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<td>Initial document – published version</td>
<td>5/7/10</td>
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2. Ambulatory Health Care Facilities

Outpatient behavioral health services (formerly mental health clinic, psychosocial rehabilitation, substance use disorder services, and service coordination for participants with mental illness) are provided under the Idaho Behavioral Health Plan. Optum Idaho is the managed care contractor who administers this program. Additional information can be obtained on their website at www.optumidaho.com.

This section covers Medicaid services provided by the following provider specialties:
- Adult Day Care (Health)
- Ambulatory Surgical Center (ASC)
- Diagnostic Screening Service
- Federally Qualified Health Center (FQHC)
- Indian Health Services (IHS)
- PW Clinic
- Rural Health Clinics (RHC)

2.1. Adult Day Care (Health)

See IDAPA 16.03.10.326.01 and 16.03.10.703.12.

Adult day care (health) is a supervised, structured service generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day care (health) services will not include room and board payments.

For DD waiver participants, adult day care (health) cannot exceed 30 hours per week, either alone or in combination with developmental therapy and occupational therapy.

Note: Adult day care (health) services are only covered for Medicaid Enhanced Plan participants who qualify for the A&D or DD waiver.

2.1.1. Adult Day Care (Health) Provider Qualifications

See IDAPA 16.03.10.329.10 and 16.03.10.705.13.

Providers of adult day care (health) must meet the following requirements.
- Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."
- Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Homes."
- Services provided in a residential adult living facility must be provided in a residential adult living facility that meets the standards identified in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho. (Note: Only participants on the A&D waiver may receive adult day care (health) in Residential Care or Assisted Living Facilities.)
- Adult day care (health) providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."
- Providers of adult day care (health) must notify the Department on behalf of the participant, if the adult day care (health) is provided in a Certified Family Home other than the participant's primary residence. The adult day care (health) provider must provide care and supervision appropriate to the participant’s needs as identified on the plan.
- Adult day care (health) providers who provide direct care or services must be free from communicable disease.
- For A&D waiver adult day care (health) providers only: all providers of adult day care (health) services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff.

**Note:** Any entity providing adult day care (health) services must be enrolled as a Medicaid Adult Day Care (Health) provider with a valid Medicaid Provider Agreement and a valid Medicaid Provider Agreement; Additional Terms – Adult Day Care (Health). Adult Day Care (Health) providers must meet all requirements identified in IDAPA 16.03.10.700-706 and IDAPA 16.03.10.320-330.

### 2.1.2. Adult Day Care (Health) Reimbursement

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<td>33 Custodial Care</td>
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<td>99 Other (Community)</td>
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See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook regarding billing, co-pays, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

See the [General Provider and Participant Information](#), Idaho Medicaid Provider Handbook for information on when billing a participant is allowable.

### 2.2. Diagnostic Clinic Services

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 diagnostic clinic must be established as a separate and distinct entity from the hospital, physician, or other provider practices.

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.

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).

### 2.3. Pregnant Women (PW) Clinic
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.

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<td>G9001</td>
<td>Coordinated care fee, initial rate</td>
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<tr>
<td>G9005</td>
<td>Coordinated care fee, risk adjusted maintenance</td>
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<tr>
<td>J9261</td>
<td>Injection, nelarabine, 50 mg</td>
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<tr>
<td>S9213</td>
<td>Home management of preeclampsia, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately); per diem (do not use this code with any home infusion per diem code)</td>
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<td>S9127</td>
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<td>S9470</td>
<td>Nutritional counseling, dietitian visit</td>
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<td>Nursing assessment/evaluation</td>
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<td>T1023</td>
<td>Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter</td>
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2.4. **Federally Qualified Health Center (FQHC)**

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.

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.

See the [IHS, FQHC and RHC Services](#) section for information about services and conditions.

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

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

2.5. **Indian Health Services (IHS)**

Indian Health Services are health services for Indians administered by the Indian Health Service within the Department of Health and Human Services. Medicaid reimburses IHS through an all-inclusive rate for each participant encounter. The all-inclusive rate for IHS is established by the Federal Office of Management and Budget as published annually in the Federal Register. IHS should always 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.
See the IHS, FQHC and RHC Services section for information about services and conditions.

### 2.5.1. Place of Service (POS)

Enter IHS code 5 in the POS field on the CMS 1500 claim form or in the appropriate field of the electronic claim form.

### 2.6. Rural Health Clinics (RHC)

A Rural Health Clinic is located in a rural area designated as a physician shortage area, and is neither a rehabilitation agency nor does it primarily provide for the care and treatment of mental diseases.

See the IHS, FQHC and RHC Services section for information about services and conditions. An RHC may also cover part-time or intermittent nursing care, and related medical services to a home bound individual, when an RHC located in an area with a shortage of home health agencies.

#### 2.6.1. Place of Service (POS)

Enter RHC code 72 in the POS field on the CMS 1500 claim form or in the appropriate field of the electronic claim form.

### 2.7. IHS, FQHC and RHC Services

All services provided by an IHS, FQHC or RHC 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 home health, hospice, a nursing home, or a hospital, etc. unless otherwise stated. Services that qualify as described in the Encounters section should be billed at the encounter rate.

#### 2.7.1. Participant Eligibility

Check eligibility to make sure the participant is eligible for Medicaid. If they are enrolled in Healthy Connections (HC), there are guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services. For more information refer to the General Provider and Participant Information, Idaho Medicaid Provider Handbook.

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

#### 2.7.2. Encounters

An encounter is defined as a face-to-face contact for the provision of medical, dental, or mental health services between a clinic patient and a physician (including a chiropractor or podiatrist), physician assistant, nurse practitioner, clinical social worker, clinical psychologist, other specialized nurse practitioner, or visiting nurse.

An encounter with more than one health professional, or multiple contacts with the same professional, in the same day, constitutes a single encounter. The exception is when a participant, subsequent to the first encounter, suffers an illness or injury that requires additional diagnosis and treatment and is supported by documentation. Qualifying additional encounters should be billed with Modifier 59.
**Incidental Services**

Services incidental to a billable medical encounter are as follows.

- In-house radiology
- Physical therapy
- Occupational therapy
- Speech therapy
- Audiology
- In-house laboratory services
- In-house nutritional education or 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 included in the encounter rate. If it is necessary for these services to be provided on a day when a qualifying encounter is not provided, the clinic must have the appropriate separate provider number to bill for those services.

Group visits are reimbursable as one encounter, but must include both components:

- Direct face-to-face visit with the patient
- Group education and/or discussion

Missed appointments, visits to pick up medication, or incidental services on the day of the encounter are not considered a separate encounter. Visiting nurse services are only covered when the facility 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.

If the facility 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.

### 2.7.3. Advance Directives

Medicaid has directed that providers of home health care (including FQHCs, RHCS, and IHS) must provide all adult Medicaid participants with advance directive information in an understandable format. See the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook section on Advance Care Planning for more information on requirements for this service.

### 2.7.4. Audiology Services

If audiology services are provided on the same day as an encounter, the service is considered part of the encounter. Audiology services provided on a day an encounter did not take place, the clinic must have a separate audiologist provider number and use audiology procedure codes. The reimbursement will be fee-for-service rather than an encounter rate. See the [Speech, Language, and Hearing](#), Idaho Medicaid Provider Handbook for more information about audiology services.

### 2.7.5. Dental Encounter

A dental encounter is a face-to-face contact for the provision of dental services between a participant and a dentist or dental hygienist. MCNA is the administrator for Idaho Smiles. For eligibility, benefits, and claims processing information, contact MCNA Customer Service at 1 (855) 235-6262, or at the [MCNA website](#).
Note: A participant’s identification number for both Idaho Smiles and Medicaid are the same. If a participant does not have an Idaho Smiles insurance card, they may use their Medicaid identification (MID) number.

2.7.6. Family Planning
All claims for services or supplies that are provided as part of a family planning must be billed with encounter code T1015 and the FP (Family Planning) modifier. Refer to the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook for more information about Family Planning services.

2.7.7. Home Health
Facilities are allowed to bill for home health visits as an encounter for participants that are homebound. See the Agency Institutional, Idaho Medicaid Provider Handbook for more information on home health services.

2.7.8. Laboratory Services
Laboratory services performed in the facility are included in the encounter visit and cannot be billed as a separate service to Medicaid. The exception is when an individual receives laboratory service on a day when there is no encounter billed for a clinic visit. These laboratory services may not be billed as an encounter. To bill for the lab services, the clinic must have a separate laboratory provider number or a separate group physician number, and use laboratory procedure codes. The reimbursement will be fee-for-service rather than an encounter rate.

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

2.7.9. Mental Health Services
Services included under the Idaho Behavioral Health Plan must be billed to Optum Idaho for these encounters. See www.optumidaho.com.

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.

2.7.10. 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. PCS are covered for Medicaid Enhanced Plan participants only. To enroll a PCS provider, contact the Regional Medicaid Services office in your area. See the Nursing Services, Idaho Medicaid Provider Handbook for more information.

2.7.11. Pharmacy
The clinic may not bill pharmaceutical services as an encounter. Pharmaceutical services for take home prescription medications are covered under the Medicaid Pharmacy Program. Claims must be submitted to Medicaid on the Idaho Pharmacy claim form under the pharmacy’s provider number. Over-the-counter (OTC) pharmaceuticals are not covered by Medicaid, with the exception of those OTC items identified as payable in the Idaho Medicaid

2.7.12. Physician and Non-Physician Practitioner Services
See the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook for details about services and requirements including, but not limited to, obstetrics, surgery, and wellness examinations.

2.7.13. Radiology
If radiology services are provided on the same day as an encounter, the service is considered part of the encounter. The exception is when an individual receives radiology services on a day when there is no encounter billed. These radiology services may not be billed as an encounter. To bill for the radiology services, the clinic must have a separate provider number and bill using the correct CPT codes. See the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook for more information.

2.7.14. Telehealth Services
Telehealth services provided as an encounter by a facility are reimbursable if the services are delivered in accordance with the Idaho Medicaid Telehealth Policy and applicable handbooks. See the General Participant and Provider, Idaho Medicaid Provider Handbook for more information about eligible services and billing requirements.

2.7.15. Vision Services
Services provided by an ophthalmologist are billable as an encounter. However, vision exams provided by other providers such as optometrists must be billed under a vision service provider number. See the Eye and Vision Services, Idaho Medicaid Provider Handbook for more information.

2.7.16. Reimbursement
Bill the encounter (T1015) with the appropriate rate charge on the first detail line, and then list all the appropriate CPT/HCPCS services provided during the encounter priced at $0 on subsequent lines.

See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding billing, co-pays, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

See the General Provider and Participant Information, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable.

2.8. Ambulatory Surgical Center (ASC)
This section addresses Medicaid covered services provided in an independent or stand-alone Ambulatory Surgical Center (ASC).

2.8.1. Covered Services
Services in an ASC facility require a Healthy Connections (HC) referral with the exception of dental procedures. See General Provider and Participant Information, Idaho Medicaid Provider Handbook Healthy Connections (HC), for more information.
ASC facility services generally include the following.
- Use of the ASC facility.
- Nursing care, technicians, and related services.
- Drugs, biologicals, surgical dressings, supplies, splints, casts, certain 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 which provide a biomedical function which are not routine supplies that are ordinarily included in the procedure, may be billed in addition to the ASC 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. 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. If you have questions about whether additional codes can be billed separately or require PA, please contact the DME Unit at 1 (866) 205-7403.

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 not approved by the Department to be reimbursed to an ASC.

### 2.8.2. Prior Authorization (PA)

Submit PA requests with appropriate documentation to the following address/fax.

Division of Medicaid
Surgery Authorizations
PO Box 83720
Boise, ID 83720-0009

Fax: 1 (877) 314-8779
Phone: 1 (866) 205-7403

*Molina is not an authorizing agency for any Medicaid services and does not issue PAs.*

### 2.8.3. Place of Service (POS) Code

ASC services can only be billed with the following POS:

24 Ambulatory Surgical Center
If hospital-based ASC please refer to the Hospital section of the Provider Handbook.

Enter this information in field 24B on the CMS 1500 claim form, or in the appropriate field of the electronic claim form.

### 2.8.4. Dental Procedures

Dental procedures performed in an ASC do not require PA. Use procedure code 41899 for all dental procedures performed in an ASC.

### 2.8.5. Ambulatory Surgical Covered Services


### 2.8.6. Reimbursement

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 16.03.09.450 - 499 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, ten times, with use of the appropriate modifier.

Medicaid payments 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.

See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding billing, co-pays, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

See the General Provider and Participant Information, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable.