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2. Ambulatory Health Care Facilities

2.1. Introduction
This section covers Medicaid services provided by the following provider specialties:
- Diagnostic Service
- Mental Health Clinic
- Rehabilitative Mental Health Services (PSR Services)
- Adult Day Care
- PWC Clinic
- Clinic/Center-Indian Health Services
- Clinic/Center-Rural Health Clinics
- Clinic/Center-Federally Qualified Health Center (FQHC)
- Clinic/Center-Ambulatory Surgical

2.2. Diagnostic Service

2.2.1. Overview
Diagnostic screening clinics coordinate the treatment between physicians and other medical professionals for Medicaid participants diagnosed with Cerebral Palsy, Myelomeningitis, or other neurological diseases and injuries with comparable outcomes. The clinic must be established as a separate and distinct entity from the hospital, physician, or other provider practices.

2.2.2. Multidisciplinary Assessment and Consultation
The clinic must perform an on-site multidisciplinary assessment and consultation with each participant and responsible parent or guardian. Diagnostic and consultation services related to the diagnosis and treatment of the participant are provided by board-certified physicians who are specialists in physical medicine, neurology, and orthopedics.

2.2.3. Service Limitations
As part of a diagnostic assessment, a medical social worker monitors and arranges participant treatments and provides medical information to providers who have agreed to coordinate the care of the participant. The clinic may bill no more than five hours of medical social services, per participant, during each state fiscal year (July 1 – June 30).

Note
Diagnostic screening clinic services are a covered benefit for Medicaid Enhanced Plan participants. See CMS 1500 Instructions for covered services.

2.3. Mental Health Clinic

2.3.1. Overview
The MH Clinic Program is designed to promote overall mental wellness for Medicaid participants. In accordance with the Federal Code of Regulations 42 CFR 440.90, all MH clinic services must be provided at the clinic, unless provided to an eligible homeless individual per regulations. Services provided outside of the clinic facility are not reimbursable by Medicaid. Clinic services are defined as preventative, diagnostic,
therapeutic, rehabilitative, or palliative services. Recreational, educational, and vocational services are not Medicaid-covered MH clinic services.

2.3.1.1. **Provider Enrollment and Credentialing**

In order to become enrolled as a Medicaid mental health clinic provider, the provider applicant must meet the requirements established through the credentialing program as identified in IDAPA 16.03.09.712 Mental Health Clinics Services – Credentialing Responsibilities of the Department. All existing MH clinic providers must meet the requirements of the credentialing program.

All locations where Medicaid MH clinic services are provided must be registered with Medicaid and must have a valid Provider Agreement. Mental health clinics must obtain a provider number for each location where they provide services.

2.3.1.2. **Physician Requirement**

All MH clinics must have a contract with a medical doctor or doctor of osteopathy in which the doctor agrees to perform the following:

See each participant at least once annually in order to establish medical necessity for clinic services. See IDAPA 16.03.09.714.07.b Mental Health Clinic Services - Provider Agency Requirements: Physician Requirement for Supervision of a participant’s Care.

Review and sign the treatment plan and all treatment plan updates. See IDAPA 16.03.09.714.07c-.d Mental Health Clinic Services - Provider Agency Requirements; Physician Requirement for Supervision of a Participant’s Care and IDAPA 16.03.09.710.04 Mental Health Clinic Services – Written Individualized Treatment Plans.

Provide overall clinic supervision, as indicated in IDAPA 16.03.09.714.06 Mental Health Clinic Services – Provider Agency Requirements: Physician Requirement for Clinic Supervision, and agree to spend as much time in the clinic as is necessary to assure that all participants are receiving services in a safe and efficient manner.

2.3.1.3. **Services**

Mental health clinic services are provided by professionals who are trained to perform evaluation, diagnostic and treatment services to participants with a variety of mental health needs.

Available services for participants in the Medicaid Basic Plan include:

- Intake, Comprehensive Diagnostic, or Functional Assessments
- Assessments must be performed prior to delivery of treatment services

Must be performed by qualified professionals as described in IDAPA 16.03.09.715 Mental Health Clinic Services – Agency Staff Qualifications

Providers must ensure assessments are conducted to match program requirements.

See IDAPA 16.03.09.709.03, Mental Health Clinic Services – Coverage and Limitations, Evaluation and Diagnostic Services in Mental Health Clinics.

**Psychological or Neuropsychological Testing**

- May be performed to provide additional clinical information when medically necessary
- Must be provided by qualified licensed professionals within the scope of their license

See IDAPA 16.03.09.709.03.d. and e, Mental Health Clinic Services – Coverage and Limitations, Evaluation and Diagnostic Services in Mental Health Clinics.
Occupational Assessment and Therapy

- Must be performed by licensed occupational therapists

See IDAPA 16.03.09.709.03.f. and 16.03.09.709.11, Mental Health Clinic Services – Coverage and Limitations, Evaluation and Diagnostic Services in Mental Health Clinics and Occupational Therapy Services.

Individual, Group, and Family Psychotherapy

- Must be provided by qualified licensed professionals within the scope of their license.

See IDAPA 16.03.09.709.04 and 05, Mental Health Clinic Services – Coverage and Limitations, Psychotherapy Treatment services in Mental Health Clinics and Family Psychotherapy.

Emergency Psychotherapy

- In the event of a psychiatric emergency, providers may deliver psychotherapy prior to intake or evaluation services
- Must be provided by qualified licensed professionals within the scope of their license
- Must be counted toward the allowable limit unless the participant’s contact results in hospitalization

See IDAPA 16.03.09.709.06, Mental Health Clinic Services – Coverage and Limitations, Emergency Psychotherapy Services.

Pharmacological Management

- In addition to management of medication, this service includes brief psychotherapy
- Must be provided by qualified licensed professionals within the scope of their license

See IDAPA 16.03.09.709.08, Mental Health Clinic Services – Coverage and Limitations, Pharmacological Management.

Nursing Services

- Must be ordered and supervised by a physician
- Must be provided by qualified licensed professionals within the scope of their license

See IDAPA 16.03.09.709.09, Mental Health Clinic Services – Coverage and Limitations, Nursing Services.

Collateral Contact

- Cannot be used to bill Medicaid for therapy to an ineligible person or for an individual who is a resident of a public institution or a nursing home including an intermediate care facility (for developmentally disabled), mentally retarded (CF/MR).
- Medicaid does not reimburse for parent education or other parent support groups.

See IDAPA 16.03.09.709.07, Mental Health Clinic Services – Coverage and Limitations, Collateral Contact

- A total of 12 hours per calendar year of evaluative or diagnostic services are allowed.
  A maximum of two hours are allowed per calendar year for treatment plan development.
Medicaid Basic Plan participants are limited to 26 services for any combination of Mental Health Clinic services. The 12 hours of evaluative or diagnostic services count toward the 26 services limitation.

See IDAPA 16.03.09.709.10; Mental Health Clinic Services – Coverage and Limitations, Limits on Mental Health Clinic Services.

For participants in the Medicaid Enhanced Plan, in addition to the services specified above, the following Mental Health Clinic benefits are available.

**Partial Care Services**
- May only be provided when other services have failed or are not appropriate for the clinical needs of the participant
- Limited to 12 hours per week
- Must be provided by qualified licensed professionals within the scope of their license

See IDAPA 16.03.10.111.18; Enhanced Outpatient Mental Health Services – Definitions, Partial Care; IDAPA 16.03.10.112.01; Enhanced Outpatient Mental Health Services – Participant Eligibility, General Participant Eligibility Criteria; and IDAPA 16.03.10.118.02; Enhanced Outpatient Mental Health Services – Descriptions – Partial Care Services

**Psychotherapy services**
- Includes individual, group, or family psychotherapy and emergency psychotherapy services.
- Limited to 45 hours annually in any combination.
- Must be provided by qualified licensed professionals within the scope of their license

See IDAPA 16.03.10.111.22; Enhanced Outpatient Mental Health Services – Definitions, Psychotherapy and IDAPA 16.03.10.118.01; Enhanced Outpatient Mental Health Services – Descriptions, Psychotherapy.

See CMS 1500 Instructions, Appendix D.1.2 for covered services.

**2.3.2. Exclusions**
Mental health clinic services are not reimbursable when performed outside of the clinic; when provided in an institution; when performed by a non-qualified staff person; or when not adequately documented in the participant’s record.

See IDAPA 16.03.09.711; Mental Health Clinic Services – Excluded Services Not Reimbursable Under Medicaid.

**2.3.3. Record Keeping**
Each Mental health clinic is required to maintain medical records on all services provided to Medicaid participants. The record must contain a current treatment plan based on an individual assessment of the participant’s needs and signed by a physician within 30 days of the initiation of treatment in the clinic.

Services must be provided in accordance with the current treatment plan, and the records must contain all of the following.
- The exact type of treatment provided.
- Who provided the treatment.
• The duration of the treatment and the start time and stop time of day delivered.
• Detailed records of exactly what occurred during the therapy session or participant contact documented by the person who delivered the service.
• The legible, dated signature, with degree credentials listed of the staff participant performing the service.
• Any service not adequately documented in the participant’s record, by the signature of the treatment professional providing the service or participant contact, the length of the session, and the date of the contact, will not be reimbursed by the Department.

See IDAPA 16.03.09.716 Mental Health Clinic Services – Record Requirements for Providers.

2.3.4. Determining How to Bill Units for 15 Minute Timed Codes

Several CPT and HCPCS codes used for evaluations, therapy modalities, procedures, and collateral contact specify that one unit equals 15 minutes. Providers bill procedure codes for services delivered using these codes and the appropriate number of units of service. Providers should not bill for services performed for less than eight minutes. This time should be documented though may not be billed for that day unless additional service time occurs on that same day for the same participant. The expectation (based on work values for these codes) is that a provider’s time for each unit will average 15 minutes in length.

For any single procedure code, providers bill one 15 minute unit for treatment greater than or equal to eight minutes. Two units should be billed when the interaction with the participant or collateral contact is greater than or equal to 23 minutes to less than 38 minutes. Time intervals for larger numbers of units are as follows:

<table>
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<th>Units</th>
<th>Minimum Time</th>
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<tr>
<td>8</td>
<td>≥113 minutes</td>
<td>&lt;128 minutes</td>
<td></td>
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</tbody>
</table>

2.3.5. Billing Procedure for Date Spanning

The dates of service billed on a single detail line must be within the Sunday through Saturday calendar week. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one detail line. When date spanning, services must have been provided for every day within that span. For example, it is incorrect to date span the entire week when services were only performed on Thursday and Saturday. Additionally, it is inappropriate to date span bill if services were provided on a Monday and a Friday and there were no services offered in between those days.

For example, services provided to the participant on
- Thursday, December 11, 2008
- Saturday, December 13, 2008

Enter each date on a separate detail line. See the following table.
### 2.3.5.1.  Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes

Professional claims for medications reported with HCPCS codes, must include the appropriate NDC of the medication supplied, units dispensed, and basis of measurement for each medication. This requirement applies on claims submitted electronically and on the paper CMS 1500 claim form.

The HCPCS medications that require NDC information are listed in the current Healthcare Common Procedure Coding System (HCPCS) Manual; Appendix 3, alphabetically by both generic, brand, or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will be denied with EOB 628, NDC required.

The collection of the NDC information allows Medicaid to collect rebates due from drug manufacturers, resulting in significant cost saving to Idaho’s Medicaid Program. This requirement is mandated by the Center for Medicare and Medicaid Services (CMS), which requires all states to develop systems to claim drug rebates when Medicaid pays any portion of a drug claim. See State Medicaid Director Letter #06-016, at [http://www.cms.hhs.gov/smdl/downloads/SMD071106.pdf](http://www.cms.hhs.gov/smdl/downloads/SMD071106.pdf).

### 2.4.  Rehabilitative Mental Health Services (PSR Services)

#### 2.4.1.  Overview

Rehabilitative MH services (psychosocial rehabilitation (PSR) services) include treatment, rehabilitation, and supportive services. The goal of rehabilitative services is to reduce to a minimum a participant’s mental disability and restore the participant to the highest possible functional level within the community.

**Note**

Services provided by PSR service agencies for participants covered under the Medicaid Basic Plan are limited to diagnostic and evaluation procedures only.

#### 2.4.2.  Provider Enrollment and Credentialing

In order to become enrolled as a PSR provider, the provider applicant must meet the requirements established through the credentialing program. All existing PSR service providers must meet the requirements of the credentialing program.

All locations where Medicaid PSR services are provided must be registered with Medicaid and must have a valid provider agreement.

#### 2.4.3.  Participant Eligibility

Children with a serious emotional disturbance (SED) are eligible for rehabilitative mental health services. See *IDAPA 16.03.10.112.05 Medicaid Enhanced Plan Benefits; Enhanced Outpatient Mental Health Services – Participant Eligibility; Level of Care Criteria – Psychosocial Rehabilitation (PSR) Services and Partial Care Services for Children*, for qualifying criteria.
Participants who are 18 years of age or older with a diagnosis of severe and persistent mental illness that directly impacts at least two identified functional areas on either a continuous or an intermittent basis are eligible for these services. Specific criteria can be found in IDAPA 16.03.10.112.06 Medicaid Enhanced Plan Benefits; Enhanced Outpatient Mental Health Services – Participant Eligibility; Level of Care Criteria – Psychosocial Rehabilitation (PSR) Services and Partial Care Services for Adults.

2.4.4. Prior Authorization (PA)

Prior authorization is required for rehabilitative MH services beyond the base service limits. Additional service authorizations are requested from DHW. The specific documentation that is required for prior authorization is dependent on the type of additional services being requested. In general, the specific documentation submitted should fully describe the participant’s situation and should justify the clinical need and medical necessity for the requested services. See IDAPA 16.03.10.128.02.-05. Medicaid Enhanced Plan Benefits; Psychosocial Rehabilitative Services (PSR) – Responsibilities of the Department. See CMS 1500 Instructions, Appendix D.1.3 for covered services and limitations.

Assessment services are limited to a maximum of six hours annually per participant when provided by a PSR Service Agency.

Note

Participants are subject to a yearly limit of 12 hours for all MH related evaluation and diagnostic services.

A comprehensive diagnostic assessment is required at least once annually for each participant and functional assessments are required in order for participant’s to receive psychosocial rehabilitation services.

Treatment plan development is limited to two hours per year per participant per provider agency.

See IDAPA 16.03.10.124 Medicaid Enhanced Plan Benefits; Psychosocial Rehabilitative Services (PSR) – Coverage and Limitations for specific limitations.

2.4.4.1. Psychotherapy

Psychotherapy services must focus on behavioral, emotional, and cognitive aspects of a participant’s functioning and must be provided by qualified licensed professionals within the scope of their license. Qualified staff are referenced at IDAPA 16.03.09.715.05 Medicaid Basic Plan Benefits; Mental Health Clinic Services – Agency Staff Qualifications; Staff Qualifications for Psychotherapy Services.

Individual, family, and group psychotherapy services are limited to a maximum of 20 hours annually when provided by PSR Service agencies. Services beyond five hours weekly must be prior-authorized by Medicaid.

2.4.4.2. Crisis Intervention Services

Community crisis support services require PA by Medicaid. Crisis support services are intended to provide interventions to ensure a participant’s health and safety or to prevent a participant’s hospitalization or incarceration. Authorization for crisis interventions should be
requested within 24 hours of the crisis onset or be prior authorized when the need for crisis support is anticipated. Crisis hours are authorized on a per incident basis.

Crisis support services may be authorized up to ten hours per crisis per seven day period. These service hours are allowed in addition to any other PSR service hours within the same time frame.

See IDAPA 16.03.10.123.04. Medicaid Enhanced Plan Benefits; Psychosocial Rehabilitative Services (PSR) - Descriptions; - Crisis Intervention Services and 16.03.10.124.04 Medicaid Enhanced Plan Benefits; Psychosocial Rehabilitative Services (PSR)- Coverage and Limitations; Crisis Intervention Service for full crisis criteria.

2.4.4.3. **Psychosocial Rehabilitation (PSR) Services**

Skill Training and Community Reintegration are the newly defined Psychosocial Rehabilitation Services.

- Skill training services are specific curriculum based inventions that are focused on helping the participant gain and utilize desired functional skills. Allowable skills are addressed in IDAPA 16.03.10.123.01 Medicaid Enhanced Plan Benefits.

- Community Reintegration services are supportive activities that include verbal prompts, positive reinforcements, and encouragement to help a participant maintain their existing skills.

PSR Services are limited to five hours per week in any combination of individual and group services. Additional services up to five hours weekly must be prior authorized by IDHW.

See IDAPA 16.03.10.123.01-03 Medicaid Enhanced Plan Benefits; Psychosocial Rehabilitative Services (PSR)-Descriptions; Skill Training, Community Reintegration and Group Skill Training.

**Note:** For PSR Service Agencies providing school-based services: The following rules apply to this type of service delivery, IDAPA 16.03.09.850-856 Medicaid Basic Plan Benefits; School-Based Services – Definition through 856 School-Based Services – Quality Assurance.

**Pharmacological Management**

Pharmacological Management services are defined as management of medications for psychiatric disorders for relief of a participant’s signs and symptoms of mental illness. See IDAPA 16.03.10.123.01.f. Medicaid Enhanced Plan Benefits; Psychosocial Rehabilitative Services (PSR) – Descriptions; Skill Training, for further description of this service within PSR service agencies.

Pharmacological management services beyond 24 encounters per calendar year must be prior authorized by Medicaid.

**Collateral Contact**

For mental health services, collateral contact is defined as follows.

“Coordination of care communication that is initiated by a medical or qualified treatment professional with participants of a participant’s interdisciplinary team or consultant to the interdisciplinary team. The communication is limited to interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or responsible persons or advising them how to assist the participant.”
Collateral contact is intended to be used only to relay particular information that will directly result in a service or action being provided to the participant by the team participant who receives the communication.

Collateral contact is not to be used for general status updates to parents; interagency staffing; or for assessment information gathering.

See IDAPA 16.03.10.010.21 Medicaid Enhanced Plan Benefits; Definitions A Through D; Collateral Contact. Collateral contact services beyond six hours per calendar year must be prior authorized by Medicaid.

### Occupational Therapy
In relation to mental health treatment, occupational therapy is the use of purposeful, goal-oriented activities to help a participant achieve optimum functional performance and independence; to prevent further disability; and to maintain the health of individuals who are limited by the symptoms of their mental illness.

For PSR service agencies, occupational therapy services must be prior authorized by DHW, based on the results of an occupational therapy evaluation. See IDAPA 16.03.10.124.08 Medicaid Enhanced Plan Benefits; Psychosocial Rehabilitative Services (PSR) – Coverage and Limitations; Occupational Therapy.

#### 2.4.5. Excluded Services
Some treatment services are considered excluded services and are not reimbursed under Medicaid. Excluded services include the following.

- Treatment services rendered to participants residing at inpatient medical facilities or nursing homes – (unless specifically approved by Medicaid through the PASARR Program).
- Recreational and social activities.
- Job training, job placement services, or job specific interventions.
- Staff performance of household tasks and chores.
- Treatment services for persons other than the identified participant.
- Services primarily available through Service Coordination Agencies.
- Delivery of medication.
- Services delivered on an expired treatment plan.
- Provision of transportation by staff.
- Services provided to participants who are incarcerated.

Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the services, leaving messages, scheduling appointments, or documenting services. See IDAPA 16.03.10.125 Medicaid Enhanced Plan Benefits; Enhanced Outpatient Mental Health Services – Psychosocial Rehabilitative Services (PSR) - Excluded Services Not Reimbursable Under Medicaid for complete details.

#### 2.4.6. Payment
Payment for rehab option services is made directly to the provider agency (with exception of PSR school-based services) in accordance with the rates established by Medicaid for the specific services.

For services paid at the 15 minute incremental rate, providers will not be reimbursed for more than one contact during a single 15 minute time period.
2.4.7. Record Keeping
Each agency is required to maintain a medical record on all services provided to Medicaid participants. See, IDAPA 16.03.10.136 Psychosocial Rehabilitative Services (PSR) – Record Requirement for Providers; 01 Name through 10 Informed Consent, for specific requirements. The records must contain a current treatment plan signed by a physician, or other licensed practitioner of the healing arts within the scope of his practice under state law. Services must be provided in accordance with the current treatment plan, and the medical record must contain all of the following.

- The name of the participant and the provider.
- The date, start time and end time, duration of service, and justification.
- Documentation of service provided, place-of-service, and response of the participant.
- The legible signature and date, with degree credentials listed of the staff participant performing the service.
- Documentation of the participant’s choice of provider.
- Documentation of review of progress/reassessment and closure of services.

2.5. Adult Day Care

2.5.1. Overview
Adult day care is a supervised, structured day program outside of the home of the participant that may offer one or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. All services must be prior authorized by Medicaid prior to payment.

Note
Adult day care services are only covered for Medicaid Enhanced Plan participants who qualify for A&D waiver.

2.5.2. Adult Day Care - Facilities
Facilities that provide adult day care must be maintained in a safe and sanitary manner and meet the requirements of the Adult Day Care Provider Agreement. Facilities will provide the staff and space necessary to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary to assure the comfort and safety of the participants served.

2.5.2.1. Adult Day Care - Provider Home (Certified Family Home)
Providers accepting participants into their home for services must maintain the home in a safe and sanitary manner and meet the standards of the Adult Day Care Provider Agreement and home certification identified in IDAPA 16.03.19 Rules Governing Certified Family Homes. The provider must provide supervision as necessary to assure the comfort and safety of the participants served. See CMS 1500 Instructions, Appendix D.1.4.

2.6. Pregnant Women (PW) Clinic

2.6.1. Pregnant Women (PW)
Some district health departments are also PW clinics. They must be Medicaid approved providers and meet the conditions for presumptive eligibility (PE) of pregnant women. A
special agreement is signed between DHW and the district health department. The district health department should only utilize personnel who have attended a DHW sponsored training program for PE qualified providers. Approved providers must be trained and certified by DHW. See CMS 1500 Instructions, Appendix D.1.5 for covered services.

2.7. **IHC Tribal/Indian Health Clinic (IHC)**

2.8. **General Policy**

Medicaid reimburses IHCs for most services through an all-inclusive rate for each participant encounter. The all-inclusive rate for IHCs is established by the Federal Office of Management and Budget as published annually in the Federal Register.

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho’s Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, there are guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services.

Tribal participants enrolled with a primary care provider (PCP) other than the IHC do not need a referral for IHC services. However, a non-tribal participant enrolled with a PCP other than the IHC will need a HC referral for IHC services.

2.9. **Prior Authorization (PA)**

Indian Health Clinic (IHC) services do not require PA for IHC services for Native Americans and Alaskan Natives. However, if the IHC is enrolled with the Idaho Medicaid Program as a provider for services other than IHC services, PA may be required.

2.10. **Policy – Indian Health Clinics (IHC)**

2.10.1. **Overview**

Medicaid covers IHC/638 Clinic physician services, physician assistant services, nurse practitioner services, nurse midwife services, clinical social worker services, clinical psychologist services and specialized nurse practitioner services, and any required supplies incidental to their services through an encounter reimbursement methodology. Medicaid covers dentist services provided in IHC.

2.10.2. **Excluded Services**

2.10.2.1. **Laboratory**

If an outside lab instead of the clinic performs a laboratory service, the outside lab must bill Medicaid directly.

Laboratory services performed in IHCs are included in the encounter rate and cannot be billed as a separate service to Medicaid. The exception to this exclusion is when an individual receives laboratory service on a day when there is no encounter billed for a clinic visit. These laboratory services may be billed but the clinic must have a separate laboratory provider number or a group physician number to bill under and use laboratory procedure codes. The reimbursement will be fee-for-service rather than an encounter rate.
2.10.2.2. Pharmacy

Over-the-counter (OTC) pharmaceuticals are not covered by Medicaid. Pharmaceutical services for take home prescription medications will be covered under the Medicaid Pharmacy Program. Claims must be submitted to Medicaid on the Idaho Pharmacy claim form under the pharmacy's provider number.

Note
The clinic may not bill pharmaceutical services as an encounter.

2.10.2.3. Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If Medicaid pays for the drug on a fee-for-service basis, and the prescription cannot be faxed, phoned, or electronically sent to the pharmacy, then providers must ensure that the prescription meets all three requirements for tamper-resistant paper.

Any written prescription presented to a pharmacy for a Medicaid participant must be written on a tamper-resistant prescription form that contains all of the following:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Note
The intent of this requirement is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

2.10.3. Encounter Definition

An encounter is a face-to-face contact for the provision of medical, mental health or dental services between a clinic patient and a physician, physician assistant, nurse practitioner, clinical social worker, clinical psychologist, specialized nurse practitioner or visiting nurse, dentist or dental hygienist. A clinic may only bill a visiting nurse visit as an encounter if the patient is homebound and the clinic is providing home health services under the provision for home health in rural areas.

Types of encounters include medical, mental health, and dental.

- Each contact with a separate discipline of health professional (medical, mental health, or dental) on the same day at the same location is considered a separate encounter and may be billed as such. An Indian Health or Tribal 638 Clinic may bill a mental health encounter for services provided to a Medicaid participant with a substance abuse diagnosis when provided by a Certified Substance Abuse Counselor with an Idaho Board of Alcohol/Drug Counselor Certification (IBADCC).
- Substance Abuse Counselor Certifications from other states will be allowed when the certification requirements are equal to the requirements of the IBADCC.
Note
Mental health encounters do not count toward the participants per year limit for mental health services.
- All contacts with all practitioners within a disciplinary category (medical, mental health, or dental) on the same day are considered one encounter.
- Reimbursement for services is limited to three encounters per participant per day; one medical, one mental health, and one dental encounter in one day. An exception to this rule may be made if the encounter is caused by an illness or injury that occurs later the same day of the first encounter, requires additional diagnosis or treatment, and is supported by documentation.

No shows, visits to pick up medication, or incidental services on the day of the encounter are not considered an encounter.

2.10.4. Incidental Services
Services incidental to a billable encounter are:
- In-house radiology.
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Audiology.
- In-house laboratory services.
- In-house nutritional education or dietary counseling and monitoring by a registered dietitian.
- Injectable medications.
- Medical equipment and supplies.

If these services happen on the same day as an encounter visit they are considered included in the encounter rate. If these services are provided by the clinic on a day when a qualifying IHC or Federally Qualified Health Center (FQHC) encounter is not provided, the clinic must have the appropriate separate provider number to bill for those services.

2.10.5. Indian Health Clinics may bill for one medical, one mental health, and one dental encounter in one day.

2.10.6. Dental Encounter
An encounter is a face-to-face contact for the provision of dental services between a participant and a dentist or dental hygienist. When billing dental services for participants on the Medicaid Enhanced Plan, use the dental encounter code D2999 with the diagnosis code V72.2.

Effective with dates of service on or after 9/1/07, participants who are eligible under the Medicaid Basic Plan, including pregnant women eligible for the Pregnant Women (PW) Program, are covered under a dental insurance program called Idaho Smiles. DentaQuest is the administrator for Idaho Smiles. For eligibility, benefits, and claims processing information, contact Idaho Smiles Customer Service at 1 (800) 936-0978, or by email at www.bcidadaho.com; click on the Idaho Smiles link, then under Dental Providers, pick the provider Web portal link which will take you to DentaQuest’s Idaho Smiles Web site.

Note
Participants’ identification numbers for both Idaho Smiles and Medicaid numbers are the same. If a participant does not have an Idaho Smiles insurance card, use their Medicaid
identification (MID) number with the point of service POS device, Health PAS-OnLine, or MACS at 1 (208) 373-1424 in the Boise calling area, or 1 (866) 686-4272 to determine eligibility. The eligibility response from Idaho Medicaid will indicate which dental program they are on.

If the participant is eligible for Medicaid Basic Plan or Pregnant Women (PW) Program, bill Idaho Smiles.

If the participant is eligible for Medicaid, without mention of Basic Plan or PW Program, they are on the Medicaid Enhanced Plan; bill Idaho Medicaid for dental services. For additional information about services considered a benefit of the dental program, see the Dental Guidelines.

2.10.7. Medical Care Evaluation for Assessment
The Medicaid Care Management Program for adults with developmental disabilities includes an assessment process which requires a history, physical examination, and referral from the physician (the participant's HC provider, if applicable).

Medicaid will reimburse history and physicals for adults when it is a Medicaid Program requirement such as above. When billing for history and physical exams for developmentally disabled adults that have been requested by the Medicaid Program, use diagnosis code V70.3 - Other medical examination for administrative purposes. You must enter, State required history and physical, in the comments field of the claim, or it will deny.

2.10.8. Advance Directives
An advance directive explains to a participant his or her right to accept or refuse medical services, or to choose among available medical services. The provider will inform the participant of their right to formulate advance directives, such as a Living Will and/or Durable Power of Attorney for Health Care. Medicaid has directed that providers of home health care (including FQHCs and IHCs) must provide all adult Medicaid participants with advance directive information in an understandable format.

If a participant is unable to read the information, the information is read to the participant by a relative or friend. If no one else is available, the provider must read the advance directive information to the participant. If the provider is unable to abide by the medical desires of the participant, the provider is required to assist the participant in finding an alternative source of service.

2.10.9. Procedure Codes
Idaho Medicaid uses the federally mandated HCPCS. Bill procedure code T1015, as the encounter code for all medical and mental health IHC services. Bill dental services with procedure code D2999. In addition to the required encounter code also include all appropriate CPT/HCPCS codes for services provided during the encounter. See CMS 1500 Instructions for covered services.

2.10.10. Billing Encounter Instructions
Bill encounter with appropriate rate charge on the 1st detail line then list all the appropriate CPT/HCPCS services provided during the encounter priced at $0 on subsequent lines.

For Children's EPSDT services see General Provider and Participant Information, Child Wellness Exams, for more information.
For Family planning services see General Provider and Participant Information, Family Planning, for more information.

The federal Department of Health and Human Services announces new rates for Tribes for outpatient encounter (per visit) rates every year. These rates are effective January 1, of each year. IHCs should bill with the most current encounter rate. This practice will allow DHW to run mass adjustments in the event that the claims processing system does not have the most current rate of file as of January 1.

**Medicare Crossover**

Participants may be dually eligible for Medicare and Medicaid. The provider must first bill Medicare for rendered services. A copy of the Medicare Remittance Notice (MRN) must be included with the Medicaid claim when billing on paper. If billing electronically, the information from Medicare must be entered in appropriate screens.

### 2.10.11. Wellness Exams

Child Wellness Exams – Up to Age 21 - Complete information regarding child wellness exams is located in General Provider & Participant Information, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Sometimes child wellness exams are referred to as EPSDT screens.

Payment for child wellness exams is the same as the rate for all inclusive participant encounters. Providers report encounter code T1015.

- Adult Wellness Exams – Adults 21 years of Age and Older
- Adult preventive medicine procedures will be limited to one per rolling year.
- Evaluation and management procedures will not be paid on the same day as a preventive medicine procedure for participants over age 21.
- Preventive medicine procedures billed for participants over age 21 must be billed with a diagnosis code of V70.0, V72.3, V72.31, or V72.32, or the claim will be denied.
- A health risk assessment/preventive physical examination for an adult that is a requirement of Idaho Medicaid is a covered service. When an exam and/or report is required by Department of Health and Welfare (DHW) for an adult participant, including annual history and physical exams for adults living in an Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR) Facility, use the primary diagnosis code V70.3.

**Note**

Special reports and pre-employment physicals for individuals age 21 and older are not covered by Idaho Medicaid.

### 2.10.12. Family Planning

All claims for services or supplies that are provided as part of a family planning must be billed with encounter code T1015.

### 2.10.13. Mental Health Clinic Services

The Mental Health (MH) Clinic Program is designed to promote overall mental wellness for Medicaid participants. In accordance with the Federal Code of Regulations 42 CFR 440.90, all MH clinic services must be provided at the clinic, unless provided to an eligible homeless
individual per regulations. Services provided outside of the clinic facility are not reimbursable by Medicaid. Clinic services are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services. Recreational, educational, and vocational services are not Medicaid-covered MH clinic services.

Indian Health Clinics that choose to enroll as a Mental Health Clinic must follow rules governing services provided in a Mental Health Clinic. The rules are located in IDAPA 16.03.09.707-718 and IDAPA 16.03.10.110-119, and the guidelines are published in Section 3 Clinic Guidelines online at:
http://www.healthandwelfare.idaho.gov/site/3438/default.aspx

2.10.14. Psychosocial Rehabilitation

Indian Health Clinics (IHC) that wish to provide community-based mental health services must do so under a Psychosocial Rehabilitation Provider agreement. Psychosocial rehabilitative services are not limited to a clinic setting as are IHC and mental health clinic services. The rules governing the provision of these services are located in IDAPA 16.03 10.120-146. See Section 3 Rehabilitative Options online at:
http://www.healthandwelfare.idaho.gov/site/3438/default.aspx

Rehabilitative mental health services (also called Rehabilitative Option or Psychosocial Rehabilitation Services - PSR ) include treatment, skill training, and supportive services. The goal of rehabilitative services is to reduce to a minimum an individual’s mental disability and restore the participant to the highest functional level within the community.

Note:
Mental health rehabilitation services are only covered for Medicaid Enhanced Plan participants.
Psychosocial rehabilitation services above the baseline services require PA from DHW.

2.10.15. Case Management Services (Service Coordination)

Service coordination services are delivered by qualified providers to assist Medicaid participants who are unable, or have limited ability, to gain access to, coordinate, or maintain services on their own or through other means. See IDAPA 16.03.10.720 Medicaid Enhanced Plan Benefits: Service Coordination through 736 Service Coordination – Provider Reimbursement for rules regarding service coordination.

Note: Service coordination for participants enrolled in the Medicaid Basic Plan is limited to diagnostic and evaluation procedures only. Participants enrolled in the Medicaid Enhanced Plan are eligible for additional service coordination services.

Indian Health Clinics (IHC) who want to bill for service coordination services must do so under a Service Coordination provider agreement. For more information, see IDAPA 16.03.10.720 Service Coordination. Service coordination is defined as a brokerage model of case management.

Reimbursable services include:
- Assessment and service plan development.
- Linking the individual to services.
- Monitoring and coordinating services.
2.10.15.1. **Eligibility**

Medicaid reimburses for service coordination services for four target populations:

- Participants 18 years of age or older diagnosed with a developmental disability who have substantial functional limitations in three or more major life areas and need assistance to adequately access services and supports necessary to maintain their independence in the community. (IDAPA 16.03.10.723)

- Participants (adults and children) who have been approved to receive state plan PCS or HCBS and require assistance to access services and supports to maintain their independence in the community. (IDAPA 16.03.10.724)

- Participants 18 years of age or older who are using or have a history of using high cost medical services associated with periods of increased severity of mental illness; who are diagnosed with a condition of severe and persistent mental illness listed in the DSM-IV-TR (see IDAPA 16.03.10.725 for diagnoses criteria); and who have illness of sufficient severity to cause a disturbance in their role performance or coping skills in at least two life areas on a continuous or intermittent basis. (IDAPA 16.03.10.725)

- Participants from birth through the month of their twenty first birthday identified in an EPSDT screen as having a developmental delay or disability, special health care needs, or severe emotional disorder and need assistance in one or more of the problems listed in IDAPA 16.03.17.204.03 associated with their diagnosis. (IDAPA 16.03.17.204)

2.10.15.2. **Limitations**

See Section 3 Service Coordination Guidelines for limitations online at: [http://www.healthandwelfare.idaho.gov/site/3438/default.aspx](http://www.healthandwelfare.idaho.gov/site/3438/default.aspx)

2.10.15.3. **Prior Authorization (PA)**

Some service coordination services must be prior authorized by DHW. Please refer to IDAPA 16.03.10.728 for guidelines.

2.10.16. **Personal Care Services (PCS)**

Medicaid covers in-home services, both through state plan PCS or, for participants with more complex needs, through the Aged and Disabled Home and Community Based Services waiver.

Personal care services (PCS) are medically oriented tasks related to a participant’s physical care in the home. (See IDAPA 16.03.10.300 for rules governing this service.) Such services must be included in an approved plan of care (POC) and include, but are not limited to, the following:

- Assistance with personal hygiene.
- Assistance with medications that are ordinarily self-administered.
- Meal preparation.
- Incidental household services essential to the participant’s comfort, safety and health.
- Independence training.

**Note:**

PCS are covered for Medicaid Enhanced Plan participants only.
2.10.16.1. Provider Qualifications

All personal assistants must have at least one of the following qualifications:

- Licensed Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- A person who meets the standards of section 39-5603 of Idaho Code and receives training to ensure the quality of services. Must be at least 18 years of age. The RMS may require a Certified Nursing Assistant (CNA) if, in their professional judgment, the participant’s medical condition warrants a CNA.

To enroll a PCS provider, contact the RMS office in your area.

2.10.16.2. Eligibility

Adults and children are eligible for PCS service if the service is determined to be medically necessary and provided in accordance with a written POC.

2.10.16.3. Limitations

PCS under the State Plan Option are limited to:

- 16 hours per week per participant.
- Participants who meet medical necessity criteria under EPSDT (IDAPA 16.03.09.535) may receive up to 24 hours per day of service delivery through the month of their 21st birthday.
- Must be provided in the participant’s home or personal residence.

2.10.16.4. Prior Authorization (PA)

Regional Medicaid services (RMS) must authorize all services reimbursed by Medicaid under the PCS program prior to the payment of services. Approved authorizations are valid for the dates shown on the PA. The PA number must be included on the claim.

2.10.17. Audiology Services

If audiology services are provided on the same day as an encounter, the service is considered part of the encounter. If rendered by a provider other than listed as those who can provide IHC services, an audiology provider number must be obtained.

2.10.18. Vision Services

Services provided by an ophthalmologist are billable as an encounter under the IHC/638 Clinic number. However, vision exams provided by other qualified providers such as optometrists must be billed under a vision service provider agreement.

2.10.19. Pathology/Laboratory

Pathology/laboratory services provided on a day when the participant does not see a health care provider in the clinic may not be billed as an encounter. The provider may bill for the laboratory services in these instances under a physician group provider number as previously mentioned or may apply for a laboratory provider number through Molina.

To enroll as a pathology/laboratory provider, contact Molina Provider Enrollment at 1 (208) 373-1424 in the Boise calling area or 1 (866) 686-4272.
2.10.20.  **Radiology**

Radiology services provided on a day when the participant does not see a health care provider in the clinic may not be billed as an encounter. The provider may bill for the radiology services by applying for a radiology provider number through Molina.

2.10.20.1.  **Covered Services**

The technical component includes charges for the following:
- Personnel.
- Material, including usual contrast media and drugs.
- Film or xerograph.
- Space, equipment, and other facility charges.

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes. Attach an invoice identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered, or attach medical records with the related information. Because of the wide variations in costs, to providers and the radioisotopes billed, this information is necessary to price each claim.

2.10.21.  **Home Health**

Indian Health Clinics are allowed to bill for home health visits for participants that are homebound.

2.11.  **Clinic/Center - Rural Health Clinics**

2.11.1.  **Overview**

Medicaid covers rural health clinic physician services including any required supervision of nurse practitioners, physician assistants, and any required supplies incidental to a physician’s professional services. Medicaid also covers the services of physician assistants, nurse practitioners, nurse midwives, clinical social workers, clinical psychologists, and specialized nurse practitioners, and any required supplies incidental to their services. Dental services are not covered in rural health clinics.

2.11.2.  **Excluded Services**

2.11.2.1.  **Laboratory**

If an outside lab instead of the clinic performs a laboratory service, the outside lab must bill Medicaid directly. Laboratory services performed in rural health clinics are included in the encounter rate and cannot be billed to Medicaid.

2.11.2.2.  **Pharmacy**

Over-the-counter (OTC) pharmaceuticals are not covered by Medicaid, with the exception of those OTC items identified as payable in the Idaho Medicaid Pharmacy Claims Submission Manual at [https://idaho.fhsc.com/providers/manuals.asp](https://idaho.fhsc.com/providers/manuals.asp).

Pharmaceutical services may not be billed as an encounter. Pharmaceutical services for take home prescription medications will be covered under the Medicaid Pharmacy Program. Claims must be submitted to Medicaid on the pharmacy claim form under the pharmacy’s provider number.
**Encounter Definition**

An encounter is defined as a face-to-face contact for the provision of medical or mental health services between a clinic patient and a physician, physician assistant, nurse practitioner, clinical social worker, clinical psychologist, or other specialized nurse practitioner, or visiting nurse. Encounters with more than one health professional or multiple contacts with the same professional, in the same day, and in the same location, for the same diagnosis constitute a single encounter. The exception is when a participant, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis and treatment. No shows or visits to pick up medication are not considered an encounter. Visiting nurse services are only covered when the RHC is located in an area that has been designated by the Centers for Medicare and Medicaid Services as an area with a shortage of home health agencies. Mental health encounters do not count toward the Medicaid Basic Plan participants 26 services per year limit.

**2.11.3. Advance Directives**

An advance directive explains to a participant their right to accept or refuse medical services, or to choose among available medical services. The provider will inform the participant of their right to formulate advance directives, such as Living Will and/or Durable Power of Attorney for Health Care. Medicaid has directed that providers of home health care (including federally qualified health clinics, and rural health clinics) must provide all adult Medicaid participants with advance directive information in an understandable format.

If a participant is unable to read the information, the information is read to the participant by a relative or friend. If no one else is available, the provider must read the advance directive information to the participant. If the provider is unable to abide by the medical desires of the participant, the provider is required to assist the participant in finding an alternative source of service.

**2.11.4. Procedure Code**

Idaho Medicaid uses federally mandated HCPCS codes. All rural health clinics must use procedure code T1015 for all services.

In addition to the required encounter code also include all appropriate CPT/HCPCS codes for services provided during the encounter.

See CMS 1500 Instructions for covered services

**2.11.5. Billing Encounter Instructions**

Bill encounter with appropriate rate charge on the 1st detail line then list all the appropriate CPT/HCPCS services provided during the encounter priced at $0 on subsequent lines.

**2.11.6. Medicare Crossover**

Participants may be dually eligible for Medicare and Medicaid. The provider must first bill Medicare for rendered services. A copy of the Medicare Remittance Notice (MRN) must be included with the Medicaid claim when billing on paper. If billing electronically, the information from Medicare must be entered on the appropriate screens.

If a person is eligible for both Medicare and Medicaid, Medicaid’s payment for services will not exceed the amount allowed by Medicaid minus Medicare’s payment for those services. See General Billing Instructions, Crossover Claims, for more information.
2.11.7.  Child Wellness Exams
All claims for services or supplies that are provided as part of a child wellness exam must be billed with encounter code T1015 and include the appropriate diagnosis code.

Complete information regarding child wellness exams is located in General Provider & Participant Information, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Sometimes child wellness exams are referred to as EPSDT screen.

2.11.8.  Family Planning
All claims for services or supplies that are provided as part of a family planning visit must be billed with encounter code T1015 and include the appropriate diagnosis code.

2.12.  Clinic/Center - Federally Qualified Health Center (FQHC)

2.12.1.  Overview
An FQHC is a community health center, a migrant health center, a provider of care for the homeless, an outpatient health program, or a facility operated by an Indian tribal organization under the Indian Self-determination Act. Some clinics that provide ambulatory services may qualify even though they are not receiving grants under Section 329, 330, or 340 of the Public Health Service Act.

All services provided by an FQHC must be provided according to the rules and guidelines set forth by Medicaid for each type of service. Medicaid will not pay for services that are the responsibility of other providers (such as; participant care in a hospice, a nursing home or a hospital, etc.).

An FQHC may enter into the respective provider agreement observing all conditions applicable to all providers of the service after the Department of Health and Human Services and the Health Resources and Service Administration (HRSA) determine that the center meets the requirements to qualify for FQHC status.

2.12.2.  Procedure Codes
Idaho Medicaid uses the federally mandated HCPCS. Bill procedure code T1015, as the encounter code for all medical and mental health IHC services. Bill dental services with procedure code D2999.

In addition to the required encounter code also include all appropriate CPT/HCPCS codes for services provided during the encounter. See CMS 1500 Instructions for covered services.

2.12.3.  Billing Encounter Instructions
Bill encounter with appropriate rate charge on the 1st detail line then list all the appropriate CPT/HCPCS services provided during the encounter priced at $0 on subsequent lines.

2.12.4.  Incidental Services
Services incidental to a billable encounter include:
- In-house radiology.
- Physical therapy.
- Occupational therapy.
• Speech therapy.
• Audiology services.
• In-house laboratory services.
• In-house nutritional education or dietary counseling and monitoring by a registered dietician.
• Injectable medications.
• Medical equipment and supplies.

If these services happen on the same day as an encounter visit they are considered included in the encounter rate.

2.12.5. **Encounters**

An encounter is a face-to-face contact for the provision of medical, mental, or dental services between a participant and a physician, physician assistant, nurse practitioner, clinical nurse specialist, clinical psychologist, clinical social worker, dentist, or dental hygienist.

Types of encounters include medical, mental health, and dental.

Each contact with a separate discipline of health professional (medical, mental, or dental) on the same day at the same location is considered a separate encounter.

All contacts with all practitioners within a disciplinary category (medical, mental, or dental) in the same day are considered one encounter.

Reimbursement for services is limited to three separate encounters per participant per day, one for each discipline (medical, mental, or dental). An exception to this rule may be made if the encounter is caused by an illness or injury that occurs later the same day as the first encounter, requires additional diagnosis or treatment, and is supported by documentation. See *CMS 1500 Instructions* for covered services.

2.12.5.1. **Place of Service (POS)**

Enter 50 FQHC code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

2.12.5.2. **Child Wellness Exams**

All claims for services or supplies that are provided as part of a child wellness exam must be billed with encounter code **T1015** and include the appropriate diagnosis code.

Complete information regarding child wellness exams is located in *General Provider & Participant Information, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*. Sometimes child wellness exams are referred to as EPSDT screens.

2.12.5.3. **Dental Encounter**

An encounter is a face-to-face contact for the provision of dental services between a participant and a dentist or dental hygienist. The dental encounter code **D2999** should be billed with the diagnosis code **V72.2**.

**Basic Plan Participants**

Participants who are eligible for the Idaho Medicaid Basic Plan, including women on the Pregnant Women (PW) Program, are covered under Idaho Smiles dental insurance. Women
on the PW Program have coverage for a preventive dental exam and other basic dental services that are necessary to promote the best outcome for mother and fetus, such as treatment for pain and infection.

Contact Idaho Smiles Customer Service toll free at 1 (800) 936-0978, by e-mail at dентalservices@bidaho.com, or online at www.bcidaho.com and click on the Idaho Smiles Dental Care link for assistance with eligibility, covered benefits, and billing questions for Basic Plan participants including women on the PW Program.

**Enhanced Plan Participants**

Participants who are eligible for the Idaho Medicaid Enhanced Plan continue to be covered under Medicaid’s Dental Program; there is no change in the process for submitting dental claims to Idaho Medicaid for Enhanced Plan participants. For information about eligibility, covered benefits, and billing information for Enhanced Plan participants, see the Dental provider type guideline at www.idmedicaid.com.

Verifying eligibility for dental benefits:

- If the participant has an Idaho Smiles insurance card, verify eligibility through Idaho Smiles Customer Service at: 1 (800) 936-0978, or online at (click on the Idaho Smiles logo).

If the participant does not have an Idaho Smiles insurance card, use the participant’s Medicaid identification (MID) number with the electronic point of service (POS) device, Medicaid Automated Customer Service (MACS) at 1 (208) 373-1424 or at 1 (866) 686-4272), to determine eligibility. The eligibility response from MACS will be given in one of three ways:
  1. Participant is eligible and limited to Basic Plan; bill Idaho Smiles.
  2. Participant is eligible and limited to pregnancy related services only (Pregnant Women - PW Program); bill Idaho Smiles.
  3. Participant is eligible for Medicaid’s Enhanced Plan; bill Idaho Medicaid).

Dental services that are not covered in the participant’s dental plan are not covered when provided by an FQHC.

**2.12.5.4. Other Ambulatory Services**

If the FQHC wishes to provide other ambulatory services that are not part of the encounter, the provider must obtain a separate Idaho Medicaid provider number to receive payment for these services.

**2.12.6. Laboratory Services**

Laboratory tests performed by an FQHC are included in the encounter rate and cannot be billed to Medicaid. If an outside lab, not the clinic, performs a laboratory service, that lab must bill Medicaid directly.

**2.12.7. Family Planning**

All claims for services or supplies that are provided as part of a family planning visit must be billed with encounter code T1015 and include the appropriate diagnosis code.
2.13. **Clinic/Center-Ambulatory Surgical (ASC)**

2.13.1. **General Policy**
This section addresses Medicaid covered services provided in an Independent, or stand alone Ambulatory Surgical Center (ASC).

2.13.2. **Covered Services**
Services in an ASC facility require a Healthy Connections (HC) referral with the exception of dental procedures. See General Provider & Participant Information Healthy Connections (HC), for more information.

ASC facility services generally include:
- Use of the ASC facility
- Nursing care, technicians, and related services
- Drugs, biologicals, surgical dressings, supplies, splints, casts, implants, appliances, and equipment directly related to the provision of surgical procedures.
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.
- Administration, record keeping, and housekeeping items and services.
- Materials for anesthesia.
- Corneal tissue: Processing, preserving, and transporting (HCPCS V2785) is a covered benefit when the ASC facility purchases the tissue. Invoice for the purchase of the corneal tissue must be included with the CMS-1500 claim form.
- Implants that provide a biomedical function, including artificial joints, pins, screws, and plates, and that are non-routine supplies may be covered when billed by a Durable Medical Equipment (DME) provider.

Implants which provide a biomedical function such as artificial joints which are not routine supplies may be billed in addition to the procedure code(s) by specifying the HCPCS code which describes the implant. The claim must include documentation detailing the reason why the implants are not routine for the surgical procedure. The ASC must bill non-routine implants under a durable medical equipment (DME) provider number. The ASC facility must enroll as a DME provider.

Bill the appropriate HCPCS with the ASC facility’s DME provider number on a separate CMS-1500 claim form or electronically. If you have questions about whether additional codes can be billed separately, please contact the DME Unit at (208) 364-1830.

Certain procedure and diagnosis codes must be prior authorized by DHW to be covered in an ASC. It is not necessary to attach a copy of the PA letter to a claim form.

ASC facility services do not include the following.

- Physician services.
- Laboratory services, x-ray, or diagnostic procedures, other than those directly related to the performance of the surgical procedure
- Prosthetic and orthotic devices
- Ambulance service
- DME for use in the participant’s home
• Any other service not specified in IDAPA 16.03.09.455.01.b, Medicaid Basic Plan Benefits; Ambulatory Surgical Center Services – Provider Reimbursement.

• Procedures appropriately performed in a physician’s office or in an inpatient setting of an acute hospital.

2.13.3. Payment

Medicaid reimburses ASCs for procedures on a fee-for-service basis using a single fee for the ASC level assigned to the procedure code. Usual and customary fees are paid up to the Medicaid maximum allowance. Ambulatory surgical centers must bill using the same procedure codes used by the performing physician.

Ambulatory surgical center facility service payments represent reimbursement for the costs of goods and services recognized by the Medicaid program as described in IDAPA 16.03.09.455 Medicaid Basic Plan Benefits; Ambulatory Surgical Center Services – Provider Reimbursement. Medicaid pays at the rate levels established by, IDAPA 16.03.09. 415.01.d. Medicaid Basic Plan Benefits; Outpatient Hospital Services – Provider Reimbursement; Outpatient Hospital; Hospital Outpatient Surgery.

Ambulatory surgical centers are paid 100 percent of the established rate for the first covered procedure and 50 percent for any remaining covered procedures. If the procedure is a unilateral code, and there is no other code for the other parts, such as 28126 (Resection, single toe, each) or 28153 (Resection, head of phalanx, toe), it may be billed as many times as anatomically appropriate, for this example 10 times.

Any Medicaid payment must be accepted as payment in full for Medicaid covered services. The participant cannot be billed for the difference between the billed amount and the Medicaid reimbursed amount.

Ambulatory surgical centers may arrange for private payment with participants or the responsible party for non-covered services. In these cases, the participant or responsible party must be informed that the service will not be covered by Medicaid before services are rendered.

2.13.4. Prior Authorization (PA)

Submit PA requests with appropriate documentation to:
Division of Medicaid
Surgery Authorizations
PO Box 83720
Boise, ID 83720-0009
Fax: 1 (877) 314-8779
Phone: 1 (208) 287-1148

Note
Molina is not an authorizing agency for any Medicaid services and does not issue PA.

2.13.5. Place of Service (POS) Code

ASC services can only be billed for in the following POS:
24 Ambulatory Surgical Center

If hospital based ASC please refer to the Hospital Provider Handbook.
Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

2.13.6. Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If Medicaid pays for the drug on a fee-for-service basis, and the prescription cannot be faxed, phoned, or electronically sent to the pharmacy, then providers must ensure that the prescription meets all three requirements for tamper-resistant paper.

Any written prescription presented to a pharmacy for a Medicaid participant must be written on a tamper-resistant prescription form that contains all of the following:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Note

The intent of this requirement is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.


2.14.1. Surgical Procedures

2.14.1.1. Abortions

Medicaid will only cover a legal therapeutic abortion in order to save the life of the mother or in cases involving rape or incest. The following documentation must be provided with your claim:

- In cases where an abortion is necessary to save the life of the woman, a licensed physician must certify in writing that the woman may die if the fetus is carried to term.
- In cases of rape or incest, the claim must include:
  - A copy of the court determination of rape or incest, or, where no court determination has been made, document that the rape or incest was reported to a law enforcement agency.
  - If the rape or incest was not reported to law enforcement, a licensed physician must certify in writing that, in the physician’s professional opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health, or
  - A licensed physician must certify in writing that the woman was under 18 years of age at the time of the sexual intercourse.

Note
All documentation concerning abortions must include the name and address of the woman. Additional information is available in the *Allopathic and Osteopathic, and the Hospital provider type guidelines*.

**2.14.1.2. Hospitalization**

Hospital charges for a therapeutic abortion are subject to the same restrictions as the physician’s charges. The physician should send a copy of the properly completed Certification of Necessity form to the hospital with the participant. The hospital is required to include a copy of the form with their claim.

**2.14.1.3. Exception for Presumptive Eligibility (PE) Participants**

Medicaid does not pay for any type of abortion for participants on the Presumptive Eligibility (PE) Program. In addition, PE participants are not covered for delivery services.

**2.14.1.4. Dilation and Curettage (D&C)**

All D&C procedures require documentation in the form of an operative report, emergency department report, or office notes. Please attach required documentation to claim for submission.

**2.14.1.5. Hysterectomy**

Prior approval from the QIO (Quality Improvement Organization), Qualis Health, must be obtained and the PA number included on the claim form in field 23 of the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Submit PA requests to:

**Qualis Health**
PO Box 33400
Seattle, WA 98133-0400
Fax: (800) 826-3836
Phone: (800) 783-9207

Medicaid pays for hysterectomies if the Authorization for Hysterectomy form is included with the claim. Outpatient hysterectomy claims are subject to Idaho Medicaid Medical Consultant review.

The Authorization for Hysterectomy form may be signed either before or after the surgery has been performed. If the form is signed after the surgery has been performed, the participant must sign a statement clearly stating that she was informed, both verbally and in writing, before the surgery was performed, that the hysterectomy would render her sterile.

**2.14.2. Dental Procedures**

Dental procedures performed in an ASC do not require PA. Use procedure code 41899 for all dental procedures performed in an ASC.
2.14.3. **Ambulatory Surgical Covered Services**

See the DHW Web site for a complete listing of approved ambulatory surgical CPT codes and payment levels.


2.15. **Clinic/Center – Rehabilitation, Substance Use Disorder**

2.15.1. **Overview**

The Rehabilitation, Substance Use Disorder Clinic Program is designed to promote overall mental wellness for Medicaid participants. In accordance with the Federal Code of Regulations 42 CFR 440.90, all Substance Use Disorder clinic services must be provided at the clinic, unless provided to an eligible homeless individual per regulations. Services provided outside of the clinic facility are not reimbursable by Medicaid. Clinic services are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services. Recreational, educational, and vocational services are not Medicaid-covered Substance Use Disorder clinic services.

2.15.1.1. **Provider Enrollment and Credentialing**

All existing Substance Use Disorder clinic providers must meet the requirements of the credentialing program on a schedule established by DHW.

All locations where Medicaid Substance Use Disorder clinic services are provided must be registered with DHW and must have a valid Provider Agreement. Substance Use Disorder clinics must obtain a provider number for each location where they provide services.

2.15.1.2. **Physician Requirement**

All Substance Use Disorder clinics must have a contract with a medical doctor or doctor of osteopathy in which the doctor agrees to perform the following:

- See each participant at least once annually in order to establish medical necessity for clinic services. See IDAPA 16.03.09.714.07.b Mental Health Clinic Services - Provider Agency Requirements: Physician Requirement for Supervision of a Participant's Care.
- Review and sign the treatment plan and all treatment plan updates. See IDAPA 16.03.09.714.07c-.d Mental Health Clinic Services - Provider Agency Requirements; Physician Requirement for Supervision of a Participant's Care and IDAPA 16.03.09.710.04 Mental Health Clinic Services – Written Individualized Treatment Plans.
- Provide overall clinic supervision, as indicated in IDAPA 16.03.09.714.06 Mental Health Clinic Services – Provider Agency Requirements; Physician Requirement for Clinic Supervision, and agree to spend as much time in the clinic as is necessary to assure that all participants are receiving services in a safe and efficient manner.

2.15.1.3. **Services**

Substance Use Disorder clinic services are provided by professionals who are trained to perform evaluation, diagnostic and treatment services to participants with a variety of Substance use needs. See *CMS 1500 Instructions*. 