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1. Section Modifications

Version	Section/Column	Modification Description	Date	SME
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32.1	9.1 Overview	Added statement regarding cost centers	2/1/2017	T Lombard D Baker E Garibovic
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31.1	11.5.3 Multiple Runs in One Day	Section rewrite	11/17/2016	W Deseron E Garibovic
31.0	All	Published version	11/3/2016	TQD
30.1	4.8.1 Limitations	Added sentence re: semiprivate room revenue codes	11/3/2016	C Lord D Baker
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29.1	4.9 Psychiatric Hospital 4.9.1 Participants under the Age of 21 4.10.2 Pregnancy Services 4.10.3 Split Billing 5.3 Outpatient Observation 6.1 Overview [PA] 6.1.1 Quality Improvement Organization (QIO) 6.6 Admission for Substance Abuse 6.7 Cesarean Section 6.10 Retrospective/Late QIO Reviews 6.11 Contacting the QIO 6.12 Medical Care Unit Prior Authorization 8.3 Bariatric Surgery for Weight Loss 8.4 Transplants	Updated QIO information due to vendor change	8/31/2016	D Boyle D Baker
29.0	All	Published version	5/29/2016	TQD
28.2	8.4 Transplants	Added lung	5/19/2016	R Natal D Baker
28.1	7.2 Prior Authorization (PA)	Updated link to AND Form	5/19/2016	D Baker
28.0	All	Published version	4/25/2016	TQD
27.1	4.10.5. Donor/Transplants	Add lung to the donor list, delete sentence concerning participants under age 21	4/25/2016	E Garibovic
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26.2	4.4.1 Present on Admission (POA) Indicators	Updated section/ deleted content	2/11/2016	D Baker J Kennedy
26.1	4.4 Health Acquired Conditions	Content deleted, CMS referral content added, Bill type content updated	2/11/2016	D Baker J Kennedy
26.0	All	Published Version	1/22/2016	TQD
25.5	8.8 Telehealth	Updated with new content	1/22/2015	C Brock D Baker C Loveless
25.4	6.1.1 Qualis Health	Removed reference to Health Home	1/22/2016	C Brock D Baker C Loveless
25.3	5.7.4 Durable Medical Equipment – Hearing Aids	New section	1/22/2016	J Siroky D Baker C Loveless
25.2	5.7.3 Healthy Connections (HC) Referral	Updated to align with PCCM changes	1/22/2016	C Brock D Baker C Loveless

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25.1	4.7 Durable Medical Equipment	Made specific to hearing aids	1/22/2016	J Siroky D Baker C Loveless
25.0	All	Published version	12/1/15	TQD
24.3	11.4.2 Medicare Participants	Updated for December 2015 COB changes	12/1/15	C Coyle D Baker
24.2	11.4.1 Third Party Recovery (TPR)	Updated for December 2015 COB changes	12/1/15	C Coyle D Baker
24.1	2.2 Third Party	Updated for December 2015 COB changes	12/1/15	C Coyle D Baker
24.0	All	Published version	9/25/15	TQD
23.1	5.7.2 Emergency Department Co-Payment	Removed "with a referral from their PCP" from bullet about care by PCP or at an urgent care clinic	9/25/15	C Brock D Baker
23.0	All	Published version	8/28/15	TQD
22.1	4.4 Health Acquired Conditions (HAC) 4.4.1 Present on Admission (POA) Indicators 4.10.2 Pregnancy Services 6.7 Cesarean Section	Updated for ICD-10	8/28/15	A Coppinger D Baker C Taylor
22.0	All	Published version	8/14/15	TQD
21.2	5.3 Outpatient Observation	Updated description of observation; updated to reflect new 48 hour rule	8/14/15	A Coppinger C Taylor D Baker
21.1	4.3 Emergency/Observation Room Visit Exceeding Census Hour	Updated to reflect new 48 hour rule	8/14/15	A Coppinger C Taylor D Baker
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20.3	4.5 Procedure Codes on Inpatient Claims	New section	6/26/15	A Coppinger D Baker
20.2	4.4.1 POA Indicators	Updated link to ICD-9 exemption list	6/26/15	A Coppinger D Baker
20.1	4.4 HAC	Updated link to fact sheet	6/26/15	A Coppinger D Baker
20.0	All	Published version	3/30/15	TQD
19.3	8.3 Bariatric Surgery for Weight Loss	Updated bullet about national medical standards	3/30/15	A Coppinger C Taylor
19.2	5.4 Outpatient Cardiac Rehabilitation, and subsections 5.4.1 - 5.4.5	Added sections	3/30/15	A Coppinger C Taylor
19.1	4.7.3 Rate Changes	Removed section	3/30/15	C Taylor
19.0	All	Published version	3/12/15	All
18.1	8.3 Bariatric Surgery for Weight Loss	Updated requirements	3/12/15	A Coppinger C Taylor D Baker
18.0	All	Published version	2/12/15	TQD
17.1	4.10 Hospital Accommodation Rate Schedule	Removed section	2/12/15	C Taylor D Baker
17.0	All	Published version	1/29/15	TQD
16.1	4.4 Health Acquired Conditions (HAC)	Added information about splitting claims	1/29/15	A Coppinger C Taylor D Baker
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15.1	8.3 Bariatric Surgery	Removed Medicare reference and added link to Surgical Review Corporation	08/15/14	M Wimmer D Baker C Taylor
15.0	All	Published version	08/08/14	TQD
14.1	8.8 Telemedicine	Added section	08/08/14	C Taylor
14.0	All	Published version	08/01/14	TQD
13.1	4.4 Health Acquired Conditions (HAC)	Removed reference in last bullet to claims being denied.	08/01/14	R Sosin C Taylor
13.0	All	Published version	07/01/14	TQD
12.3	5.6 Emergency Department	Added section for ED; added new subsections 5.6.1 and 5.6.4; updated co-pay amount in 5.6.2	07/01/14	A Coppinger C Taylor D Baker
12.2	4.6 DME Referral	Added section	6/30/14	A Coppinger C Taylor
12.1	4.4.1 POA Indicators	Updated information to clarify and added links to exemption lists for ICD-9 and ICD-10.	6/30/14	R Sosin
12.0	All	Published version	5/28/14	TQD
11.1	9.4 Incremental Nursing codes 0230-0234	Added rev code 0233	5/28/14	A Coppinger C Taylor
11.0	All	Published version	5/23/14	TQD
10.1	9.4 Incremental Nursing codes 0230-0234	Added section	5/23/14	C Taylor D Baker
10.0	All	Published version	4/25/14	TQD
9.4	8.3 Bariatric Surgery	Added last bullet the procedure must be performed in a BSC or BSCE.	4/25/14	D Baker C Taylor
9.3	5.3 Other Provider Preventable Conditions (OPPCs)	Removed section	4/25/14	A Coppinger C Taylor
9.2	4.8.2. Pregnancy Services, Diagnosis Codes; 6.7 Cesarean Section	Updated ICD-10 dates to 2015.	4/25/14	C Taylor D Baker
9.1	4.4 Health Acquired Conditions	Added new section	4/25/14	A Coppinger C Taylor
9.0	All	Published version	3/21/14	TQD
8.2	5.6 ED Limitations	Removed section	3/21/14	C Taylor
8.1	4.2 Inpatient Day	Added additional information	3/21/14	C Taylor
8.0	All	Published version	2/14/14	TQD
7.1	4.7.3	Added bullet for clarity	2/14/14	C Taylor D Baker
7.0	All	Published version	1/24/14	TQD
6.1	4.3 Emergency/Observation Room Visits Exceeding Census Hour	Updated to include observation	1/24/14	D Baker
6.0	All	Published version	1/17/14	TQD
5.2	5.6 ED Limitations	Clarified meaning of "immediate admission"	1/17/14	C Taylor D Baker
5.1	4.3 Emergency Room Visits Exceeding Census Hour	Added section	1/17/14	C Taylor D Baker
5.0	All	Published version	1/10/14	C Taylor
4.1	13.3.2 Children (Up to 21 st Birthday)	Removed references for PW; added statement that pregnancy related diabetic diagnosis is required.	1/10/14	J Siroky
4.0	All	Published version	10/04/13	TQD
3.4	8.3 Bariatric Surgery	Removed last bullet as the requirement for facilities to have the COE designation perform the bariatric surgery was rescinded.	10/04/13	K Gudmunson C Taylor

Version	Section/Column	Modification Description	Date	SME
3.3	7.5 Billing Procedures	Updated first bullet for Type of Bill to use code 131.	10/04/13	D Baker C Taylor
3.2	4.6.2 Pregnancy Services; 6.7 Cesarean Section	Updated references to ICD-9 to include ICD-10 information	10/04/13	L Neal C Taylor
3.1	3. Swing Beds	Updated reference link to LTC guidelines	10/04/13	K Gudmunson C Taylor
3.0	All	Published version	09/16/13	TQD
2.11	11. Ambulance Service Policy (and all subsections)	Updated to align with current policy	09/16/13	W Walther C Taylor
2.10	10. Hospital Surgical Procedure Billing (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor
2.9	9.1 Revenue Codes Overview	Updated for clarity	09/16/13	A Farmer C Taylor
2.8	8. Coverage Limits (and all subsections)	Updated to align with current policy; removed 8.1 Global Surgery Fees	09/16/13	A Farmer C Taylor
2.7	7. AND (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor
2.6	6. Prior Authorization (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor
2.5	5. Outpatient Hospital Policy (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor J Siroky
2.4	4. Inpatient Hospital Service Policy (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor
2.3	2.3 Type of Bill Codes	Removed	09/16/13	A Farmer C Taylor
2.2	All	Published version	1/18/12	TQD
2.1	9.0 Hospital Surgical Procedure Billing	Added first two paragraphs to clarify billing procedures	1/18/12	A Ramirez
2.0	All	Published version	8/27/10	TQD
1.2	All	Replaced member with participant	8/27/10	TQD
1.1	All	Updated numbering for sections to accommodate Section Modifications	8/27/10	TQD
1.0	All	Initial document – published version	5/7/10	TQD

2. Introduction

2.1 Eligibility

Always check a participant's eligibility. For additional information, see [General Provider and Participant Information](#).

2.2 Third Party

Medicaid is the last payer after all other insurance carriers. See [General Billing Instructions](#), [Third Party Recovery](#) and [Coordination of Benefits](#), regarding Medicaid policy on billing Medicare and other third party resources before submitting claims to Medicaid.

2.3 General Policy

This section describes Medicaid-covered services provided by hospital facilities. It addresses the following:

1. Swing beds
2. Inpatient policy
3. Outpatient policy
4. Prior authorization (PA)
5. Administratively necessary days (AND)
6. Coverage limits
7. Revenue codes
8. Hospital surgical procedure billing
9. Ambulance service policy
10. Diabetes education and training
11. Dietitian service policy

3. Swing Beds

3.1 Overview

Swing bed room and board is not billable using the hospital provider number. For those hospitals that meet the Code of Federal Regulation requirements and are approved by the Centers for Medicare and Medicaid Services (CMS) to provide swing bed care, a separate provider number is needed from the Idaho Medicaid Program. When an application has been approved, the provider will review the [LTC](#) handbook that explains the billing requirements particular to swing beds.

3.2 Reimbursement

Reimbursement of ancillary services not included in the swing bed rate must be billed on an outpatient claim (bill type **0131**) and settled on a cost basis with other outpatient services. Prescription drugs must be billed on the outpatient hospital claim form.

4. Inpatient Hospital Service Policy

4.1 Overview

Medicaid pays for inpatient services ordinarily furnished in a hospital for the care and treatment of a patient under the direction of a physician or, under certain circumstances, a dentist.

4.2 Inpatient Day

An inpatient day is counted for a patient who is admitted to the hospital for inpatient services, intends to stay overnight, and is in the inpatient bed at the midnight census hour. Emergency department visits that are followed by an immediate admission on the same date of service should be billed as part of the inpatient service.

4.3 Emergency/Observation Room Visit Exceeding Census Hour

Emergency/Observation room department visits that exceed the 24 hours for dates of service prior to 9/1/2015, or 48 hours on or after 9/1/2015, and result in a direct admit to inpatient status, should be billed as two separate claims. Emergency department and observation services should be billed as an outpatient type of bill. All inpatient services should be billed as an inpatient type of bill. The "from date of service" on the inpatient claim cannot be prior to the admit date.

Note: While Medicare supports the 72-hour rule for combining inpatient and outpatient services, Medicaid does not.

Deficit Reduction Act (DRA) of 2005

4.4 Health Acquired Conditions (HAC)

- Services needed to treat health acquired conditions are not covered. The system will use the combination of POA indicator, procedure codes, and diagnosis codes to identify HAC. Please refer to CMS for conditions determined to be Health Acquired Conditions. The POA indicator is required for all claims involving Medicaid inpatient admissions.
- Providers must split their claims when a claim with a HAC condition has an indicator of N or U. Covered items on a claim will not be paid when an HAC diagnosis code with a POA of N or U are on the claim.
- When splitting the claim, both new claims will be inpatient bill types with the number of days on each claim before and after the situation that caused an HAC; use an interim bill type. When using a through date that is less than the discharge date, you must have a patient status of 30 to indicate an interim billing.
- Bill type 0110 Non Payment / Zero Claim should be used on a claim with HAC diagnoses.

4.4.1 Present on Admission (POA) Indicators

POA is defined as present at the time the order for inpatient admission occurs. The POA indicator is assigned to each diagnosis submitted.

Figure 4-1: POA Indicators

Code	Definition	Idaho Medicaid
Y	Present at the time of inpatient admission	Idaho Medicaid will pay for all services as usual, including those selected HACs that are coded with a POA indicator of "Y"
N	Not present at the time of inpatient admission	Idaho Medicaid will not pay for services with HACs that are coded with a POA indicator of "N". All other services not identified as HACs will be paid as usual.
U	Documentation is insufficient to determine	Idaho Medicaid will not pay for services with HACs that are coded with a POA indicator of "U". All other services

Code	Definition	Idaho Medicaid
	if condition is present on admission	not identified as HACs will be paid as usual.
W	Provider is unable to clinically determine whether condition was present on admission or not.	Idaho Medicaid will pay for services as usual, including those selected HACs that are coded with a POA indicator of "W".

4.4.2 Documentation

Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission. Providers must resolve issues related to inconsistent, missing, conflicting, or unclear information.

Providers who do not code their claims correctly in accordance with HIPAA and national coding standards are subject to claim recoupment and review for potential fraud. Federal guidelines require providers to bill Medicaid correctly, and to identify these types of situations, even if the provider does not bill actual charges for the services related to the conditions.

4.5 Procedure Codes on Inpatient Claims

When reporting revenue codes 036x (Operating Room) on inpatient hospital claims, the principal procedure must be reported using the ICD procedure code in Box 74 on the UB-04. International Classification of Diseases procedure codes (ICD-PCS) are required for inpatient hospital claims.

The principal procedure code, as well as other procedure codes (Box 74 a – e), must include all applicable digits. Use the full ICD-9-PCS or ICD-10-PCS procedure codes based on dates of service. For more information on which ICD version to use, refer to [ICD-9 and ICD-10 Diagnosis Billing Requirements](#).

4.6 Reimbursement

Medicaid reimburses inpatient charges according to the facility's inpatient reimbursement rate established by the Department.

4.7 Durable Medical Equipment (DME) – Hearing Aids

Hearing aids are not covered as a hospital inpatient or outpatient service. The claim must be submitted by a hearing aid vendor as a professional claim, and may not be billed as a hospital claim.

4.8 Accommodation Rates

4.8.1 Limitations

Birthing room charges should reflect the normal administrative, nursing, and physical resources utilized for the mother and child occupying the same room. Ancillary services may not be combined with the charge for the accommodation.

Private and psychiatric accommodations will not be reimbursed at more than the semiprivate room rates on file with Medicaid except as stated in the next section,

Exceptions. Except as provided in section 4.8.2, hospitals that offer only private room accommodations are instructed to bill Medicaid using semiprivate room revenue codes.

If the participant is placed in a private room for the hospital's convenience, Medicaid will pay the semiprivate or all-inclusive room rate only.

4.8.2 Exceptions

Payment is limited to a semiprivate room accommodation rate except when an isolation room or private room is medically necessary and ordered by a physician, in which case Medicaid will pay the private room rate. A copy of the statement of medical necessity signed by the physician must be attached to the claim form.

4.9 Psychiatric Hospital

Inpatient mental health services require prior authorization (PA). Freestanding psychiatric hospitals are only covered for participants age 21 and under or age 65 and older. Please refer to the [QIO Provider Manual](#).

4.9.1 Participants under the Age of 21

The Department of Health and Welfare will pay for medically necessary inpatient psychiatric services for participants under 21 years of age who have a DSM IV diagnosis with substantial impairment in thought, mood, perception, or behavior. Both severity of illness and intensity of services criteria must be met for admission.

The Department of Health and Welfare or its designee must authorize admissions. Admission to an Institute for Mental Disease (IMD) for participants under age 21 requires a pre-admission review prior to an elective admission, which is defined as an admission that is planned and scheduled in advance, and is not an emergency in nature.

Emergency admissions require authorization within one workday of the admission. An emergency for purposes of admission is defined as the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part of the individual, death or harm to the individual, or death or harm to another person.

For more information refer to the [QIO Provider Manual](#).

Note: Failure to request a pre-admission or continued stay review in a timely manner will result in a retrospective review conducted by DHW or its designee and potential penalties. See *Section 6 Prior Authorization (PA)*.

4.10 Diagnostic Tests and Procedures

Physician ordered, medically necessary diagnostic tests and procedures related to the diagnosis and treatment of the participant's medical condition(s) are reimbursable. Those tests and procedures include, but are not limited to:

- Laboratory tests
- Pathology tests
- Diagnostic imaging procedures
- Admission tests

Some procedures may require PA. See *Section 6 Prior Authorization (PA)* for more information.

4.10.1 Birth/Delivery Billing

Charges for both the mother and the child can be billed on one claim form with the mother's Idaho Medicaid identification (MID) number if both leave the hospital at the same time. Combine all charges for the same revenue codes unless a corresponding CPT/HCPCS is required.

If mother and child are not discharged at the same time, or if the child is admitted to the neonatal intensive care unit (NICU) anytime during the stay, the child's charges must be billed separately under their individual MID.

4.10.2 Pregnancy Services

The Pregnant Women (PW) Program is restricted to pregnancy-related services only, including the following:

- All pregnancy-related services and services for other conditions that might complicate the pregnancy or are necessary to promote a positive outcome for the mother and/or baby.
- Pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include but are not limited to, prenatal care, delivery, postpartum care, and family planning services.

If there is a concern that a claim might be denied as not pregnancy-related, the provider can attach a) a statement to their claim from the attending physician documenting how the treatment is pregnancy-related, or b) a signed Medical Necessity form (pregnancy-related). This form is available on the Molina Medicaid website.

Diagnosis Codes

The primary diagnosis code on your claim must be pregnancy-related or indicate the woman is in a pregnancy or postpartum status. Use ICD-9-CM codes 630-679, including the 5th digit if applicable, or the applicable ICD-10-CM codes from Chapter 15. For more information on which ICD version to use, refer to [ICD-9 and ICD-10 Diagnosis Billing Requirements](#).

Family Planning

Family planning services are covered postpartum as long as the woman is eligible under the PW Program. A Healthy Connections referral is not required for family planning.

PW Eligibility

The eligibility period for PW extends to the end of the month of delivery plus two more full months. For example, if a woman delivers on 7/1/09, her eligibility would end on 9/30/09. If she delivers on 7/29/09, her eligibility would still end on 9/30/09. **There are no exceptions to this rule—claims with dates of service after the woman's PW eligibility ends will be denied.**

See [General Participant and Provider Information](#), for more information on PE or PW.

Otherwise Ineligible Non-Citizen Participants

An otherwise ineligible non-citizen is only eligible for medical services necessary to treat an emergency medical condition that can reasonably be expected to seriously harm the patient's health, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ without immediate medical attention.

Deliveries are considered emergencies.

Submit application requests for consideration to:

Self-Reliance Program	Phone 1 (877) 456-1233
PO Box 83720	Fax 1 (866) 434-8278
Boise, ID 83720-0026	

Use the general application used to apply for all benefit programs. Hospitals may attach medical records with applications if they are helping the non-citizen participant to apply for assistance.

The Division of Medicaid will determine if the condition is an emergency and if the treatment services will be covered by Idaho Medicaid. If the services are approved, Medicaid eligibility will begin no earlier than the date the participant experienced the medical emergency and ends the date the emergency condition stops. The QIO does not perform reviews for non-citizens.

4.10.3 Split Billing

When billing, a participant's charges must occasionally be split out and billed on separate claims. Instances when a split billing would occur include:

- Change in participant program eligibility.
- Portions of an inpatient stay which have been denied by the QIO or Idaho Medicaid.
- Inpatient stays that reflect transfers to psychiatric or rehabilitation units with a different Medicaid provider number than the general hospital.
- Inpatient discharges in which administratively necessary days (AND) are billed on an outpatient claim.
- When the participant has other insurance, COB dollars must be prorated and applied between the split claims.

Any inpatient claim submitted with a statement, "Through date that is less than the discharge date," must have a patient status of **30** to indicate that this is an interim billing.

Use Medicaid Automated Customer Service (MACS) to verify changes in a participant's eligibility. Call 1 (866) 686-4272 or 1 (208) 373-1474.

4.10.4 Rate Changes

When rate change occurs during the span of an inpatient stay and results in multiple rates for the same accommodation revenue code, a separate revenue line should be used. Report each rate with the same revenue code on each line with the applicable dates of service. Failure to split out these multiple rates will result in payment at the lower rate.

4.10.5 Donor/Transplants

Donor costs for bone, heart, liver, lung, and kidney transplants should be billed using the participant's name and Medicaid Identification (MID) number. Enter *Donor Charges* in the Remarks field of the paper claim form to prevent a denial of the claim as a duplicate. A liver transplant from a live donor is not covered by Medicaid. Claims submitted electronically need to have an attachment indicating that the charges are for the donor.

5. Outpatient Hospital Service Policy

5.1 Overview

Outpatient services are to be provided at a service location over which the hospital exercises financial and administrative control. Financial and administrative control means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill, and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location shall be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g., from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or 35 miles from a rural hospital).

All same revenue codes with the same dates of service, with the exception of revenue codes requiring CPT/HCPCS procedure codes, should be billed on one line of the outpatient claim form or the electronic claims screen. See [UB04 Instructions](#) for valid revenue codes.

Note: All imaging services must include the TC modifier.

5.2 Reimbursement

Medicaid pays the covered charges multiplied by an outpatient reimbursement rate, except for the following:

- Outpatient diagnostic laboratory procedures.
- Diagnostic imaging services.
- Any ancillary services that require a specific CPT/HCPCS code.

Medicaid establishes an upper limit on reimbursement based on Medicare's reasonable cost. Payment will not exceed this limit.

5.3 Outpatient Observation

Observation is used by the treating physician for a short period of time to assess and decide whether a patient requires admission for inpatient care or should be discharged.

Revenue code 0760 or 0762 should be used to reflect the costs of the routine observation services. Effective 9/1/2015, outpatient observation will be covered up to 48 hours; prior to 9/1/2015, observation is covered for no more than 24 hours.

Observation room and time may not be billed as a substitute for an emergency department visit or nursing services rendered outside the emergency department. Observation time cannot be substituted for stays denied by the QIO when the intensity of services does not justify an inpatient day.

5.4 Outpatient Cardiac Rehabilitation (CR)

Effective for dates of service starting April 1, 2015, outpatient cardiac rehabilitation (CR) is aligned with Medicare's policy. CR in the outpatient setting is a medically supervised program with the goal of preventing future cardiac events. CR can be provided in either a physician's office or an outpatient hospital setting, and must have a physician immediately available and accessible for medical consultations and emergencies at all times.

5.4.1 Qualifying Cardiac Events

Participants who have experienced one or more of the following cardiac events are eligible for CR:

- An acute myocardial infarction (MI- heart attack) within the preceding 12 months
- A coronary artery bypass graft (CABG) surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- A heart or heart-lung transplant
- Stable chronic heart failure

Note: A heart assist device (V43.21) is no longer a qualifying event as of 4/1/2015.

5.4.2 Covered Diagnoses

Hospitals should use revenue code 0943 for outpatient CR billing with the appropriate diagnosis. The complete list of covered diagnoses is available under Resources in the policy document found on the [Medical Care Unit's website](#).

5.4.3 Components of Cardiac Rehabilitation

Components of cardiac rehabilitation program must include all of the following:

- Physician-prescribed exercise each day that cardiac rehabilitation items and services are furnished.
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the patient's individual needs.
- Psychosocial assessment.
- Outcomes assessment.
- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

5.4.4 Limitations for Coverage

- Cardiac rehabilitation program sessions are limited to a maximum of two, one-hour sessions per day for up to 36 sessions, over a period of 36 weeks with the option for an additional 36 sessions over an extended period with prior approval.
- Place of service (POS) that is covered when CR is done is a physician's office or hospital outpatient setting.

5.4.5 Conditions Not Covered

- Physical and/or occupational therapy are not medically necessary in conjunction with cardiac rehabilitation unless performed for an unrelated diagnosis.
- Participation in another outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational.
- Programs that only offer supervised exercise training are not considered to be cardiac rehabilitation.

5.5 Presumptive Eligibility (PE) and Pregnant Women (PW) Clinic

Presumptive eligibility participants are only eligible for outpatient pregnancy related services. PE only covers prenatal care and not deliveries, miscarriages, or abortions. Some hospitals and district health departments are Pregnant Women (PW) clinics. They must be a

Medicaid-approved provider and meet the conditions for PE or PW. Additionally, approved providers must be trained and certified by DHW. For more information on the training process, please contact your local DHW eligibility office.

See [General Provider and Participant Information](#), *Presumptive Eligibility (PE)*, for more information.

5.6 Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) Services

5.6.1 Overview

Medicaid covers the following physician-ordered therapy services:

- Medically necessary SLP services provided by a licensed speech language pathologist.
- Medically necessary therapy services when provided by or under the supervision of a licensed physical therapist or occupational therapist.

Services must be part of a plan of care (POC) based on a physician order. The participant's progress must be reviewed and the POC updated and reordered every 90 days by the physician or midlevel practitioner. If the therapist has documentation from the participant's primary care provider indicating that the participant has a chronic condition making therapy necessary for more than six months, an order for continued care is required every six months.

The written physician's order must stipulate the type of services to be provided, the frequency of treatment, the expected duration of therapy, and the anticipated outcomes along with the physician's/midlevel's signature and date. The provider must maintain a copy of the POC and written physician's order in the participant's record.

5.6.2 Supervision

Services provided by OT and PT assistants may be billed to Medicaid when general supervision by the appropriate professional is provided in the hospital outpatient setting. General supervision requires direct, on-premises contact between the therapist, the therapy assistant, and the participant at least every five visits, or at least once a week if seen on a daily basis. The supervising therapist is required to co-sign documentation signed by the assistant. Services provided by SLP assistants are not covered.

5.6.3 Limitations

Medicaid aligned its reimbursement caps with Medicare using the caps in effect on January 1, 2012. The amount of the cap for PT and SLP services combined is set at \$1870, and there is a separate \$1870 cap for OT services. Once Medicaid has reimbursed the cap amount for PT and SLP services combined or for OT services, providers should assess the participant and determine:

1. If the services continue to be medically necessary, and
2. The skills of a therapist are required.

If the services continue to be necessary, the provider may continue to bill for services by appending a "KX" modifier to subsequent claims. The KX modifier is the provider's attestation that the services are medically necessary.

The first time that a "KX" modifier is used, the provider must also submit supporting documentation to the Department. Fax documentation for each patient and each type of therapy separately. Please do not send a single fax with multiple patients and/or therapy types. You do not need to submit documentation for each individual claim, only for each patient and therapy type. Once the documentation has been received by the Department, reviewers will be able to access that documentation for subsequent claims.

Submitting updated documentation for services continuing 90 days or more past the date of the original documentation will assist with reviews. The Department may pend claims and request updated documentation at the time of review if available documentation is outdated. The required documentation includes:

- Therapy Service Documentation Coversheet
- Physician order (signed and dated)
- Evaluation
- Current plan of care signed and dated by the physician or mid-level. (Completed every 90 days for acute conditions and every six months for chronic conditions.) It must specify:
 - Diagnosis
 - Modalities
 - Anticipated short and long-term goals that are outcome-based with measurable objectives
 - Frequency of treatment
 - Expected duration of treatment
 - Home follow-through program
 - Discharge plan
- Current progress notes

Fax or mail supporting documentation to:

Fax: 1 (877) 314-8779

Mail to:

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009

Note: Fax documentation at least one business day PRIOR to submitting claims to allow the system time to recognize that the documentation has been received. If documentation is mailed, please allow one week prior to billing.

The Department will select a number of claims billed with the KX modifier to review. All other claims will continue through the claims process. If, after the review, it is determined that a service does not meet criteria for coverage, the claim will be denied and all future claims submitted for that type of therapy in that calendar year will be denied. If the participant has a setback, has a new condition, or if there is new information available, the provider can submit that information to the Department.

5.6.4 Non-covered Services

The following services are not reimbursable by Idaho Medicaid; see *IDAPA 16.03.09.730.03* and *IDAPA 16.03.10.215*.

- Continuing services for participants who do not exhibit the capability to achieve measurable improvement.
- Services that address developmentally acceptable error patterns.
- Services that do not require the skills of a therapist or therapy assistant.
- Services provided by unlicensed aides or technicians, even if under the supervision of a therapist.
- Massage.
- Work hardening and conditioning.
- Services not medically necessary, as defined in *IDAPA 16.03.09.011*.
- Maintenance programs.
- Duplicate services.
- Group therapy.
- Any non-covered service code.
- Acupuncture and biofeedback therapy (*IDAPA 16.03.09.390.01*)

5.6.5 Daily Entries

According to *IDAPA 16.05.07.101*, "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five years from the date the item or service was provided."

Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries should include the following:

- Date and time of service.
- Duration of the session (time in and time out).
- Specific treatment provided and the corresponding procedure codes.
- Problem(s) treated.
- Objective measurement of the participant's response to the services provided during the treatment session.
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist.

If a session does not occur as scheduled, the provider must document why the POC was not followed. Missed visits are not covered and cannot be billed to Medicaid.

5.7 Emergency Department

5.7.1 Follow-Up for ED Patients

Hospitals are directed to refer Medicaid participants who are not enrolled in Healthy Connections to an HC primary care provider. In coordination with [IDAPA16.03.09.413.02](#):

- Policies and procedures must be established for referring Medicaid participants to a Healthy Connections provider, and
- Hospitals must coordinate care of patients who already have a Healthy Connections provider with that PCP

For help finding a provider in the participant's area, call the Healthy Connections Unit at 1 (800) 799-5088.

5.7.2 Emergency Department Co-Payment

A Medicaid participant can be assessed a three dollar and sixty-five cent (\$3.65) co-payment for inappropriate emergency room utilization when these three conditions are met:

- The required medical screening indicates that an emergency medical condition does not exist as determined by the emergency room physician applying the prudent layperson standard. A co-payment may not be charged if the physician determines that a prudent layperson would have sought emergency treatment in the same circumstances, even if the care rendered is for a non-emergent condition.
- The Medicaid participant is not a Native American or Alaskan Native.
- There is an alternative setting for the Medicaid participant to receive treatment at no cost. A Medicaid participant can receive no cost treatment from their Healthy Connections primary care provider (PCP) or at an Urgent Care Clinic. The hospital is required to facilitate a referral to an appropriate provider in order to impose a co-pay or deny treatment to a Medicaid participant who does not make a co-payment.

When a hospital determines that a co-payment can be imposed, the hospital can require the Medicaid participant make the co-payment in order to receive treatment.

Note: The collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid. However, all the conditions outlined above must be met if a hospital wishes to deny treatment to a Medicaid participant who presents in the emergency room with a non-emergent condition.

5.7.3 Healthy Connections (HC) – Referral

Outpatient hospital services billed on an UB-04 claim form with revenue code **0450** and services billed on a CMS-1500 claim form (with POS **23**) are exempt from the HC referral requirement.

ED services and hospital admissions subsequent to an ED visit do not require a referral when the patient is discharged in coordination with their PCP.

5.7.4 Durable Medical Equipment – Hearing Aids

Hearing aids are not covered as a hospital inpatient or outpatient service. The claim must be submitted by a hearing aid vendor as a professional claim, and may not be billed as a hospital claim.

5.8 Sterilization Procedures

Idaho Medicaid is required to meet the Centers for Medicare and Medicaid (CMS) requirements for sterilization consent forms. Medicaid cannot cover sterilizations unless a valid, complete, and legible Sterilization Consent Form is received. For more information refer to Sterilization Procedures Overview in the [Allopathic and Osteopathic](#) guidelines.

6. Prior Authorization (PA)

6.1 Overview

Multiple entities review requests for authorizations for hospital and related services.

- [QIO](#)
- [Medicaid Medical Care Unit](#)
- [Medicaid Ambulance](#)

6.1.1 Quality Improvement Organization (QIO)

The Idaho Medicaid Program has contracted with Telligen, a quality improvement organization (QIO), to conduct the medical and surgical reviews of inpatient and selected

outpatient hospital services. The appropriateness and necessity of the participant's admission and length of stay are subject to QIO review.

See the [QIO Provider Manual](#) for a listing of diagnoses and procedures that require PA for details regarding review processes.

The attending physician is ultimately responsible for obtaining preadmission approval (except for emergencies). However, the QIO will accept preadmission monitoring calls from the surgeon, physician office personnel, or facility personnel when applicable. Healthy Connections (HC) participants require a referral from their primary care provider (PCP) for all inpatient and outpatient hospital services in addition to the QIO PA, except for dental procedures.

Claims for services requiring PA will be denied if the provider did not obtain a PA from the authorizing authority. PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated on the approval. For HC or HH participants, PA will be denied if the requesting provider is not the PCP or if a referral has not been obtained.

6.2 Admitting and Principal Diagnoses

It is very important to include the admitting diagnosis code in field **69** and the principal diagnosis code in field **70** on the claim. These codes are used to determine if the admission requires QIO review.

If the admitting diagnosis and the principal diagnosis are different and one of them is a condition that does require preadmission review, the admission requires QIO preadmission review.

6.3 Length of Stay Review

Concurrent review is required when the admission exceeds day three, or day four if the patient had a cesarean delivery, or the number of days assigned by the QIO for a procedure. In the event the admitting diagnosis is different from the principal diagnosis, the diagnosis that allows the greatest length of stay is used to determine the length of stay for the admission. When QIO approval has been given for a portion of the hospital stay, accommodation days are payable only to the QIO's last approved day.

6.4 Transfers

Quality improvement organization authorization is not required for transfers from hospital to hospital inpatient status (inter-facility).

Authorization is required for transfers into psychiatric, substance abuse, or rehabilitation units within the same hospital (intra-facility). The receiving unit is responsible for obtaining the authorization within one working day of the transfer. The sending unit is not required to obtain a transfer review.

6.5 Out-of-State Providers

All medical care provided outside the state of Idaho is subject to the same PA and continued stay review requirements and restrictions as medical care provided within Idaho.

The participant's physician(s) or the treating facility may initiate the request for PA. The treating physician(s) and the treating facility are equally responsible for obtaining PA.

If ambulance transport is needed, refer to the [Transportation Services Guidelines](#).

6.6 Admission for Substance Abuse

Quality improvement organization approval is required for inpatient services under either the psychiatric or the chemical dependency admissions category. Refer to the [QIO's Pre-Authorization List](#).

6.7 Cesarean Section

When billing for a cesarean section under the mother's member identification number (MID), use the appropriate diagnosis code indicating the reason for the cesarean section and the appropriate ICD-9-PCS Volume III procedure code 74.0-74.99, or the applicable ICD-10-PCS code, based on dates of service. For more information on which ICD version to use, refer to [ICD-9 and ICD-10 Diagnosis Billing Requirements](#).

The diagnoses in the table below have a four day length of stay (LOS) only when a separate claim is billed under the newborn MID.

If the patient is not discharged after the fourth day and a C-section delivery surgical procedure is not indicated on the mother's claim, or a C-Section diagnosis is not indicated on a separate newborn claim, a review with the QIO is required.

Contact the QIO at 1 (866) 538-9510 for a review or fax your requests to 1 (866) 539-0365.

ICD-9-CM Diagnosis Code	ICD-10-CM Diagnosis Code	Description
669.70 669.71	O82	Caesarean delivery, with or without mention of indication.
763.4	P03.4	Fetus or newborn affected by other complication of labor and delivery, cesarean delivery.
V30.01	Z38.01	Single live born, born in a hospital, delivered by cesarean delivery.
V31.01	Z38.31	Twin, mate live born, born in a hospital, delivered by cesarean delivery.
V32.01	Z38.31	Twin, mate stillborn, born in a hospital, delivered by cesarean delivery.
V33.01	Z38.31	Twin, unspecified, born in a hospital, delivered by cesarean delivery.
V34.01	Z38.62 Z38.64 Z38.66 Z38.69	Other multiple, mates all live born, born in a hospital, delivered by cesarean delivery.
V35.01	Z38.62 Z38.64 Z38.66 Z38.69 Z38.8	Other multiple, mates all stillborn, born in a hospital, delivered by cesarean delivery.

ICD-9-CM Diagnosis Code	ICD-10- CM Diagnosis Code	Description
V36.01	Z38.62 Z38.64 Z38.66 Z38.69 Z38.8	Other multiple, mates live and stillborn, born in a hospital, delivered by cesarean delivery.
V37.01	Z38.62 Z38.64 Z38.66 Z38.69 Z38.8	Other multiple, unspecified, born in a hospital, delivered by cesarean delivery.

6.8 Medicaid/Medicare PA Requirements

Some Medicare participants have both Medicare and Medicaid coverage for hospitalizations. For those participants with Part A Medicare (inpatient services), QIO review is not necessary if Medicare is the primary payer. Medicare guidelines should be followed. If, however, the participant has only Part B Medicare (outpatient services), the admission is subject to QIO review because Medicaid is the primary payer for the inpatient services. For additional information regarding third party coverage or to verify eligibility, log in to your trading partner account or contact MACS at 1 (208) 373-1424 or 1 (866) 686-4272.

6.9 Other Insurance

Any other insurance must be billed prior to billing Medicaid and QIO authorization is also required. For additional information regarding third party coverage or to verify eligibility, log in to your trading partner account or contact MACS at 1 (208) 373-1424 or 1 (866) 686-4272.

6.10 Retrospective/Late QIO Reviews

Retrospective Review

Medicaid does not assess penalties to providers for participants who were determined eligible after admission. In these cases, a retrospective review is required.

A QIO review does not override the requirement of timely filing.

Late Review

A late review is defined as a case where the participant was eligible but a PA was not obtained prior to services being provided. The QIO accepts late reviews only when they are notified while the participant is still in the hospital. If the participant has been discharged, providers must request a Retrospective Review Request. Refer to the [QIO Provider Manual](#) for more information.

Medicaid assesses penalties if a hospital does not secure a timely QIO review. Penalties are based on the lateness of the review.

One day late =	\$260
Two days late =	\$520
Three days late =	\$780
Four days late =	\$1,040
Five days late =	\$1,300

The QIO does not have authority to reverse late review penalties. Appeal requests regarding penalties should be directed to:

Hearings Coordinator
Idaho Department of Health and Welfare Administrative Procedures Section
P.O. Box 83720
Boise, ID 83720-0036
Fax: 1 (208) 334-6558

6.11 Contacting the QIO

Telligen
670 E Riverpark Ln. Suite 120
Boise, ID 83706
Phone 1 (866) 538-9510
Fax 1 (866) 539-0365

Help desk e-mail: idmedicaidsupport@telligen.com

6.12 Medical Care Unit Prior Authorization

Medicaid PA is required for the following procedures:

- Surgeries not reviewed by the QIO that are documented as medically necessary.
- Administratively necessary days (AND).
- Excluded services, including surgeries found medically necessary during a Child Wellness Exam, sometimes referred to as EPSDT.
- Speech-language pathology, occupational therapy, and physical therapy exceeding cap limitations.
- Certain genetic pathology and laboratory testing.
- Medical equipment and supplies exceeding specified limits.

See *Section 6.13 Medical Surgical Procedures Requiring Medicaid Prior Authorization (PA)*, for the listing of medical and surgical procedure codes that require PA from Medicaid.

Send PA requests to the [Medical Care Unit](#).

Healthy Connections participants require a referral from their PCP, in addition to a Medicaid or QIO PA, for all inpatient and outpatient hospital services.

6.13 Medical Surgical Procedures Requiring Medicaid Prior Authorization (PA)

Please refer to the [Idaho Medicaid Medical Care Unit Prior Authorization List](#).

6.14 Attachments

Inpatient attachments include:

- **Third party recovery (TPR):** When billing on a paper claim form, attach the Explanation of Benefits (EOB) statement from the other insurer that includes the adjustment reason codes (ARC). When billing electronically, use the appropriate ARC codes from the other insurer; no attachment is required.
- **Hysterectomies:** Authorization for hysterectomy and documentation of medical necessity.
- **Sterilizations:** Appropriately completed consent form. For more information concerning sterilizations, see *Section 5.8* of this handbook.
- **Therapeutic abortions:** Completed certification of necessity from physician. For more information concerning abortions, see *Section 8.11* of this handbook.
- **Private room:** Statement of medical necessity or physician order.

Outpatient attachments include:

- TPR: When billing on a paper claim form, attach the EOB statement from the other insurer that includes the ARC. When billing electronically, use the appropriate ARC from the other insurer; no attachment is required.
- Sterilization: Appropriately completed consent form.

6.15 Hospital Physicians

Hospital based physician billers should refer to [Allopathic and Osteopathic Physician Guidelines](#) for more information on submitting a CMS-1500 claim form.

7. Administratively Necessary Days (AND)

7.1 Overview

Administratively necessary days (AND) are intended to allow a hospital the time for an orderly transfer or discharge of inpatients who are no longer in need of a continued acute level of care. Administratively necessary days may be authorized for inpatients that are awaiting placement in a skilled nursing facility (SNF), intermediate care facility for developmentally disabled/intellectually disabled (ICF/ID), in-home services that are not available, or when catastrophic events prevent the scheduled discharge of an inpatient.

7.2 Prior Authorization (PA)

The hospital discharge planner, utilization reviewer, or attending physician must contact the Medical Care Unit by phone or fax to request an AND. The AND form must be submitted to the Medical Care Unit prior to the patient being decertified as needing acute hospital care. This can be done as soon as the discharge planner anticipates a possible discharge issue, even if the final non-certified date is not yet known. The facility must supply the additional required documentation within ten working days of the submitted request.

The [Administrative Necessary Day](#) form is located online.

If the AND is not needed, notify the Medical Care Unit immediately at the number below, and the request will be voided.

To request an AND, fax the AND form and required documentation to 1 (877) 314-8779.

For questions, call 1 (208) 364-1830.

The following documentation is required for PA of an AND:

- AND form.
- Summary of patient's medical condition.
- Current history and physical.
- Physician progress notes.
- Statement as to why patient cannot receive necessary medical services in a non-hospital setting.
- Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services.

7.3 Retroactive Eligibility

Medicaid will not authorize services retroactively unless:

- The participant's eligibility was approved after services were provided.
- The participant's service limitations were exceeded and medical need is determined.

7.4 Notice of Decision (NOD)

The Department of Health and Welfare will review each AND request and issue a NOD, which contains the PA number and decision.

7.5 Billing Procedures

Administratively Necessary Day services must be billed on the UB-04 claim form as an outpatient service. The first AND should be the same day the participant was discharged from the inpatient acute level of care.

The hospital should utilize the same billing procedure as is currently used for outpatient claims with the following exceptions when billing for an AND:

- Type of Bill (field **4**) use code **131**.
- Revenue Codes (field **42**).
- Supplies and ancillary charges (except those listed in *Section 7.5.1 Revenue Codes*) are part of the content of care.

7.5.1 Revenue Codes

AND should be billed using revenue code **0671**. See [UB04 Instructions](#) for a list of the only revenue codes that can be billed with an AND.

8. Coverage Limits

8.1 Therapy Services

8.1.1 Speech and Physical Therapy

Therapy services for speech and physical therapy combined are limited to \$1,870 annually. Additional services may be covered when medically necessary.

8.1.2 Occupational Therapy

OT services are limited to \$1,870 annually. Additional services may be covered when medically necessary.

8.2 Cosmetic Surgery

Surgery done solely for cosmetic reasons is not covered. All surgeries must be medically necessary and may require prior authorization if the surgery appears to be for cosmetic reasons.

8.3 Bariatric Surgery for Weight Loss

Medicaid will cover bariatric surgeries, including abdominoplasty and panniculectomy, when all conditions listed below are met as defined in [IDAPA 16.03.09.431 Surgical Procedures for Weight Loss-Participant Eligibility](#) through [section 434 Provider Qualifications and Duties](#).

- The participant meets the criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than 40, or
- The participant has a BMI equal to or greater than 35 with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities.
- The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition who is not associated by clinic or other affiliation with the surgeons who will perform the surgery.
- The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory, or other systemic disease.
- The participant must have a psychiatric evaluation to determine the stability of personality at least 90 days prior to the date a request for prior authorization is submitted to Medicaid.
- The procedure is prior authorized by the QIO. If approval is granted, the QIO will issue the authorization number and conduct any necessary length-of-stay reviews.
- The procedure(s) must be performed in an Idaho Medicaid-enrolled hospital that is also Medicare certified.
- Hospital practices should be in keeping with national medical standards for weight loss surgery to promote positive outcomes.

8.4 Transplants

The Department of Health and Welfare (DHW) may authorize organ transplant services for bone marrow, kidneys, hearts, intestines, livers, and lungs when provided by hospitals approved by the Centers for Medicare and Medicaid Services (CMS) for the Medicare program. The hospital must have completed a provider agreement with DHW.

All transplants, except for cornea transplants, must be prior authorized by the QIO.

Hospitals should obtain and use a separate provider number, issued by Idaho Medicaid, for transplants. This allows the hospital to accurately receive the lesser of 96.5 percent of reasonable costs under Medicare's payment principals or customary charges.

The transplant costs for actual or potential living donors are covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Donor costs for transplants should be billed using the participant's name and Medicaid identification (MID) number. To prevent denial of the claim as a duplicate, enter *Donor Charges* in the remarks field of the paper claim form or for electronic claims attach documentation to explain these are donor charges.

Payments for post-operation expenses of a donor will be limited to the period of actual recovery.

Follow-up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to independent organ procurement agencies and independent histocompatibility laboratories will not be covered.

See *IDAPA 16.03.10.090 Organ Transplants through 096 Organ Transplants - Provider Reimbursements* for additional information.

8.5 Fertility

Procedures or testing for the inducement of fertility are not a benefit of the Medicaid program. This includes, but is not limited to:

- Artificial insemination
- Consultations
- Counseling
- Genetic testing and counseling for the purpose of family planning
- Office exams
- Tuboplasties
- Vasovasotomies

8.6 Take Home Drugs

Outpatient take home drug charges that exceed \$4.00 must be billed as a pharmacy claim through Magellan. For more information go to <https://Idaho.fhsc.com>. Inpatient take home drugs dispensed upon discharge must also be submitted on the Pharmacy claim form. All outpatient take home drugs must have the National Drug Code (NDC) identified on the claim.

8.7 Mammography Services

Idaho Medicaid will cover screening or diagnostic mammography performed with mammography equipment and by staff that is considered certifiable or certified by the Bureau of Laboratories.

- Screening mammography will be limited to one per calendar year for women who are 40 or more years of age.
- Diagnostic mammography will be covered when a physician orders the procedure for a participant, of any age, who is at high risk.

Note: Use the appropriate CPT code for the type of mammography performed.

8.8 Telehealth

Effective February 1, 2016: The Idaho Medicaid Telehealth Policy has been revised. Multiple policy documents have been revised and providers should review them before providing Telehealth services. The revised policy, Medicaid Information Release MA15-11, and provider handbooks have been updated to provide guidance. Reimbursement for the use of Telehealth equipment (site fees) ends January 31, 2016.

8.9 Dialysis Units

Outpatient dialysis procedures provided by a freestanding dialysis facility should be billed on a UB-04 claim form in the following manner:

- Report with bill type **0721** through **0724**. Refer to the [UB04 Instructions](#) for more information.
- Dialysis procedures are reported with the following revenue codes:
0821 Outpatient dialysis, CPT code **90999** (hemodialysis composite or other rate)

- 0270** Dialysis supplies (medical surgical supplies)
- 0272** Special supplies (sterile supplies)
- 0634** Epoetin up to 10,000 units (one billing unit = 1000 Units)^{CPT}
- 0635** Epoetin over 10,000 units (one billing unit = 1000 Units)^{CPT}
- 0636** Dialysis drugs CPT (drugs requiring detailed coding); use the appropriate corresponding J-code from the most current *HCPCS Level II Manual* and attach the NDC detail attachment with claim form (see [Medicaid Information Release MA03-69](#))
- 0831** Peritoneal composite rate, **90945** or **90947**^{CPT}
- 0841** CAPD composite or other rate, **90945/90947** or **90993**^{CPT}
- 0851** CCPD composite or other rate; **90945/90947** or **90993**^{CPT}

^{CPT} Must indicate a valid CPT procedure code when billing outpatient claims.

Note: When billing using a date span, make sure the header date span is reflected in the detail dates. You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.

When the dates of service are not consecutive, each date of service must be billed on a separate detail line.

8.10 Therapeutic Abortion Coverage

Medicaid will cover abortions only under circumstances where the abortion is necessary to save the life of the woman, or in cases of rape or incest as determined by the courts, or, where no court determination has been made, if reported to a law enforcement agency.

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

In the case of rape or incest, the following documentation must be provided to the Department with the physician's claim:

- a. A copy of the court determination of rape or incest must be provided; or
- b. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency.
- c. Where the rape or incest was not reported to a law enforcement agency, a licensed physician must certify in writing that, in the physician's professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest to a law enforcement agency. The certification must contain the name and address of the woman.

When the abortion is necessary to save the life of the woman, the following information must be included with the physician's claim. A licensed physician must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman.

For more information, refer to the [Allopathic and Osteopathic Physicians](#) handbook.

8.11 Excluded Services

Services excluded from Medicaid coverage include the following:

- Acupuncture services.
- Biofeedback therapy.
- Laetrile therapy.
- Eye exercise therapy.
- Surgical procedures on the cornea for myopia.
- Cosmetic surgery, excluding reconstructive surgery that has prior approval by the Department of Health and Welfare (DHW).
- Elective medical and/or surgical treatment, except for family planning services, without DHW prior authorization (PA).
- Vitamin injections in the doctor's or other licensed prescriber's offices that are not needed for a specific diagnosis.
- New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service. If these procedures are excluded by the Medicare program, they are also excluded from Medicaid payment.
- Treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid coverage, unless the resultant condition is deemed life threatening as determined by Medicaid.
- Examinations in connection with the attendance, participation, enrollment, or accomplishment of a program or for employment.
- Naturopathic services.

8.12 Exceptions to Excluded Services

Some excluded services or procedures that require treatment, services, or supplies not included in the regular scope of Medicaid coverage may be payable when identified as medically necessary during a Child Wellness exam, sometimes referred to as EPSDT. Such excluded services/procedures must be prior authorized by Medicaid.

Some examples of the services for which payment may be made are private duty nursing in the participant's home and outpatient substance abuse treatment. Any service recognized under the provisions of the Social Security Act can be made available if the above conditions are met.

9. Revenue Codes

9.1 Overview

All hospital services must be billed using the following unique, four-digit revenue codes.

Idaho Medicaid does not support billing and payment by cost centers, hospitals should bill all associated revenue codes as identified in the Idaho MMIS Handbook, [UB04 Instructions](#).

9.2 Accommodation Revenue Codes

See [UB04 Instructions](#), *Hospital* for revenue codes that can be billed.

9.3 Ancillary Revenue Codes

See [UB04 Instructions](#), *Hospital* for revenue codes that can be billed.

9.4 Incremental Nursing Codes 0230 - 0234

Incremental nursing charges billed under revenue codes 0230, 0231, 0232, 0233, or 0234 must have documentation in the medical record to support the need for these additional services.

Idaho Medicaid adheres to the National Uniform Billing Committee UB-04 Data Specifications Manual definition of these codes which states, "Extraordinary charges for nursing services assessed in addition to the normal nursing charge associated with the typical room and board unit. These codes do not support unbundling of nursing charges from standard room and board."

10. Hospital Surgical Procedure Billing

Hospital providers can submit claims for outpatient surgery using bill type **131** and revenue code **0360/0361** with appropriate surgical CPT codes. Hospitals billing as a hospital based Ambulatory Surgical Center (ASC) must establish a separate NPI for their ASC, and must bill type **831** and revenue code **0490** with the appropriate surgical CPT codes.

Providers billing with bill type **131** and revenue code **0360/0361** will be reimbursed based on that provider outpatient interim percentage. Providers who choose to obtain a separate NPI for their ASC services will continue to be reimbursed at 2.5 times the ASC level fee schedule pricing for the corresponding surgical procedure.

Multiple ASC procedures must be listed separately with a CPT code for each procedure. It is not necessary to break out the operating room charges for each line that a procedure is billed under revenue code **0490**. The hospital may list all ASC procedures with only one total charge per revenue code. Any ASC procedure code billed with revenue code **0490** may display the total operating room charges. Each of the other lines billing operating room revenue code **0490** with an ASC procedure code may have a total charge of zero entered. Other ancillary services included in the procedure(s) must be billed with the related total customary charges on each line. Ancillary charges must not be bundled into revenue code **0490**.

10.1 Dental Procedures

An HC referral is not required for dental procedures performed in a hospital outpatient or ASC setting.

All dental procedures performed in an outpatient or ASC setting must be billed under the CPT code **41899** (Surgical). Prior authorized dental procedures should also be billed with CPT code **41899**.

Oral Surgeons, see [Allopathic and Osteopathic Physicians](#), *Oral Surgeons* for more information on billing.

10.2 Ambulatory Surgical CPT Codes

See the [Medicaid ASC fee schedule](#) for a complete listing of approved ASC CPT codes and payment levels. Consult your *Current Procedural Terminology (CPT) Manual* for complete descriptions of the codes.

11. Ambulance Service Policy

11.1 Overview

Hospital based ambulance service is payable only if used in the event of an emergency situation or after authorization has been obtained from the Medicaid Ambulance Review Unit. The Medicaid Ambulance Review Unit does retrospective medical review of all ambulance transportation requests.

Medicaid Ambulance Review 1 (208) 287-1157
Medicaid Ambulance Review Fax 1 (877) 314-8781

11.1.1 Definition of Emergency Services

Medical necessity is established when the participant's condition is of such severity that use of any other method of transport would endanger the participant's life or health. An emergency exists when the severity of the medical situation is such that the usual PA procedures are not possible because the participant requires immediate medical attention.

11.1.2 Definition of Non-Emergency Service

Medicaid defines non-emergency service as transportation provided when the physical condition of the participant requires ambulance transport and another form of transportation will place the participant's life or health in serious jeopardy. This includes inter-facility transfers, nursing home to hospital transfers, and transfers to the participant's home from the hospital.

Transportation of a participant residing in a long-term care facility (LTC) is the responsibility of the LTC facility unless the condition of the participant requires ambulance transport and PA has been obtained. Claims for services requiring PA will be denied if the provider did not obtain a PA from the authorizing authority.

11.2 Co-Payment for Non-Emergency Use of Ambulance Transportation Services

Ambulance providers may bill Medicaid participants a three dollar and sixty-five cent (\$3.65) co-payment for inappropriate ambulance service utilization when the following two conditions are met:

- The Department of Health and Welfare determines that the Medicaid participant's medical condition did not require emergency ambulance transportation.
- The Department of Health and Welfare determines that the Medicaid participant is not exempt from making co-payments according to Federal statute.

The Department of Health and Welfare (DHW) will notify both the ambulance provider and the Medicaid participant on the Notice of Decision letter when a participant may be billed for a co-payment.

Note: Collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid.

11.3 Licensing Requirements

Ambulance services providers must hold a current license issued by Emergency Medical Services (EMS) according to the level of training and expertise personnel maintain, and must comply with the rules governing EMS services. Ambulance services providers based outside the state of Idaho must hold a current license issued by that State's EMS licensing authority. No payment will be made to ambulance services providers that do not hold a current license.

Emergency Medical Services (EMS)
EMSPROVLIC@dhw.idaho.gov
1 (877) 554-3367
1 (208) 334-4015 (Fax)

11.4 Billing Information

Hospital based providers must bill on the UB-04 claim form or the electronic claim using hospital revenue codes **540-549**. See Section *9.3 Ancillary Revenue Codes* for more information.

Both ground and air ambulance services owned and operated by hospitals must bill on the UB-04 claim form or the electronic claim using hospital revenue codes. UB-04 claim forms are available from local form suppliers. Required attachments include third party EOB for other insurance payments and denials.

11.4.1 Third Party Recovery (TPR)

Required attachments to UB-04 claim forms include third party EOB for other insurance payments and denials. The correct Medicare Adjustment Codes (MAC) and other insurance information must be entered on claims submitted electronically. See [General Billing Instructions](#), *Third Party Recovery*, *Coordination of Benefits*, and *Crossover Claims* for information on Medicaid policy for billing all other TPR resources before submitting claims to Medicaid.

11.4.2 Medicare Participants

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. If billing electronically, the information from Medicare must be entered on the appropriate screens.

For inpatient claims, Medicaid's payment for services will be calculated according to the "Member Responsibility" methodology as described in the [General Billing Instructions](#), *Third Party Recovery*, *Coordination of Benefits*, and *Crossover Claims*.

For outpatient claims, Medicaid's payment for services will be calculated according to the "Lesser Of" methodology as described in the [General Billing Instructions](#), *Third Party Recovery*, *Coordination of Benefits*, and *Crossover Claims*.

See [General Billing Instructions](#), *Third Party Recovery*, *Coordination of Benefits*, and *Crossover Claims* for information on Medicaid policy for billing all other TPR resources before submitting claims to Medicaid. Participants cannot be billed for any non-reimbursed amount. Providers may only bill non-covered services to the participant if the provider has informed the participant of their responsibility to pay, preferably in writing, prior to rendering services.

Electronic Crossovers

Medicaid receives claims electronically from Medicare; these are called Medicare Crossover claims. Claims that have Medicare excluded services and Medicare covered services will cross over. For Medicare covered services denied by Medicare, whether it is the entire claim or a claim detail, submit a paper claim to Medicaid with the Medicare denial EOB. Crossover claims may require rebilling to Medicaid with appropriate Medicaid approved coding for consideration, for example, FQHC/RHC/IHC, LTC.

11.5 Covered Services

11.5.1 Air Ambulance

Air ambulance services are covered when one of the following occurs:

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential.
- The participant's condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and would be less costly, payment is based on the amount that would be paid for a ground ambulance.

Air ambulance must be approved by Medicaid Ambulance Review in advance except in emergency situations.

If the aircraft is owned and operated by a hospital, the service must be billed on a UB-04 claim form or the electronic claim using appropriate revenue codes. Air ambulance services not owned by a hospital must bill on the CMS-1500 claim form or the electronic claim using HCPCS procedure codes.

11.5.2 Ground Ambulance

Ambulance services, which are owned and operated by a hospital, must be billed on the UB-04 claim form or the electronic claim using hospital revenue codes. All other ambulance providers must submit claims on the CMS-1500 claim form or electronic claim using HCPCS procedure codes.

11.5.3 Multiple Runs in One Day

When the ambulance transports a participant, returns to the base station, and transports the participant a second time on the same date, two base rate payments and loaded mileage are allowed. Use modifier 76 on the second base rate procedure code to prevent denials for duplicate claims. Modifier 76 should not be included on either loaded mileage.

When the ambulance transports a participant, the participant is transferred to another facility, and the ambulance does not return to the base station, one base rate, waiting time, and loaded mileage are allowed.

11.5.4 Round Trip

Medicaid allows round trip charges when a hospital inpatient goes to another hospital to obtain specialized services not available in the original hospital, and the referral hospital is the nearest one with such facilities.

Medicaid places restrictions on round trip charges, depending on whether the ambulance returns to service between trips. When the ambulance does not return to service, bill for one base rate with the total round trip miles.

11.5.5 Nursing Home Residents

Ambulance services are covered only in an emergency situation or when a non-emergent and medically necessary transport has been authorized by Medicaid Ambulance Review. Payment for any non-authorized service is the responsibility of the facility, and cannot be billed to the participant.

11.5.6 Trips to Physician's Office

Ambulance transport to a physician's office is not covered unless it has been authorized by Medicaid Ambulance Review.

11.5.7 Treat and Release or Respond and Evaluate

A treat and release payment may be authorized if the participant is treated at the scene and not transported. Disposable supplies used at the scene are also covered.

A respond and evaluate payment may be authorized if the ambulance responds to the scene and evaluates the participant, but no treatment or transport is necessary.

Medicaid Ambulance Review may downgrade a transport to respond and evaluate or treat and release if it is determined there was no medical necessity for transport.

11.5.8 Deceased Participants

Medicaid does not pay for transport of deceased participants. If a participant is pronounced deceased by appropriate personnel between dispatch and upon arrival of ambulance, a respond and evaluate payment may be authorized.

11.6 Reimbursement Information

11.6.1 Customary Fees

Medicaid reimburses hospital owned and operated ambulance services on a usual and customary outpatient Medicaid schedule.

11.7 Requests for Reconsideration

Providers may appeal an authorization decision made by the Medicaid Ambulance Review Unit by following these steps:

1. Carefully examine the Notice of Decision for Medical Benefits to ensure that the requested service(s) have actually been denied. Occasionally a requested service has been denied but a downgraded service may be approved. If the provider believes an inappropriate denial of service has occurred, the next step is to contact the Medicaid Ambulance Review Unit to request reconsideration or submit a formal appeal.
2. If the provider disagrees with the decision from the Medicaid Ambulance Review Unit, prepare a Request for Reconsideration. Include any additional or extenuating circumstances and specific information that will assist the authorizing agent in the reconsideration review.
3. Submit the written request directly to Medicaid Ambulance Review within 28 days of the date on the Notice of Decision for Medical Benefits.

Mail the Request for Reconsideration to:

Division of Medicaid
Ambulance Review
PO Box 83720
Boise, ID 83720-0009

Medicaid Ambulance Review will return a second Notice of Decision for Medical Benefits to the requestor within 28 days of receipt of the provider's Request for Reconsideration. If the reconsidered decision is still contested by the provider, the provider may then submit a written request for an appeal of the reconsideration review decision directly to DHW.

11.8 Requests for Reconsideration (Appeals) of Medicaid Ambulance Review

To submit a written request for an appeal of the Medicaid Ambulance Review decision, follow the steps below. Providers may fax all documentation, but the fax must be followed with copies of original documents in the mail. Prepare a written request for an appeal that includes:

- A copy of the Notice of Decision for Medical Benefits from Medicaid Ambulance Review.
- A copy of the Request for Reconsideration from the provider.
- A copy of the second Notice of Decision for Medical Benefits from Medicaid Ambulance Review showing that the request for reconsideration was performed.
- An explanation of why the reconsideration remains contested by the provider.
- Copies of all supporting documentation.

Mail the information to:

Hearings Coordinator
Idaho Department of Health & Welfare
Administrative Procedures Section
PO Box 83720
Boise, ID 83720-0036

12. Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training. These outpatient services are limited to participants and providers who meet the criteria specifically identified in *Medicaid Basic Plan Benefits IDAPA 16.03.09.640 Diabetes Education and Training Services – Definitions* through *645 Diabetes Education and Training Services – Provider Reimbursement*. Providers must operate an American Diabetes Association (ADA) recognized Diabetes Education Program to provide group diabetes counseling/training. Only Certified Diabetes Educators (CDE) may provide individual counseling through a recognized program in a physician's office or outpatient hospital. Their counseling services must be billed under the provider number of their employer, i.e., the hospital or physician's clinic provider number.

12.1 Individual Counseling - Diabetes/Education Training

For reimbursement, bill with procedure code **G0108** (1 Unit = 30 Minutes) in conjunction with revenue code **0942** to comply with Medicare billing instructions. The CDE's services are to augment and not be substituted for the services a physician is expected to provide to diabetic participants. Medicaid allows only 12 hours per participant, every five years, for individual counseling.

12.2 Group Counseling - Diabetes Education/Training

For reimbursement, bill with procedure code **G0109** (1 Unit = 30 Minutes), in conjunction with revenue code **0942** to comply with Medicare billing instructions. Only hospitals operating an ADA recognized program may bill for group counseling. Group counseling for diabetes education and training is limited to 24 hours, per participant, every five years.

13. Dietitian Service Policy

13.1 Overview

Dietitians may bill the Medicaid program directly for nutritional services provided to women on the PW (pregnant women) program and to children. Nutritional services include intensive nutritional education, counseling, and monitoring. Services must be rendered by either a registered dietitian or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university, and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association (ADA). If a dietitian works for a hospital, the hospital bills Medicaid directly for the services.

13.2 Covered Services

13.2.1 Pregnant Women (PW) Services

Nutritional services for women enrolled in the PW Program. All listed criteria must be met:

- Must be ordered by the participant's physician, nurse practitioner, or nurse midwife.
- Must be delivered after confirmation of pregnancy.

Extend only through the 60th day after delivery.

13.3 Limitations

13.3.1 Pregnant Women PW

Payment for two visits during the calendar year is available at a rate established under the provisions of *IDAPA 16.03.09.635 Nutritional Services – Provider Reimbursement*.

Note: If a dietitian works for a hospital, then the hospital bills directly for this service.

13.3.2 Children (Up to 21st Birthday)

Payment for two visits during the calendar year is available at a rate established under the provisions of *IDAPA 16.03.09.635 Nutritional Services – Provider Reimbursement*. Children may receive additional visits when medically necessary and prior authorized.

Mail PA request to:

Division of Medicaid
 Medical Care Unit
 PO Box 83720
 Boise, Idaho 83720-0009

Procedure Codes

Service	Code	Modifier	Description
PW nutritional services	S9470		Nutritional counseling, dietitian visit.
Children's nutritional services	S9470	No modifier required	Nutritional counseling, dietitian visit.
Education/Training	0942	HCPCS	For diabetes education and training, use HCPCS G0108 (Individual Counseling) and G0109 (Group Counseling). When billing for PW members, a pregnancy related diabetic diagnosis is required.