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Ambulatory Surgical Centers

This chapter of the Idaho Medicaid Provider Handbook describes Medicaid-covered services provided by ambulatory surgical centers (ASC) and hospitals with an ASC. Services must be within the scope of practice, licensure and training of the provider rendering them.

Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Handbook chapters which always apply to this provider type include the following:

- General Billing Instructions;
- General Information and Requirements for Providers; and
- Glossary.

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3.a The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3.a.

References are included throughout the handbook for provider and staff convenience. Not all applicable references have been incorporated into the handbook. Not all references provided are equal in weight.

- Case Law: Includes references to court cases that established interpretations of law that states and providers would be required to follow.
- CMS Guidance: These references reflect various Centers for Medicare and Medicaid Services (CMS) publications that Idaho Medicaid reviewed in the formulation of their policy. The publications themselves are not required to be followed for Idaho Medicaid services.
- Federal Regulations: These references are regulations from the federal level that affected policy development. Usually these include the Code of Federal Regulations, the Social Security Act and other statutes. They are required to be followed.
- Idaho Medicaid Publications: These are communications from Idaho Medicaid to providers that were required to be followed when published. These are included in the handbook for historical reference. The provider handbook supersedes other communications unless the documents are listed in the Department's Rules, Statutes, and Policies webpage under policies in Medicaid's department library.
- Idaho State Plan: The State Plan is the agreement between the State of Idaho and the Centers for Medicare and Medicaid Services on how the State will administer its medical assistance program.
- Professional Organizations: These references reflect various publications of professional organizations that Idaho Medicaid reviewed in the formulation of their policy. Providers may or may not be required to follow these references, depending on the individual reference and its application to a provider's licensure and scope of practice.
- Scholarly Work: These references are publications that Idaho Medicaid reviewed in the formulation of their policy. The publications themselves are not required to be followed for Idaho Medicaid services.

- State Regulations: These references are regulations from the state level that affected policy development. They usually include statute and IDAPA. They are required to be followed.

1. Important Contacts

The Directory, Idaho Medicaid Provider Handbook contains a comprehensive list of contacts. The following contacts are presented here for provider convenience.

1.1. Gainwell Technologies

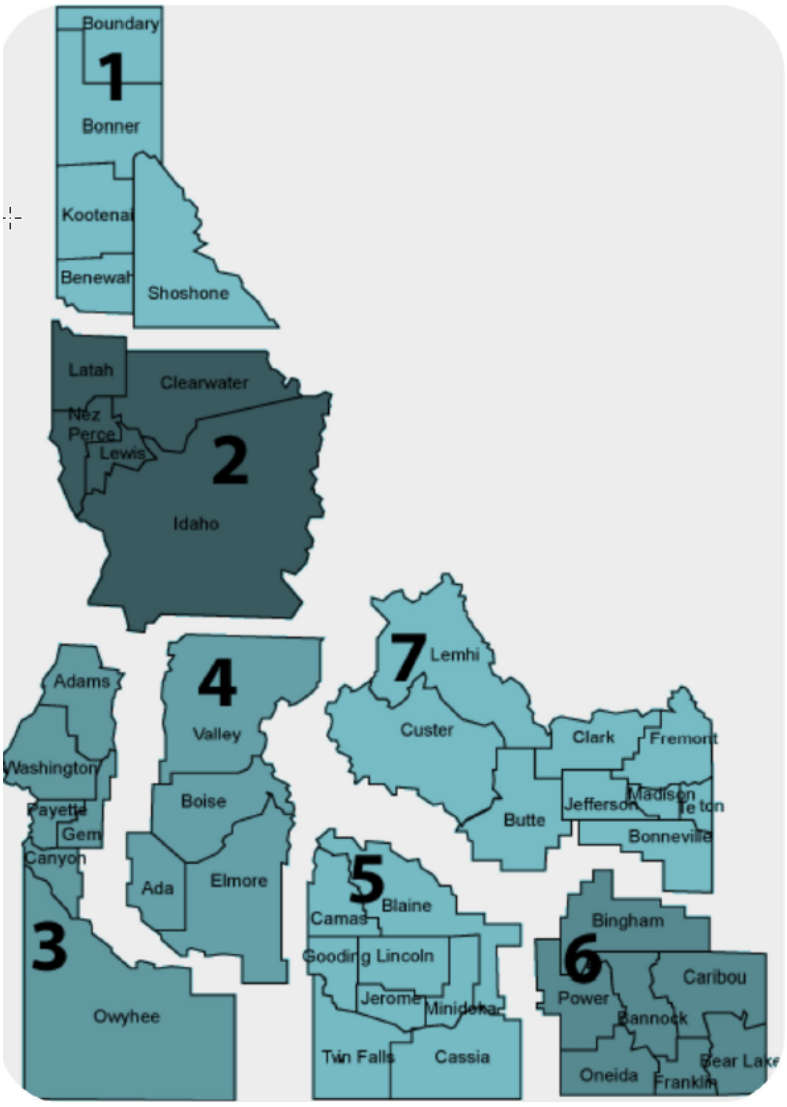
Gainwell Technologies is Idaho Medicaid's fiscal agent that handles all claims processing and customer service issues.

Gainwell Technologies Contact Information
Gainwell Technology Provider Services P.O. Box 70082 Boise, ID 83707 Phone: 1 (888) 686-4272 Fax: 1 (877) 661-0974 IDProviderServices@gainwelltechnologies.com The Medicaid Automated Call Service (MACS) is available 24 hours a day, seven days a week. Provider service representatives are available Monday through Friday, 7:00 A.M.-7:00 P.M. MT.
Provider Enrollment P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2041 IDProviderEnrollment@gainwelltechnologies.com
Technical Services Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2040 IDEDISupport@gainwelltechnologies.com

1.2. Provider Relations Consultants

Gainwell Technologies Provider Relations Consultants help keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid. Provider Relations Consultants accomplish this by:

- Conducting provider workshops;
- Conducting live meetings for training;
- Visiting a provider's site to conduct training; and
- Assisting providers with electronic claims submission



Region 1 and the state of Washington
1 (208) 202-5735
Region.1@gainwelltechnologies.com

Region 2 and the state of Montana
1 (208) 202-5736
Region.2@gainwelltechnologies.com

Region 3 and the state of Oregon
1 (208) 202-5816
Region.3@gainwelltechnologies.com

Region 4
1 (208) 202-5843
Region.4@gainwelltechnologies.com

Region 5 and the state of Nevada
1 (208) 202-5963
Region.5@gainwelltechnologies.com

Region 6 and the state of Utah
1 (208) 593-7759
Region.6@gainwelltechnologies.com

Region 7 and the state of Wyoming
1 (208) 609-5062
Region.7@gainwelltechnologies.com

Region 9 all other states (not bordering Idaho)
1 (208) 609-5115
Region.9@gainwelltechnologies.com

1.3. Medicaid

The Medical Care Unit is Idaho Medicaid's team that reviews prior authorizations for some surgical procedures as listed on the Numerical Fee Schedule.

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009
Phone 1 (866) 205-7403
MedicalCareUnit@dhw.idaho.gov

The status of a prior authorization request submitted to the Medical Care Unit may be checked online at the Gainwell Technologies portal under "Authorization Status", using your NPI. If you have questions on a Denial, click on the Notes, which will explain the reason for the Denial.

1.4. Telligen, Inc.

Telligen, Inc. is Idaho Medicaid's quality improvement organization (QIO) that reviews prior authorization requests for some services and surgical procedures as listed on the Numerical Fee Schedule or when a prior authorization would otherwise be indicated.

Telligen
670 E Riverpark Ln. Suite 120
Boise, ID 83706
Phone: 1 (866) 538-9510
E-mail: idmedicaidsupport@telligen.com

2. Provider Qualifications

An ambulatory surgical center (ASC) is a distinct entity, which exclusively provides surgical services to patients not requiring hospitalization. ASCs in any state are eligible to participate in the Idaho Medicaid Program. They must be surveyed by the Bureau of Facility Standards or the equivalent in the state where the services are performed. ASCs must have a National Provider Identification (NPI).

A Medicare certificate is required for enrollment and the name on the certification must match the provider. ASCs are required to have their site credentialed. Should the provider have a change of address they must complete and submit a new W9 that reflects the new address, a new provider agreement and proof of the new site being credentialed.

Providers that lose their Medicare certification or have conditions identified as a threat to the safety of participants are grounds for revocation of their provider agreement.

ASCs must enroll as an Idaho Medicaid provider prior to submitting claims for services. See *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.1.1. References: Provider Qualifications

(a) Federal Regulations

"General Conditions and Requirements." 42 C.F.R. 416, Subpart B (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol3/pdf/CFR-2019-title42-vol3-part416-subpartB.pdf.

"Specific Conditions for Coverage." 42 C.F.R. 416, Subpart C (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol3/pdf/CFR-2019-title42-vol3-part416-subpartC.pdf.

(b) State Regulations

"Ambulatory Surgical Center (ASC)." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 010.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Ambulatory Surgical Center Services: Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 454. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.2. Hospital-Owned Centers

Ambulatory surgical centers (ASC) owned or operated by a hospital may qualify to enroll as an ASC if they are:

- Enrolled with Medicare under a separate agreement from the hospital;
- Administratively, financially and physically independent from the hospital;
- Not including ASC costs on the hospital's cost reports; and
- In agreement to be subject to the same requirements as independent ASCs.

ASCs that do not meet these conditions are treated as outpatient departments of the hospital and shall bill accordingly.

2.2.1. References: Hospital-Owned Centers

(a) CMS Guidance

"Ambulatory Surgical Center Payment System." *MLN Booklet 006819, March 2020,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AmbSurgCtrFeepymtfctsht508-09.pdf.

3. Eligible Participants

Participants with Medicaid Basic and Enhanced Plans are eligible to receive ambulatory surgical center (ASC) services. ASC services are not available for incarcerated participants or otherwise ineligible non-citizens. When billing for participants enrolled in other eligibility segments, refer to General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for coverage. Providers must check participant eligibility prior to delivery of the service by calling MACS at 1 (866) 686-4272; or through the trading partner account on the Idaho Gainwell Technology Medicaid website.

3.1. Referrals

Services in an ASC facility require a Healthy Connections (HC) referral with the exception of dental procedures. See *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook *Healthy Connections (HC),* for more information.

4. Covered Services and Limitations

The services of an ambulatory surgical center (ASC) are a covered benefit under Idaho Medicaid. Covered services are indicated on the Idaho Medicaid Numerical Fee Schedule with a reimbursement amount. Amounts of $0.00 are covered and require manual pricing per the General Billing Instructions, Idaho Medicaid Provider Handbook. Services must meet the criteria for the procedure found in the Physician and Non-Physician Practitioner and Hospital, Idaho Medicaid Provider Handbooks. Certain procedures must be prior authorized to be covered in an ASC. See the Prior Authorizations section for more information.

Idaho Medicaid may cover any procedure designated for ASCs by the Medicare program in addition to procedures that the Department determines meet the following criteria:

- Does not pose a significant safety risk if performed in an ASC;
- Standard medical practice would not usually require active medical monitoring and care at the midnight census hour;
- Does not result in extensive blood loss;
- Does not require major or prolonged invasion of the body's cavities;
- Does not directly involve major blood vessels;
- Would not be emergent or life threatening;
- Does not commonly require systemic thrombolytic therapy;
- Are not considered inpatient only services by CMS;
- Are not excluded from coverage by the Medicare program; and
- Are not reported with an unlisted CPT® code.

The following services are non-covered when provided by an ASC:

- Laboratory services, x-ray, or diagnostic procedures, other than those directly related to the performance of the surgical procedure;
- Non-implantable prosthetic and orthotic devices;
- Ambulance services;
- Durable medical equipment and supplies for use in the participant's home; and
- Any other service not explicitly covered in this handbook.

4.1.1. References: Covered Services and Limitations

(a) Federal Regulations

"General Conditions and Requirements." 42 C.F.R. 416.164 (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol3/pdf/CFR-2019-title42-vol3-sec416-164.pdf.

"Specific Conditions for Coverage." 42 C.F.R. 416.166 (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol3/pdf/CFR-2019-title42-vol3-sec416-166.pdf.

(b) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Ambulatory Surgical Center Services: Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 452. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.2. Provider Preventable Conditions

Idaho Medicaid is prohibited from reimbursing providers for provider preventable conditions including:

- Wrong Surgical or other invasive procedure performed on a patient;
- Surgical or other invasive procedure performed on the wrong body part;
- Surgical or other invasive procedure performed on the wrong patient; and
- Any service addressing the consequence of a provider preventable condition unless the condition was pre-existing before the provider assumed care of the participant.

Any provider involved in the procedure, including the site of service, are not eligible for reimbursement and cannot bill the participant for their services. Providers are required to append the appropriate modifier below to any claim line that represents services for a provider preventable condition or its consequences with the exception of pre-existing consequences for providers new to the participant.

Provider Preventable Condition Modifiers	
Modifier	**Description**
PA	Surgical or other invasive procedure on wrong body part.
PB	Surgical or other invasive procedure on wrong patient.
PC	Wrong surgery or other invasive procedure on patient.

4.2.1. References: Covered Services and Limitations

(a) Federal Regulations

"Payment Adjustment for Health Care-Acquired Conditions." H.R. 3590, "The Patient Protection and Affordable Care Act," Sec. 2702. Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

"Prohibition on Payment for Provider-Preventable Conditions." 42 C.F.R. 447.26 (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec447-26.pdf.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(4) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

(b) Idaho Medicaid Publications

"Payment Reduction for Provider-Preventable Conditions." *MedicAide Newsletter,* December 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202012%20MedicAide.pdf.

(c) Idaho State Plan

"Attachment Page 4.19B – Other Provider Preventable Conditions (OPPCs)." State Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Payment Adjustment for Provider Preventable Conditions." State Plan, Attachment 4.19-A. Division of Medicaid, Department of Health and Welfare, State of Idaho.

4.3. Dental Procedures

Effective May 1, 2023, the Department will require ambulatory surgical centers (ASC) to bill for dental procedures not represented by a CPT® code with the appropriate codes from the American Dental Association's® Code on Dental Procedures and Nomenclature (CDT) code set that represent the services provided. Services must be medically necessary and meet all other requirements to be eligible for reimbursement.

Some services may have limitations that require a prior authorization if the amount is exceeded. Prior authorizations for dental services are requested through Idaho Smiles, administered by MCNA Dental. Please, call 1 (855) 235-6262 or visit the Idaho Smiles website for more information.

Codes that always require a prior authorization by Idaho Smiles, regardless of amount, do not require the ASC to directly obtain an authorization. However, to be eligible for reimbursement, the ASCs are required to verify the provider performing the procedure has an approved prior authorization. If no prior authorization was obtained for a procedure requiring one, neither the dental provider or the ASC are eligible for reimbursement. An exception is made for emergency procedures where exigent circumstances made obtaining a prior authorization impossible. The facility must document the situation in the participant's file.

4.3.1. References: Dental Procedures

(a) Idaho Medicaid Publications

Dental Services by Ambulatory Surgical Centers, *Information Release MA23-08* (4/4/2023). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

(b) State Regulations

"Ambulatory Surgical Center Services: Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 452. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.4. Corneal tissue

Processing, preserving, and transporting corneal tissue (HCPCS V2785) is a covered benefit when the ambulatory surgical center purchases the tissue. Invoice for the purchase of the corneal tissue must be included with the CMS 1500 claim form.

4.4.1. CMS Guidance

"Ambulatory Surgical Center Payment System." *MLN Booklet 006819, March 2020,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AmbSurgCtrFeepymtfctsht508-09.pdf.

5. Prior Authorizations

A prior authorization (PA) is a written, faxed or electronic approval from the Department or its designee that permits payment or coverage of an item or service that is only covered by such an authorization. Some items and services always require a PA, but others may only require a PA under these circumstances:

- The participant has exhausted their benefit;
- The participant does not meet the established criteria, but can demonstrate a medical need; or
- The participant has an alternative benefit such as EPSDT or waiver that can only be accessed through a prior authorization.

Items and services that require a PA must receive approval before they can be delivered to the participant except as otherwise noted. It is the provider's responsibility to verify the participant's eligibility on the date of service and to request any required PA. PA requirements specific to a service or item are listed throughout the handbook for the provider's convenience. For information regarding if a prior authorization is required, providers can:

- Check participant eligibility and PA requirements through your Trading Partner Account at www.idmedicaid.com; and
- Check the Idaho Medicaid Numerical Fee Schedule available online for items that always require a PA and the authorizing entity.

Participants with Medicare as their primary insurance do not require a PA from Idaho Medicaid for Medicare approved items and services. Participants with a different primary payor, or a participant with Medicare receiving services non-covered by Medicare, do require a PA from Idaho Medicaid as if they were Medicaid only participants.

A request for a PA or an approved authorization for services does not guarantee payment. All other Department requirements must be fulfilled. Authorizations only confirm medical necessity criteria for the item or service based on the documentation submitted. The Department's review of prior authorizations includes general criteria requirements in addition to any item specific criteria. They do not review if a provider or place of service is appropriate or any other considerations. Reimbursement is dependent on the participant being eligible on the date authorized services are rendered and the request must meet any other requirements such as:

- Meet medical necessity as established in section 011 or 880 of IDAPA 16.03.09, "Medicaid Basic Plan Benefits";
- Meet all policy requirements;
- Be appropriate and effective treatment for the participant's current medical condition;
- Be furnished by providers with the appropriate credentials;
- Be the most cost-effective method of meeting the participant's medical needs; and
- Meet all federal and state regulations.

Medicaid issues a written notification of authorization or denial for all written requests for PA. Participants will receive a mailed notice of decision with information on their appeal rights and how to request a hearing if they disagree with the Department's decision. Providers receive notifications based on their profile's preferences. If the participant or provider disagrees with the Department's decision they can consider requesting a reconsideration or file an appeal.

Approved authorizations are valid only for the period between the start and stop dates. If the service is going to be delivered outside of the approved dates, a new PA request must be

submitted. Requests should be made before the expiration of the previous request to avoid breaks in care.

When authorized services or items are billed, PA numbers must be included on the appropriate claim line. Effective May 1, 2014, the claim line will be denied if the PA number is not present. Claims for inpatient services must have the prior authorization number on the header or each claim line, or the claim will deny. Some authorizations may also include modifiers as part of the approval. If the modifier listed in the authorization is missing from the claim line it will deny. The PA number and any required modifier are found on the paper Notice of Decision (NOD) letter or online through the Trading Partner Account (TPA) under View Authorizations.

Payment will be denied for any medical item or service that requires a PA from Idaho Medicaid's designated authorizing entity, but the item or service was provided prior to obtaining authorization. An exception may be allowed on a case-by-case basis in which, despite efforts on the part of the provider to submit a timely request or due to events beyond the control of the provider, PA was not obtained; e.g., a hospital discharge outside of business hours, etc. An explanation of the delay in submission must accompany the PA request and be submitted to the Department with any supporting documentation and a request for an exception. In addition, the provider may not bill the Medicaid participant for services not reimbursed by Medicaid because the PA was not obtained in a timely manner or because the provider failed to verify that a PA was required.

If an individual was not eligible for Medicaid at the time items requiring a PA were provided but was subsequently found eligible pursuant to *IDAPA 16.03.05.051.03,* a request must be submitted with all required documentation within 30 days of the date the provider became aware of the individual's Medicaid eligibility. The medical item or service will be reviewed by the Department retroactively using the same medical necessity guidelines that apply to other prior authorization requests. If approved, the provider should refund to the participant any amount previously collected for the item or service.

See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on billing prior authorized services.

5.1.1. References: Prior Authorizations

(a) Federal Regulations

Excessive Claims or Furnishing of Unnecessary or Substandard Items and Services, 42 CFR 1001.701 (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec1001-701.pdf.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(10)(d) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

Sufficiency of Amount, Duration, and Scope, 42 CFR 440.230(d) (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec440-230.pdf.

(b) Idaho Medicaid Publications

"Modifiers and Prior Authorization (PA)." *MedicAide Newsletter, October 2015*, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202015%20MedicAide.pdf.

"Prior Authorization Number on Claims." *MedicAide Newsletter, February 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202014%20MedicAide.pdf.

5.2. The Medical Care Unit

Prior authorization requests will be rejected if there is no clear indication that a prior authorization is required. Providers should note the reason for the request on the form if the item or service does not always require a prior authorization. Idaho Medicaid request forms are available at www.idmedicaid.com or by calling Provider Services at 1 (866) 686-4272 to request a paper copy.

The Medical Care Unit is Idaho Medicaid's team that reviews prior authorization requests for some services and surgical procedures as listed on the Numerical Fee Schedule or when a prior authorization would otherwise be indicated. Prior authorizations must be submitted on the correct form with documentation supporting the request, and any additional items within the item specific criteria. Requests for codes that do not have a price on file on the Idaho Medicaid Numerical Fee Schedule must include pricing documentation with their request. See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding acceptable documentation for manually priced goods and services.

The Medical Care Unit does not accept requests via phone or e-mail. Submit complete requests by the trading partner account, postal mail or fax to:

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009
Fax 1 (877) 314-8779

Medicaid staff may request additional documentation to establish medical necessity for the item. The requested documentation must be received by the Medical Care Unit within two working days or the request may be denied.

The status of a prior authorization request submitted to the Medical Care Unit may be checked online at the Gainwell Technologies portal under "Authorization Status", using your NPI. If you have questions on a Denial, click on the Notes, which will explain the reason for the Denial. A notice of decision will be mailed to the participant once the review is complete.

Modifications, including transfers to another provider, may be requested via the trading partner account or by faxing the request form with the prior authorization number, requested change and justification to 1 (877) 314-8779. Include any additional documentation if the change is not supported by the original submission. Requests from a provider other than the original requestor must have documentation from the participant or their legal guardian approving the change otherwise a new prior authorization is required.

5.3. Telligen, Inc.

Telligen, Inc. is Idaho Medicaid's quality improvement organization (QIO) that reviews Prior Authorization requests for some services and surgical procedures as listed on the Numerical Fee Schedule or when a prior authorization would otherwise be indicated. Prior authorization requests will be rejected if there is no clear indication that a prior authorization is required. Providers should note the reason for the request in the notes section if the service does not always require a prior authorization. All prior authorization requests must use the Telligen Qualitrac provider portal. To apply for access to the Telligen Portal please fill out the registration packet located in the document library on the Telligen site.

Prior authorization requests must be submitted with a detailed written physician or non-physician practitioner's order, and the items listed in the Documentation Requirements subsection, and any additional items within the service specific criteria. Requests for codes that do not have a price on file on the Idaho Medicaid Numerical Fee Schedule must include pricing documentation with their request. See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding acceptable documentation for manually priced goods and services. Incomplete or incorrectly filled out prior authorization requests will be denied for improper documentation.

Telligen staff may request additional documentation to establish medical necessity for the item. The requested documentation must be received by Telligen within two working days, or the request may be denied.

Authorizations are usually completed within ten business days, but complex requests may require additional time.

See the QIO Provider Manual for information about requesting prior authorizations from the QIO, Telligen.

5.3.1. References: Telligen, Inc.

(a) Idaho Medicaid Publications

"Changes to QIO Prior Authorization and Post Payment Review Submission Procedures." *MedicAide Newsletter, June 2023*, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202023%20MedicAide.pdf.

5.4. Modifying a Prior Authorization

Modifications may be requested by contacting the issuer of the prior authorization, the Medical Care Unit or Telligen, with the prior authorization number, requested change and justification. Submit any additional documentation if the change is not supported by the original submission.

5.5. Status of a Prior Authorization

The status of a prior authorization request through Telligen may be checked online at the provider portal, or by contacting Telligen, Inc. customer service at 1 (866) 538-9510.

A completed prior authorization request's status is available online at the Gainwell Technologies portal under "Authorization Status", using your NPI. A notice of decision will be mailed to the participant once the review is complete. If you have questions on a Denial, click on the Notes, which will explain the reason for the Denial.

5.6. Prior Authorization Reconsiderations

Providers should request reconsiderations of a prior authorization (PA) decision when requests are denied for being incomplete, extenuating circumstances should be considered, or additional documentation is being submitted to support medical necessity. Reconsiderations shall be requested within 28 days of the Department's decision. Providers must include the PA number on the request for it to be considered with previous documentation. If the PA number is not provided, a denial may be issued for an incomplete request. Reconsiderations are submitted to the same reviewer as the original request.

Upon completion of the reconsideration review, Medicaid or its designee will issue a second Notice of Decision for Medical Benefits. If the provider or participant disagrees with the PA reconsideration decision made by Medicaid or its designee, they may file a Request for Appeal. The provider or participant has 28 days from the mailing date of the second Notice of Decision for Medical Benefits to submit a formal appeal.

5.7. Prior Authorization Appeals

Providers and participants may appeal a prior authorization (PA) decision made by Medicaid or its designee, by sending a request in writing. Appeals are for when there is a disagreement about the decision made based on documentation already provided. Appeals should not be used to submit new documentation for consideration. Participants and Providers should use the Prior Authorization Reconsideration process if they have additional details that may change the Department's decision.

Appeals are requested by submitting a cover letter detailing why the formal appeal is requested and including a copy of the PA denial letter. Appeals are sent to:

Division of Medicaid
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036
Fax: 1 (208) 364-1811
MedicaidAppeals@dhw.idaho.gov

5.7.1. References: Prior Authorization Appeals

(a) State Regulations

Appeal and Fair Hearing, Idaho Code 56-216 (1941). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-216/.

Board — Composition — Officers — Compensation — Powers — Subpoena — Depositions — Review — Rules, Idaho Code 56-1005(6) (2009). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH10/SECT56-1005/.

Board — Composition — Officers — Compensation — Powers — Subpoena — Depositions — Review — Rules, Idaho Code 56-1005(7) (2009). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH10/SECT56-1005/.

"Burden of Proof – Provider Cases." IDAPA 16.05.03, *"Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160503.pdf.

Contested Cases, Idaho Code 67-5240 (1992). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title67/T67CH52/SECT67-5240/.

"Department Responsibility." IDAPA 16.05.03, *"Contested Case Proceedings and Declaratory Rulings,"* Sec. 100. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160503.pdf.

Exhaustion of Administrative Remedies, Idaho Code 67-5271 (1992). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title67/T67CH52/SECT67-5271/.

"Filing of Appeals." IDAPA 16.05.03, *"Contested Case Proceedings and Declaratory Rulings,"* Sec. 101. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160503.pdf.

Right of Review, Idaho Code 67-5270 (1992). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title67/T67CH52/SECT67-5270/.

5.8. Transferring a Prior Authorization

Participants have the right to a provider of their choice and may change that provider at any time. The initial prior authorization (PA) does not automatically transfer if the participant chooses a new provider. The participant, parent or guardian is required to contact the issuer of the prior authorization, the Medical Care Unit or Telligen, verbally or in writing of their intent to change providers. Supporting documentation is not necessary to transfer an existing PA.

6. Documentation Requirements

All documentation must follow standard retention requirements including, but not limited to, those listed in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

Documentation must be made available to Department personnel acting in their official capacity immediately upon request. Services without documentation are not eligible for reimbursement. Providers should only submit records requested by the Department. Documentation sent unsolicited, or not for a service requiring prior authorization, will not be reviewed by the Department. Unreviewed documentation does not constitute approval or authorization of a service.

6.1.1. References: Documentation Requirements

(a) State Regulations

"Review of Records." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 230.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

7. Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Idaho Medicaid reimburses medically necessary services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance listed in the Numerical Fee Schedule. Effective July 1, 2020, rates for ambulatory surgical centers (ASC) are initially set for codes at 90% of the Medicare fee schedule when the code becomes covered by Idaho Medicaid, if a Medicare amount is available. ASCs are paid up to 100 percent of the established rate on the fee schedule for the first covered procedure and 50 percent for any remaining covered procedures.

Codes covered for ASCs are listed with an amount in the ASC Allowed Amount of the Numerical Fee Schedule. ASCs must bill using the same codes for the procedures used by the performing physician or dentist. ASC claims may only be billed with the POS 24: Ambulatory Surgical Center. Reimbursement for ASC services include a package rate for the procedure performed, which includes all of the following services:

- 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 that are not allowed separate payment under Medicare OPPS;
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure that are not allowed separate payment under Medicare OPPS;
- Administration, record keeping, and housekeeping items and services; and
- Materials for anesthesia.

C-Codes are temporary codes for the outpatient prospective payment system (OPPS) used by Medicare. The OPPS payment method is not utilized by Idaho Medicaid. However, Idaho Medicaid has adopted C-codes to support providers required to use the OPPS methodology and decrease incidents of split billing.

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 procedures 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.

Physician and Non-physician practitioner services must be separately billed by those providers using their NPI. An ASC cannot bill for their professional services.

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

See the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-pays.

7.1.1. References: Reimbursement

(a) CMS Guidance

"Ambulatory Surgical Center Payment System." *MLN Booklet 006819, March 2020,* Centers for Medicare and Medicaid Services, Department of Health and Human Services,

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AmbSurgCtrFeepymtfctsht508-09.pdf.

(b) Federal Regulations

"General Conditions and Requirements." 42 C.F.R. 416.164 (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol3/pdf/CFR-2019-title42-vol3-sec416-164.pdf.

(c) Idaho Medicaid Publications

"Changes to ASC Payment Methodology." *MedicAide Newsletter,* June 2020, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202020%20MedicAide.pdf.

"Medicaid Coverage of C-Codes." MedicAide Newsletter, February 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202018%20MedicAide.pdf.

"**Medicaid Program Integrity:** Ambulatory Surgical Centers." *MedicAide Newsletter,* August 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202018%20MedicAide.pdf .

(d) State Regulations

"Ambulatory Surgical Center Services: Provider Reimbursement." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 455. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Appropriations – Health and Welfare – Medicaid. S.B. 1418 (2020). Idaho State Legislature, https://legislature.idaho.gov/sessioninfo/2020/legislation/S1418/.

"General Payment Procedures." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 230. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Provider Payment, Idaho Code 56-265 (2020). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265/.

Appendix A. Ambulatory Surgical Centers, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date.

Ambulatory Surgical Centers, Provider Handbook Modifications				
Version	**Section**	**Update**	**Publish Date**	**SME**
6.0	All	Published version	8/16/2023	TQD
5.9	7. Reimbursement	Clarified use of fee schedule.	8/3/2023	W Deseron T Kinne
5.8	5.8. Transferring a Prior Authorization	New section.	8/3/2023	W Deseron T Kinne
5.7	5.5. Status of a Prior Authorization	New section.	8/3/2023	W Deseron T Kinne
5.6	5.4. Modifying a Prior Authorization	New section.	8/3/2023	W Deseron T Kinne
5.5	5.3. Telligen, Inc.	Clarified process.	8/3/2023	W Deseron T Kinne
5.4	5.2. The Medical Care Unit	Clarified process.	8/3/2023	W Deseron T Kinne
5.3	5. Prior Authorizations	Clarified process.	8/3/2023	W Deseron T Kinne
5.2	4.3. Dental Procedures	Incorporated latest information release's instructions.	8/3/2023	W Deseron T Kinne
5.1	1.4. Telligen, Inc.	Updated Telligen's information and scope.	8/3/2023	W Deseron T Kinne
5.0	All	Published version	11/18/2022	TQD
4.1	1.2 Provider Relations Consultants	Updated contact phone numbers for PRCs	11/18/2022	A Boparai M Payne J Kennedy-King
4.0	All	Published version	6/17/2022	TQD
3.1	1.2 Provider Relations Consultants	Updated to add Region 9 contact information	6/14/2022	G Branscum M Payne J Kennedy-King
3.0	All	Published version	4/5/2022	TQD
2.1	5.5. Prior Authorization Appeals	Removed 3232 Elder Street address due to permanent closure of building.	4/5/2022	M Payne E Garibovic
2.0	All	Published version	3/5/2021	TQD
1.0	All	Initial document – Published version	3/2/2021	W Deseron E Garibovic