

Table of Contents

IHS, FQHC and RHC Services	3
1.Important Contacts.....	5
1.1. Gainwell Technologies.....	5
1.2. Provider Relations Consultants.....	6
1.3. Medicaid	7
1.4. Telligen, Inc	8
2.Provider Qualifications	9
2.1. Indian Health Services.....	9
2.1.1. References: Indian Health Services	9
2.2. Federally Qualified Health Center	10
2.2.1. References: Federally Qualified Health Center	10
2.3. Rural Health Clinics	12
2.3.1. References: Rural Health Clinics	12
3.Eligible Participants	13
3.1. Referrals.....	14
4.Covered Services and Limitations	15
4.1. Encounters.....	16
4.1.1. References: Encounters	17
4.2. Advance Directives.....	19
4.3. Audiology Services	20
4.4. Dental Encounter	21
4.5. Family Planning	22
4.5.1. References: Family Planning.....	22
4.6. Laboratory Services.....	23
4.7. Mental Health Services	24
4.8. Visiting Nursing Services.....	25
4.8.1. References: Visiting Nursing Services.....	25
4.9. Obstetric Care	27
4.10. Pharmacy.....	28
4.11. Radiology.....	29
4.12. Telehealth Services	30
4.13. Vision Services	31
5.Prior Authorizations	32
5.1. References: Prior Authorizations	33
5.1.1. Federal Regulations.....	33
5.1.2. Idaho Medicaid Publications.....	33
5.2. The Medical Care Unit.....	34
5.3. Telligen, Inc	35
6.Documentation Requirements.....	36

6.1. References: Documentation Requirements 36

6.1.1. State Regulations..... 36

7.Reimbursement 37

7.1. Indian Health Service Reimbursement 37

7.1.1. References: Indian Health Service Reimbursement 37

7.2. FQHC/RHC Reimbursement 38

7.2.1. References: FQHC/RHC Reimbursement..... 39

7.2.2. FQHC Residents..... 41

7.2.3. Managed Care Supplemental Payments 42

7.3. Overpayments and Underpayments..... 43

7.3.1. References: Overpayments and Underpayments 43

Appendix A. IHS, FQHC and RHC Services, Provider Handbook Modifications..... 44

IHS, FQHC and RHC Services

This chapter of the Idaho Medicaid Provider Handbook describes Medicaid-covered services provided by:

- Indian Health Service Clinics (IHS);
- Federally Qualified Health Center (FQHC); and
- Rural Health Clinics (RHC).

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

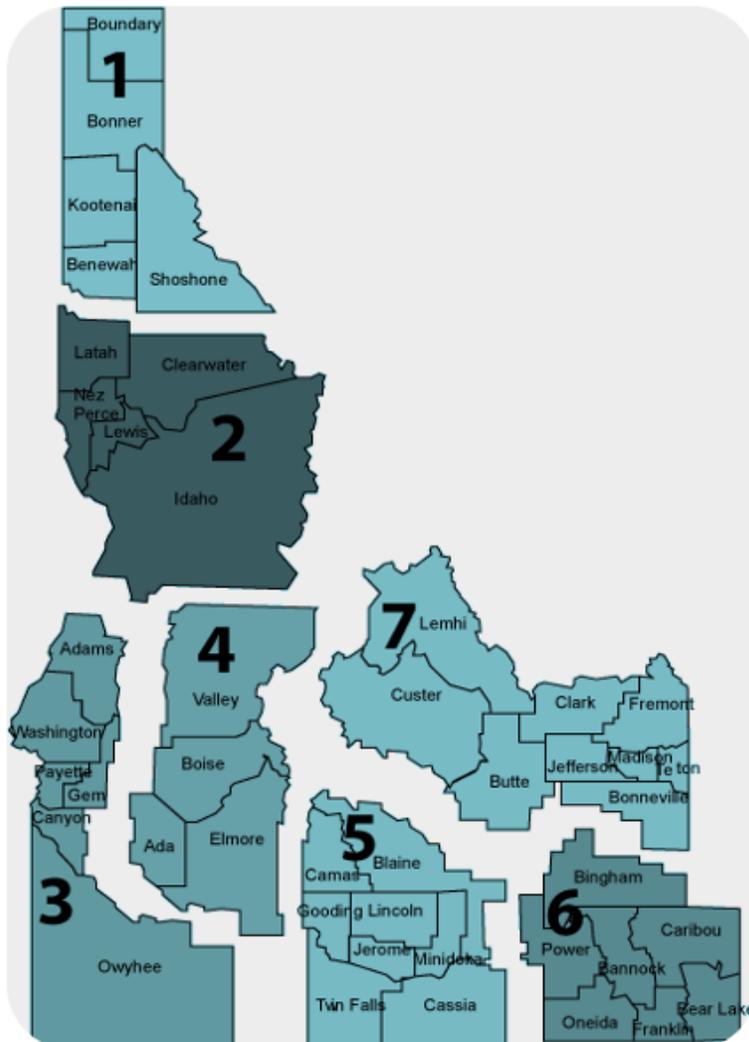
[Gainwell Technologies](#) is Idaho Medicaid's fiscal agent that handles all claims processing and customer service issues.

Gainwell Technologies Contact Information
<p>Gainwell Technologies Provider Services P.O. Box 70082 Boise, ID 83707 Phone: 1 (888) 686-4272 Fax: 1 (877) 661-0974 IDProviderServices@dxc.com</p> <p>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.</p>
<p>Provider Enrollment P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2041 IDProviderEnrollment@dxc.com</p>
<p>Technical Services Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2040 IDEDISupport@dxc.com</p>

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) 373-1309
Region.1@dxc.com

Region 2 and the state of Montana

1 (208) 373-1326
Region.2@dxc.com

Region 3 and the state of Oregon

1 (208) 373-1475
Region.3@dxc.com

Region 4 and all other states

1 (208) 373-1351
Region.4@dxc.com

Region 5 and the state of Nevada

1 (208) 373-1357
Region.5@dxc.com

Region 6 and the state of Utah

1 (208) 373-1325
Region.6@dxc.com

Region 7 and the state of Wyoming

1 (208) 373-1408
Region.7@dxc.com

1.3. Medicaid

The Medical Care Unit is Idaho Medicaid’s team that reviews prior authorizations for a number of services.

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](#). They also conducted reviews of inpatient stays and laboratory services.

Telligen
670 E Riverpark Ln. Suite 120
Boise, ID 83706
Phone: 1 (866) 538-9510
Fax: 1 (866) 539-0365
E-mail: idmedicaidsupport@telligen.com

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

2. Provider Qualifications

2.1. Indian Health Services

Indian Health Service clinics (IHS) are health services for Indians administered by the Indian Health Service within the Department of Health and Human Services. Medicaid reimburses IHS through an all-inclusive rate for each participant [encounter](#). IHS in any state are eligible to participate in the Idaho Medicaid Program. Clinics must have a National Provider Identification (NPI). A group roster with signatures is required for provider enrollment.

Clinics must follow the provider handbook and all applicable state, and federal, rules and regulations. 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: Indian Health Services

(a) *Federal Regulations*

Definitions, 42 CFR 447.51 (2019). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec447-51.pdf>.

"Indian Health Service Facilities." Social Security Act, Sec. 1911 (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1911.htm.

Participation by Indian Health Service Facilities, 42 CFR 431.110 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec431-110.pdf>.

(b) *State Regulations*

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

2.2. Federally Qualified Health Center

A federally qualified health center (FQHC) is a community health center, a migrant health center, a provider of care for the homeless, an outpatient health program, or a facility operated by an Indian tribal organization under the Indian Self-determination Act. Some clinics that provide ambulatory services may qualify even though they are not receiving grants under *Section 329, 330, or 340* of the [Public Health Service Act](#). An FQHC may enter into the respective provider agreement observing all conditions applicable to all providers of the service after the Department of Health and Human Services and the Health Resources and Service Administration (HRSA) determine that the center meets the requirements to qualify for FQHC status.

FQHC in any state are eligible to participate in the Idaho Medicaid Program. FQHCs must have certification and National Provider Identification (NPI). A group roster with signatures is required for provider enrollment. If an FQHC is enrolled as a rural health clinic (RHC), it must terminate its RHC enrollment while enrolling as an FQHC.

FQHCs must follow the provider handbook and all applicable state, and federal, rules and regulations. See [General Information and Requirements](#) for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.2.1. References: Federally Qualified Health Center

(a) Federal Regulations

Coverage of Rural Health Clinic and Federally Qualified Health Center (FQHC) Services, 42 CFR 440.365 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec440-365.pdf>.

"Definitions." Social Security Act, Sec. 1905(a)(2)(C) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions." Social Security Act, Sec. 1905(l)(2) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Public Health Service Act. P.L. 116-260 (2020). Government Printing Office, <https://www.govinfo.gov/content/pkg/COMPS-8773/pdf/COMPS-8773.pdf>.

"State Flexibility in Benefit Packages." Social Security Act, Sec. 1937(b)(4) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1937.htm.

(b) Idaho State Plan

"Federally Qualified Health Center (FQHC)." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

(c) State Regulations

"Federally Qualified Health Center (FQHC)." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 10.26. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Federally Qualified Health Centers (FQHCs)." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 830.04. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

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

2.3. Rural Health Clinics

A rural health clinic (RHC) is located in a rural area designated as a physician shortage area, and is neither a rehabilitation agency nor does it primarily provide for the care and treatment of mental diseases. The provider must be confirmed as eligible by the Public Health Service and the Centers for Medicare and Medicaid Services. Clinics in any state are eligible to participate in the Idaho Medicaid Program. RHCs must have Medicare certification and National Provider Identification (NPI). A group roster with signatures is required for provider enrollment. If an RHC is enrolled as a federally qualified health center (FQHC), it must terminate its FQHC enrollment while enrolling as an RHC.

Clinics must follow the provider handbook and all applicable state, and federal, rules and regulations. See [General Information and Requirements](#) for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.3.1. References: Rural Health Clinics

(a) Federal Regulations

Coverage of Rural Health Clinic and Federally Qualified Health Center (FQHC) Services, 42 CFR 440.365 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec440-365.pdf>.

"Definitions." Social Security Act, Sec. 1905(a)(2)(B) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions." Social Security Act, Sec. 1905(l)(1) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions of Services, Institutions, Etc." Social Security Act, Sec. 1861(aa) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

"State Flexibility in Benefit Packages." Social Security Act, Sec. 1937(b)(4) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1937.htm.

(b) Idaho State Plan

"Rural Health Clinics." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

(c) State Regulations

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

"Rural Health Clinic (RHC) Services." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 820. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Rural Health Clinic (RHC) Services: Coverage and Limitations." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 823. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

3. Eligible Participants

Participants with Medicaid Basic and Enhanced Plans are eligible to receive services in an Indian Health Services Clinic (IHS), federally qualified health center (FQHC) or rural health clinic (RHC). IHS, FQHC and RHC 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

Participants enrolled in Healthy Connections (HC), may require a referral for services to be reimbursed. For more information refer to the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook.

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

4. Covered Services and Limitations

The services of Indian Health Services (IHS), Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) 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. See the [Prior Authorizations](#) section for more information. Services that qualify as described in the Encounters section shall be billed at the encounter rate.

4.1. Encounters

Encounters fall into one of two categories depending on the provider. Indian Health Service Clinics (IHS) and Federally Qualified Health Centers (FQHC) provide either dental or medical/mental health encounters. Rural Health Clinics (RHC) provide either medical or mental health encounters. An encounter is defined as a face-to-face contact for the provision of one of these types of services between a participant and one of the following:

- A physician;
- A physician assistant;
- A nurse practitioner;
- A podiatrist;
- A chiropractor;
- A clinical social worker;
- A clinical psychologist;
- An other specialized nurse practitioner; or
- A [visiting nurse](#).

All contact with providers for the same type of encounter counts as a single encounter. An encounter with more than one health professional, or multiple contacts with the same professional, in the same day, and all incidental services constitutes a single encounter. If a participant has a visit with a healthcare professional that qualifies as an encounter, any group education or activities provided on the same day are included in the encounter. Missed appointments, visits to pick up medication, or incidental services on the day of the encounter are not considered a separate encounter. Encounters are limited to two per day for RHCs, and three per day for IHS and FQHCs.

An exception is allowed for an additional encounter of the same type when a participant, subsequent to the first encounter, suffers an illness or injury that requires additional diagnosis and treatment and is supported by documentation. Qualifying additional encounters should be billed with Modifier 59.

On a day in which an encounter occurs all of these services are bundled into the encounter rate as incidental services:

- In-house radiology;
- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Audiology;
- In-house laboratory services;
- In-house nutritional education or counseling and monitoring by a registered dietitian;
- Injectable medications (Does not apply to non-FQHC/RHC Indian Health Services); and
- Medical equipment and supplies.

An exception to the above incidental services is long acting reversible contraception (LARC) and non-surgical Transcervical permanent female contraceptive devices, which may be reimbursed outside the encounter under standard fee-for-service reimbursement. Payment is made through either 340B drug pricing, or the lower of the provider's customary charge for the service or the rate listed on the [Numerical Fee Schedule](#).

If the services bundled into an encounter are provided on a day when a qualifying encounter does not occur, the clinic may bill these services separately and be reimbursed the lessor of their customary charge or the amount listed on the [Numerical Fee Schedule](#). The provider must have a separate provider number to bill for those services. The provider may also bill

any other ambulatory services that are not part of the encounter under a separate provider number from their IHS, RHC or FQHC NPI.

Encounters are billed with HCPCS T1015 with the appropriate rate charge. All services bundled into the encounter are listed on the claim below the T1015 claim line using the appropriate CPT®/HCPCS for the services provided and billed at \$0.

Places of Service for Encounters	
Place of Service	Description
4	Homeless Shelter
5	Indian Health Services
6	Indian Health Service; Provider-based Facility
7	Tribal 638; Free-standing Facility
8	Tribal 638; Provider-based Facility
12	Home
14	Group Home
15	Mobile Unit
16	Temporary Lodging
50	Federally Qualified Health Center
72	Rural Health Clinic
99	Other Place of Service

4.1.1. References: Encounters

(a) Federal Regulations

Incident to Services and Direct Supervision, 42 CFR 405.2415 (2017). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol2/pdf/CFR-2019-title42-vol2-sec405-2415.pdf>.

Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services, 42 CFR 405.2414 (2014). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol2/pdf/CFR-2019-title42-vol2-sec405-2414.pdf>.

Outpatient Hospital Services and Rural health Clinic Services, 42 CFR 440.20(b) (2009). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec440-20.pdf>.

Services and Supplies Incident to a Physician's Services, 42 CFR 405.2413 (2017). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol2/pdf/CFR-2019-title42-vol2-sec405-2413.pdf>.

(b) Idaho Medicaid Publications

"Attention Federally Qualified Health Centers (FQHC), Indian Health Clinic (IHC), and Rural Health Clinic (RHC) Providers." *MedicAide Newsletter*, November 2012, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202012%20MedicAide.pdf>.

"Encounter Billing for Group Visits." *MedicAide Newsletter*, June 2015, <https://www.idmedicaid.com/MedicAide%20Newsletters/June%202015%20MedicAide.pdf>.

"Federally Qualified Health Clinic/Rural Health Clinic Billing." *MedicAide Newsletter*, October 2006, <http://healthandwelfare.idaho.gov>.

Indian Health Clinics, *Information Release MA03-08* (2003). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov>.

Indian Health Clinics, *Information Release MA03-66* (2003). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov>.

Place-of-Service Codes for Professional Claims, *Information Release MA03-85* (11/01/2003). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov>.

Reimbursement for Long Acting Reversible Contraception (LARC) and Non-Surgical Transcervical Permanent Female Contraceptive Devices, *Information Release MA16-12* (08/12/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13362&dbid=0&repo=PUBLIC-DOCUMENTS>.

Rural Health Clinics, Federally Qualified Health Centers (FQHCs), and Indian Health Providers, *Information Release MA03-50* (2003). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov>.

(c) Idaho State Plan

"Federally Qualified Health Center (FQHC)." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Rural Health Clinics." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

(d) State Regulations

"Encounter." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 830.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Federally Qualified Health Center (FQHC) Services: Coverage and Limitations." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 832. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"FQHC Encounter Limitations and Exceptions." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 835.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Indian Health Service (IHS): Coverage and Limitations." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 842. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"RHC Encounter." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 826.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

4.2. Advance Directives

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

4.3. Audiology Services

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

4.4. Dental Encounter

A dental encounter is a face-to-face contact for the provision of dental services between a participant and a dentist or dental hygienist. MCNA is the administrator for Idaho Smiles. For eligibility, benefits, and claims processing information, contact MCNA Customer Service at 1 (855) 235-6262, or at the [MCNA website](#).

A participant's identification number for both Idaho Smiles and Medicaid are the same. If a participant does not have an Idaho Smiles insurance card, they may use their Medicaid identification (MID) number.

4.5. Family Planning

All claims for services or supplies that are provided as part of a family planning must be billed with encounter code **T1015** and the **FP** (Family Planning) modifier. An exception to billing the encounter code are the charges for long acting reversible contraception (LARC) and non-surgical Transcervical permanent female contraceptive devices, which may be reimbursed outside the encounter under standard fee-for-service reimbursement. Payment is made through either 340B drug pricing, or the lower of the provider's customary charge for the service or the rate listed on the [Numerical Fee Schedule](#).

Refer to the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook for more information about Family Planning services.

4.5.1. References: Family Planning

(a) *Idaho Medicaid Publications*

Federally Qualified Health Centers (FQHC), Rural Health Clinics, *Information Release MA03-64* (2003). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov>.

Indian Health Clinics, *Information Release MA03-66* (2003). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov>.

(b) *Idaho State Plan*

"Federally Qualified Health Center (FQHC)." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

4.6. Laboratory Services

Laboratory services performed in the facility are included in the encounter visit and cannot be billed as a separate service to Medicaid. The exception is when an individual receives laboratory services on a day when there is no encounter billed for a clinic visit. These laboratory services may not be billed as an encounter. The clinic must have a separate laboratory provider number or a separate group physician number to bill for lab services. The reimbursement will be fee-for-service rather than an encounter rate. If an outside laboratory instead of the clinic performs a pathology/laboratory service, the outside lab must bill Medicaid directly.

4.7. Mental Health Services

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

An Indian Health or Tribal 638 Clinic may bill a mental health encounter for services provided to a Medicaid participant with a substance abuse diagnosis when provided by a Certified Substance Abuse Counselor with an Idaho Board of Alcohol/Drug Counselor Certification (IBADCC). Substance Abuse Counselor Certifications from other states will be allowed when the certification requirements are equal to the requirements of the IBADCC.

4.8. Visiting Nursing Services

Visiting nursing services are a covered benefit under Idaho Medicaid. Services include personal care services, and those provided by a registered professional nurse or licensed practical nurse so long as the participant's safety and the medical efficacy of the service can be assured. Personal care services include assistance with bathing, ambulation and medications. It does not include custodial care services such as housekeeping. Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) can provide visiting nursing services if they are located in an area determined to have a shortage of home health agencies by the Secretary of Health and Human Services.

Participants must be homebound to receive visiting nursing services. Homebound means a participant who is permanently or temporarily confined to their residence, other than a hospital or skilled nursing facility, because of a medical or health condition. A participant may still be considered homebound if they leave their residence infrequently.

The services must be provided by a registered professional nurse or licensed practical nurse that is employed or contracted by the FQHC or RHC. Visiting nursing services must be furnished under a written plan of care established, signed and recertified every 60 days by a physician or non-physician practitioner (except pharmacist). Plans established by non-physician practitioners must be certified by a physician every 60 days.

Visiting nursing services are billed as encounters.

4.8.1. References: Visiting Nursing Services

(a) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(l)(1) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions of Services, Institutions, Etc." Social Security Act, Sec. 1861(aa) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

Outpatient Hospital Services and Rural health Clinic Services, 42 CFR 440.20(b) (2009). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec1001-701.pdf>.

Visiting Nurse Services: Determination of Shortage of Agencies, 42 CFR 405.2417 (2014). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec1001-701.pdf>.

(b) Idaho State Plan

"Federally Qualified Health Center (FQHC)." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Rural Health Clinics." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

(c) State Regulations

"FQHC Services." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 832.09. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Home Health Agency Shortage Area Services." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 823.08. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

4.9. Obstetric Care

Obstetrical care is considered part of the prospective payment system for encounters. Indian Health Service Clinics (IHS), Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must follow the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook for obstetric care. Providers in an IHS, FQHC or RHC bill the global charge or, when appropriate, bundled visit code for obstetrical care under a single encounter.

4.10. Pharmacy

The clinic may not bill pharmaceutical services as an encounter. Pharmaceutical services for take home prescription medications are covered under the Medicaid Pharmacy Program. Claims must be submitted to Medicaid on the Idaho Pharmacy claim form under the pharmacy's provider number. Over-the-counter (OTC) pharmaceuticals are not covered by Medicaid, with the exception of those OTC items identified as payable in the [Idaho Medicaid Pharmacy Claims Submission Manual](#). Please, see the 340B Pharmacy Billing section of the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for information about 340B requirements.

4.11. Radiology

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

4.12. Telehealth Services

Telehealth services provided as an encounter by a facility are reimbursable if the services are delivered in accordance with the Idaho Medicaid Telehealth Policy and applicable handbooks. See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for more information about eligible services and billing requirements.

4.13. Vision Services

Services provided by an ophthalmologist are billable as an encounter. However, vision exams provided by other providers such as optometrists must be billed under a vision service provider number. See the [Eye and Vision Services](#), Idaho Medicaid Provider Handbook for more information about criteria, and billing for non-ophthalmologist services.

5. Prior Authorizations

A prior authorization (PA) is a written, faxed or electronic approval from the Department 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. If the services are not covered by Medicare, or the participant has another primary payor, Medicaid prior authorizations are required as if the participant had Medicaid primary.

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. 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. References: Prior Authorizations

5.1.1. 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>.

5.1.2. 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. A copy of 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](#). 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](#). Prior authorization requests through Telligen, Inc. may be submitted through their online portal, fax or mail:

Telligen
670 East Riverpark Lane, Suite 170
Boise, ID 83706
Fax: 1 (800) 826-3836
[Telligen 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](#). The status of a prior authorization request may be checked online at the [provider portal](#), or by contacting Telligen, Inc. customer service at 1 (866) 538-9510.

See the [QIO Provider Manual](#) for information about requesting prior authorizations from the QIO, Telligen.

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. In addition, Federally Qualified Health Centers must submit a copy of their Medicare cost report to the Department on an annual basis using the same deadline as Medicare.

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. References: Documentation Requirements

6.1.1. State Regulations

"Annual Filing Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 836.04. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"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

7.1. Indian Health Service Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Medicaid reimburses Indian Health Service clinics (IHS) through an all-inclusive rate for each participant encounter. The all-inclusive rate for IHS is established by the Federal Office of Management and Budget as published annually in the Federal Register. IHS should always bill with the most current encounter rate. This practice will allow DHW to run mass adjustments in the event that the claims processing system does not have the most current rate on file as of January 1. Prescription drugs will be reimbursed separately. A dispensing fee will be reimbursed at the midpoint of the range of fees in effect on the date of service unless the pharmacy cost of operations report justifies a higher fee. Services are billed on a CMS-1500 claim form.

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.

7.1.1. References: Indian Health Service Reimbursement

(a) State Regulations

"Indian Health Service (IHS): Coverage and Limitations." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 842. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Indian Health Service (IHS): Provider Reimbursement." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 845. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

7.2. FQHC/RHC Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Idaho Medicaid reimburses medically necessary services through Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) using a prospective payment system (PPS) for qualifying encounters. Prospective payment rates are set based on the amount paid in the previous federal fiscal year for the encounter categories medical/mental health and dental. The amount is calculated by taking the total amount of annual costs in the previous year for the encounter category and dividing it by the total number of encounters of that category for the year. The resulting encounter rate is then adjusted by the percentage increase in the Medicare Economic Index (MEI) for primary care services with additional adjustments for any changes in scope of services. This sets the interim encounter rate for existing FQHCs.

Out-of-state FQHC/RHC providers with less than 100 encounters or less than \$10,000 in payments will be designated a low utilization provider. Low utilization providers have encounter rates set as if they were a new FQHC/RHC. At the Department's discretion an audit may be conducted to set a new rate if there is an increase in encounters or payments on the provider's Medicare cost report.

New FQHC/RHC PPS interim rates are established by reference to centers with similar caseloads in the same or adjacent areas. If one is unavailable, rates will be set using historical cost information. In the absence of historical cost information, the Department will use budgeted cost reporting submitted by the provider. If none of these methods are possible, interim rates will be set based on FQHC/RHCs with similar caseloads in adjacent regional areas.

Prospective payment rates can be adjusted to an interim rate if the FQHC or RHC experiences a change in its scope of services, but not if the cost of those services fluctuates. A change in the scope of service is the addition or discontinuation of any service included in the PPS, or a change to the type, intensity, duration or amount of services. Changes for scope of service must be approved by the federal [Human Resources and Services Administration \(HRSA\), Bureau of Primary Healthcare](#). Requests must be made to the Department within 60 days of HRSA's approval, or the planned change if approval is not required. The request must contain the same documentation required by HRSA for a change. The Department makes the final determination on if the scope of services has changed. If it is determined that the scope of services has changed from the established prospective payment rate, the Bureau of Financial Operations (BFO) will request a budget from the provider to determine an interim rate, and may audit the Medicare cost report.

The Department will set a finalized rate for FQHC/RHCs that have been FQHC/RHCs for at least 24 months and provide historical cost and encounter information. The finalized rate will be calculated using the second full twelve-month Medicare cost report. A supplemental worksheet is available to identify additional costs. Once a finalized rate is set, claim payments will be adjusted on all interim rates to the finalized amount, which may cause an [overpayment or underpayment](#).

Idaho Medicaid reimburses medically necessary services that do not qualify as an encounter on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance listed in the [Numerical Fee Schedule](#).

Services must be billed on a CMS-1500 claim form. 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.

Some participants may be responsible for a co-pay for services provided in an FQHC and RHCs. See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-pays.

7.2.1. References: FQHC/RHC Reimbursement

(a) Federal Regulations

Outpatient Hospital Services and Rural Health Clinic Services, 42 CFR 440.20(b) (2009). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec1001-701.pdf>.

Services Furnished by Rural Health Clinic Services, 42 CFR 447.371 (1986). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec447-371.pdf>.

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

(b) Idaho Medicaid Publications

Co-payments (Co-pays), *Information Release MA11-29* (01/22/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov>.

Scope of Service Changes, *Information Release MA06-02* (2002). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov>.

(c) Idaho State Plan

"Federally Qualified Health Center (FQHC)." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

(d) State Regulations

"Change in Intensity of Services of an FQHC." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 830.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Encounter Rate." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 830.03. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Federally Qualified Health Center (FQHC) Services: Rate Setting Methodology." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 836. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Federally Qualified Health Center (FQHC) Services: Reimbursement Methodology." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 835. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Indian Health Service (IHS): Coverage and Limitations." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 842. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Medicare Economic Index (MEI)." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 830.06. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Rural Health Clinic (RHC) Services: Reimbursement Methodology." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 826. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

7.2.2. FQHC Residents

Additional payments are available to Federally Qualified Health Centers (FQHC) outside the prospective payment system (PPS) for primary care resident physicians. A primary care resident physician is an individual with an Idaho post graduate training certificate, who is enrolled in an Idaho FQHC primary care residency program. Additional payments are made on a quarterly basis to eligible FQHCs. In order to be considered eligible the FQHC must enter into an agreement with the Department and submit quarterly reports with the hours worked by primary care resident physicians and the percentage of participants treated during that quarter. These payments cannot replace or duplicate any payments for residents received from Medicare.

(a) References: FQHC Residents

(i) Federal Regulations

Allowable Costs, 42 CFR 405.2468(f) (2014). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol2/pdf/CFR-2019-title42-vol2-sec405-2468.pdf>.

(ii) Idaho State Plan

"Federally Qualified Health Center (FQHC)." Enhanced Alternative Benefit Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

7.2.3. Managed Care Supplemental Payments

Federally Qualified Health Centers that contract with an Idaho Medicaid managed care organization (MCO) will receive quarterly supplemental payments to address any difference between payments received from the MCO for an encounter and the prospective payment system rate through the Department.

(a) References: Managed Care Supplemental Payments

(i) State Regulations

"Quarterly Supplemental Payments." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 836.05. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

7.3. Overpayments and Underpayments

Idaho Medicaid will pay interest on underpayments and collect interest on overpayments made to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) at the rate of 12¢ per \$100.

The Department will send a notice of overpayment to providers. If the provider doesn't pay the balance in full within 60 days of receiving the notice, interest will begin to accrue on the unpaid balance. Interest will be charged every month and applied to the unpaid balance. Payments made will be applied first toward the outstanding interest and then the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. The Department has the right to waive interest charges if the administrative cost of collection is greater than the amount due. The principal and accumulated interest will be retroactively adjusted based on any changes ordered through a final determination in the administrative appeal or judicial appeal process. Additionally, the Department may garnish Medicare payments from a provider with an outstanding balance.

Providers may request a repayment plan of one year or less in writing with adequate documentation that full repayment sooner would irreparably compromise the financial integrity of the business. Requests must be made within 30 days of receiving notice of the overpayment.

Information about self-reporting overpayments and the benefits are available in the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook.

7.3.1. References: Overpayments and Underpayments

(a) State Regulations

"Handling of Overpayments and Underpayments." IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 231. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Money of Account and Interest, Idaho Code 28-22-104 (1996). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title28/t28ch22/sect28-22-104/>.

Appendix A. IHS, FQHC and RHC Services, Provider Handbook Modifications

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

IHS, FQHC and RHC Services, Provider Handbook Modifications				
Version	Section/ Column	Modification Description	Publish Date	SME
2.0	All	Published version	3/5/2021	TQD
1.0	All	Initial document – Published version	3/2/2021	W Deseron E Garibovic