personally Supervised by a Physician**. The payment level for clinical diagnostic laboratory tests performed by or personally supervised by a physician will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be a rate established by the Department. (3-30-07)

0~~2~~3. **Tests Performed by an Independent Laboratory**. The payment level for clinical diagnostic laboratory tests performed by an independent laboratory will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (3-30-07)

0~~3~~4. **Tests Performed by a Hospital Laboratory**. The payment level for clinical diagnostic laboratory tests performed by a hospital laboratory for anyone who is not an inpatient will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (3-30-07)

0~~4~~5. **Specimen Collection Fee**. Collection fees for specimens drawn by venipuncture or catheterization are payable only to the physician or laboratory who draws the specimen. If done during an office visit on the same day the service is ordered, specimen collection may be reimbursed even if prior authorization is not approved.

~~(3-30-07)~~( )

## 656. LABORATORY AND RADIOLOGY SERVICES: QUALITY ASSURANCE.

Laboratories, as a condition of payment, must maintain a quality-control program, including proficiency testing consistent with federal requirements, as detailed in the Idaho Medicaid Provider Handbook. The laboratory must provide the results of proficiency testing to the Department or their Quality Improvement Organization vendor upon request. ( )

## 65~~6~~7. -- 659. (RESERVED)

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 19, 2018

**MEDICAID INFORMATION RELEASE #MA18-12**

**TO:** All service providers who provide services or supports to children and/or adults with developmental disabilities

**FROM:** Matt Wimmer, Administrator

**SUBJECT: DEPARTMENT APPROVED ASSESSMENT TOOLS EFFECTIVE July 1, 2018**

**Effective July 1, 2018,** the Department is accepting the following tools, or the most current version of the tool, to determine eligibility for individuals with developmental disabilities.

**TEST INSTRUMENTS FOR ADULTS IN THE COMMUNITY**

Any community provider working within the scope of their practice can determine IQ for diagnostic purposes using one of these Department Approved Cognitive Test Instruments for Adults:

- Wechsler Adult Intelligence Scale-Third Edition (WAIS-III), for ages sixteen (16) years to ninety (90) years, eleven (11) months;
- Stanford Binet Intelligence Scales, for ages two (2) years through adult;
- Test of Nonverbal Intelligence, Fourth Edition (TONI-4), for ages six (6) years through eighty-nine (89) years, eleven (11) months.

To determine eligibility, the Department's Independent Assessment Provider (IAP) can use the following Department Approved Functional Test Instruments for Adults:

- Scales of Independent Behavior-Revised (SIB-R), for ages birth through adult.

**TEST INSTRUMENTS FOR CHILDREN IN THE COMMUNITY**

Any community provider working within the scope of their practice can determine IQ for diagnostic purposes using one of these Department Approved Cognitive Test Instruments for Children:

- Bayley Scales of Infant Development, for ages birth through forty-two (42) months;
- Stanford Binet Intelligence Scales, for ages two (2) years through adult;
- Weshsler Preschool and Primary Scale of Intelligence, for ages two (2) years, six (6) months to seven (7) years, seven (7) months;
- Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), for ages six (6) years through sixteen (16) years, eleven (11) months;
- Wechsler Adult Intelligence Scale-Third Edition (WAIS-III), for ages sixteen (16) years to ninety (90) years, eleven (11) months;

- Test of Nonverbal Intelligence, Fourth Edition (TONI-4), for ages six (6) years through eighty-nine (89) years, eleven (11) months.

To determine eligibility for community services, the Department's Independent Assessment Provider (IAP) can use the following Department Approved Functional Test Instruments for Children:

- Scales of Independent Behavior-Revised (SIB-R), for ages birth through adult;
- Mullen Scales of Early Learning (MSEL), for ages birth to three (3) years;
- Vineland Adaptive Behavior Scales, Third Edition (Vineland-3), for ages birth to ninety (90) years.

**TEST INSTRUMENTS FOR CHILDREN AND/OR ADULTS IN THE SCHOOL**

Any school-based provider working within the scope of their practice can determine IQ for diagnostic purposes using one of these Department Approved Cognitive Test Instruments for Children or Adults:

- Bayley Scales of Infant Development, for ages birth through forty-two (42) months;
- Stanford Binet Intelligence Scales, for ages two (2) years through adult;
- Weshsler Preschool and Primary Scale of Intelligence, for ages two (2) years, six (6) months to seven (7) years, seven (7) months;
- Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), for ages six (6) years through sixteen (16) years, eleven (11) months;
- Wechsler Adult Intelligence Scale-Third Edition (WAIS-III), for ages sixteen (16) years to ninety (90) years, eleven (11) months;
- Test of Nonverbal Intelligence, Fourth Edition (TONI-4), for ages six (6) years through eighty-nine (89) years, eleven (11) months.

To determine eligibility for School-Based Services, a School District or Charter School can use the following Department Approved Functional Test Instruments for Children or Adults:

- Battelle Developmental Inventory, Second Edition (BDI-2), for ages birth to ninety-fine (95) months;
- Scales of Independent Behavior-Revised (SIB-R), for ages birth through adult;
- Mullen Scales of Early Learning (MSEL), for ages birth to three (3) years;
- Vineland Adaptive Behavior Scales, Third Edition (Vineland-3), for ages birth to ninety (90) years.

If additional assessments are identified as Department-approved assessment tools, a notice will be released. If you have questions about this information, please contact Carolyn.Burt@dhw.idaho.gov for Children's Developmental Disability Services, Angie.Williams@dhw.idaho.gov for School-Based Services, or Karen.Westbrook@dhw.idaho.gov for Adult Developmental Disability Services.

Thank you for participating in the Idaho Medicaid Program.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

MATT WIMMER - Administrator
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FAX: (208) 364-1811

September 6, 2018

**MEDICAID INFORMATION RELEASE #MA18-13**

**TO:** Idaho Dual Eligible Stakeholders

**FROM:** Matt Wimmer, Administrator

**SUBJECT:** **Idaho Medicaid Plus – Delayed Implementation in Twin Falls County**

Enrollment letters were mailed to participants who reside in Twin Falls County in July explaining the Idaho Medicaid Plus Program (IMPlus) for Idaho dual eligible members who have elected not to enroll in the Medicare Medicaid Coordinated Plan (MMCP).

To ensure enough time to secure Federal approval of the IMPlus Program and support a successful launch, **the IMPlus Program implementation date for Twin Falls County will be moved from October 1, 2018, to November 1, 2018.**

Dual eligible participants that reside in Twin Falls County may not be affected by this delay.

- If a participant is already enrolled in MMCP this change will have no impact.
- If a participant has already chosen a Health Plan for IMPlus, Medicaid coverage with that Plan will begin on November 1, 2018.
- If a participant has not chosen a Health Plan for IMPlus, he or she has extra time to select a Health Plan for IMPlus.

Providers that serve members who will be enrolled into IMPlus should not submit claims to a participating Health Plan until member coverage for IMPlus becomes effective. Providers are encouraged to review member eligibility in the MMIS to ensure claims are submitted to the correct entity. This change will also allow providers additional time to contract with Blue Cross of Idaho and Molina Healthcare of Idaho if they are not already in the Health Plan(s) network.

For additional information on IMPlus and the MMCP, visit our website at www.mmcp.dhw.idaho.gov, email the program at IdahoDuals@dhw.idaho.gov, or call the program toll free at (833) 814-8568.

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**MEDICAID INFORMATION RELEASE MA 18-14**

To: All Hospice Providers

From: Matt Wimmer, Administrator P.P.
Division of Medicaid

Subject: Medicaid Hospice Rates Update

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 FY, 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 01, 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 November 1st of each year through October 31st of the following year. The hospice cap amount for the cap year ending October 31, 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 Molina Medicaid Solutions Regional Provider Relations Consultants.

**October: Claim Adjustments**
This course will assist you in adjusting claims on the Trading Partner Account for quick resolution.

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.

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

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 43 of this newsletter.

# Medical Care Unit Contact and Prior Authorization Information

**Prior Authorizations, Forms, and References**
To learn about prior authorization (PA) requirements, QIO review, or print request forms, go to the medical service area webpage at www.medunit.dhw.idaho.gov. Prior authorization request forms containing the "fax to" number can be found at www.idmedicaid.com. Click on **Forms** under the References section and you will see the PA request forms under the DHW Forms heading. If you prefer to mail in your form, the mailing address is:

Medicaid Medical Care Unit
P.O. Box 83720
Boise, ID 83720-0009

**Note:** The Medical Care Unit (MCU) does not give authorizations for services over the telephone or for services which do not require a prior authorization.

**To Check Prior Authorizations Status**
Log on to your Trading Partner Account on www.idmedicaid.com. Choose **Form Entry**, then choose **View Authorizations**. If you are unable to identify the reason for a denied service, a Molina Medicaid Solutions representative can provide the medical reviewer's reason captured in the participant's non-clinical notes. If you are unable to view the authorization status, please review the Trading Partner Account (TPA) User Guide located under **User Guides** on www.idmedicaid.com. To speak to a Molina Medicaid Solutions representative, call 1 (866) 686-4272, option 3.

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

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

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

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

# DHW Resource and Contact Information

| | |
|---|---|
| **DHW Website** | www.healthandwelfare.idaho.gov |
| **Idaho CareLine** | 2-1-1<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 |

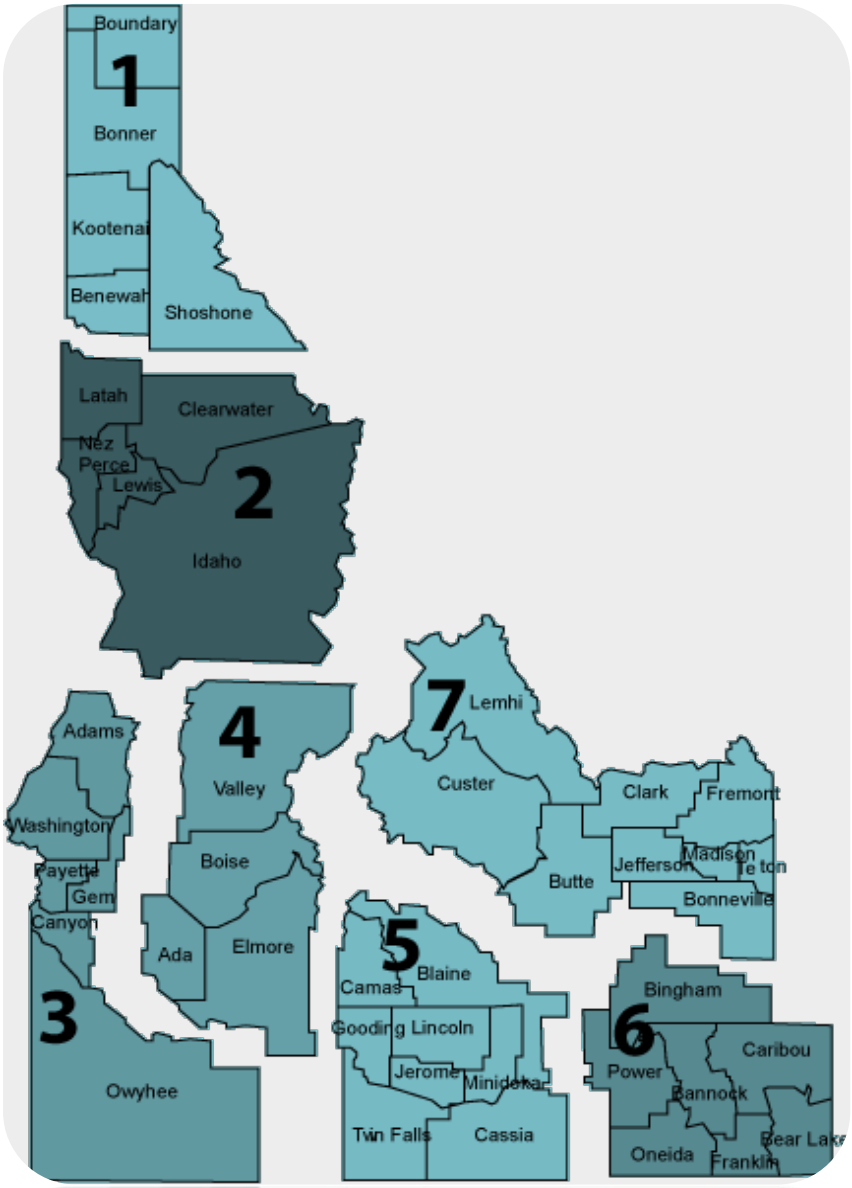
# Molina Provider and Participant Services Contact Information

| | |
|---|---|
| **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 |

# 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**
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

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

IDAHO DEPARTMENT OF HEALTH & WELFARE

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