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IHS, FQHC and RHC Services

This 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.

Should the handbook ever appear to contradict relevant provisions of Idaho or federal rules and regulations, the rules and regulations prevail. Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies’ Idaho Medicaid website. Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Handbooks 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 These are included in the handbook for historical reference.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 Policies, Procedures, and Waivers webpage under policies in Medicaid Policies 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.

Some citations may not be available on the internet. Copies of the documents may be requested with a public records request. Guidance for public records requests is available on the Department’s website.
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.

<table>
<thead>
<tr>
<th>Gainwell Technologies Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gainwell Technologies Provider Services</td>
</tr>
<tr>
<td>P.O. Box 70082</td>
</tr>
<tr>
<td>Boise, ID 83707</td>
</tr>
<tr>
<td>Phone: 1 (888) 686-4272</td>
</tr>
<tr>
<td>Fax: 1 (877) 661-0974</td>
</tr>
<tr>
<td><a href="mailto:IDProviderServices@gainwelltechnologies.com">IDProviderServices@gainwelltechnologies.com</a></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Provider Enrollment</th>
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</thead>
<tbody>
<tr>
<td>P.O. Box 70082</td>
</tr>
<tr>
<td>Boise, ID 83707</td>
</tr>
<tr>
<td>Phone: 1 (866) 686-4272</td>
</tr>
<tr>
<td>Fax: 1 (877) 517-2041</td>
</tr>
<tr>
<td><a href="mailto:IDProviderEnrollment@gainwelltechnologies.com">IDProviderEnrollment@gainwelltechnologies.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1 (866) 686-4272</td>
</tr>
<tr>
<td>Fax: 1 (877) 517-2040</td>
</tr>
<tr>
<td><a href="mailto:IDEDISupport@gainwelltechnologies.com">IDEDISupport@gainwelltechnologies.com</a></td>
</tr>
</tbody>
</table>
1.2. Provider Relations Consultants

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

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

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

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

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

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

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

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

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

Region 9 all other states (not bordering Idaho)
1 (208) 609-5115
Region.9@gainwelltechnologies.com
1.3. Magellan Healthcare, Inc.

Magellan Healthcare, Inc. is Idaho Medicaid’s managed care contractor for the Idaho Behavioral Health Plan. Magellan covers all behavioral health and substance use disorder claims with a primary diagnosis code listed in the Behavioral Health and Social Services, Idaho Medicaid Provider Handbook.

Magellan Healthcare, Inc.
P.O. Box 1029
Maryland Heights, MO 63043
Phone: 1 (855) 202-0983
Fax: 1 (888) 656-9795
E-mail: IdahoProvider@MagellanHealth.com

The Idaho Behavioral Health Plan does not cover participants enrolled in Idaho Medicaid Plus or the Medicare Medicaid Coordinated Plan (MMCP). Participants enrolled in dual plans receive their behavioral health services from the health plans in which they are enrolled.
1.4. 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.
1.5. 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
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 provider 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


(b) State Regulations

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


(b) Idaho State Plan


(c) State Regulations


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


(b) Idaho State Plan


(c) State Regulations


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 individuals 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.
3.2. Copayments

Tribal members cannot be charged a copayment when receiving services through the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or their contractors. Reimbursement for these services may not be decreased for a copayment amount.

3.2.1. References: Copayments

(a) CMS Guidance


(b) Federal Regulations


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 three (3) categories depending on the provider. Indian Health Service Clinics (IHS) and Federally Qualified Health Centers (FQHC) provide either dental, medical, or 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 dentist;
- A dental hygienist;
- A physician;
- A physician assistant;
- A nurse practitioner;
- Any other specialized nurse practitioner;
- A clinical nurse specialist;
- A visiting nurse;
- A podiatrist;
- A chiropractor;
- A licensed professional counselor;
- A licensed clinical professional counselor;
- A licensed marriage and family therapist;
- A licensed social worker;
- A licensed clinical social worker;
- A licensed master’s social worker;
- A clinical psychologist; or
- Any other behavioral health or substance use disorder license type recognized by the Idaho Division of Professional Licensing.

All contact with providers for the same type of encounter (dental, medical or mental health) counts as a single encounter. An encounter for the same category of service 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.

If multiple categories of service are provided by the same provider, for example medical and behavioral health services from a physician, these are billed as a single encounter under either the medical or behavioral health benefit depending on the primary diagnosis. Providers cannot bill both medical and behavioral health encounters in this situation.

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 (2) per day for RHCs, and three (3) 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; and
• Medical equipment and supplies.

Long-acting reversible contraception (LARC) and non-surgical Transcervical permanent female contraceptive devices, reimbursement 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 lesser 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. Encounter claims will be denied when there are no payable services listed with CPT®/HCPCS under T1015. This may occur if no codes are listed, codes listed include non-covered services, or a service is denied for another reason.

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>4</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td>5</td>
<td>Indian Health Services</td>
</tr>
<tr>
<td>6</td>
<td>Indian Health Service; Provider-based Facility</td>
</tr>
<tr>
<td>7</td>
<td>Tribal 638; Free-standing Facility</td>
</tr>
<tr>
<td>8</td>
<td>Tribal 638; Provider-based Facility</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
</tr>
<tr>
<td>16</td>
<td>Temporary Lodging</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>99</td>
<td>Other Place of Service</td>
</tr>
</tbody>
</table>

Depending on the service, encounters and non-encounter services are billed to the following:
• Mental health services provided by FQHCs and RHCs are billed to Magellan Healthcare, Inc. IHS may bill these services to Gainwell Technologies or Magellan Healthcare, Inc.
• Dental services are billed to MCNA.
• Medical services are billed to Gainwell Technologies.
4.1.1. References: Encounters

(a) Federal Regulations


(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.


(c) **Idaho State Plan**


(d) **State Regulations**


4.2. Advance Directives
Medicaid has directed home health care (including FQHCs, RHCs, and IHS) providers to give all adult Medicaid participants information on advance directives 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 provided as part of 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 rate 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**


(b) **Idaho State Plan**

4.6. Laboratory Services

Laboratory services performed in the facility are included in the encounter rate 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 a separate 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 laboratory must bill Gainwell Technologies directly.
4.7. Mental Health Services

Idaho Medicaid’s mental health and substance use services are covered under the Idaho Behavioral Health Plan (IBHP) with benefits administered under contract by Magellan Healthcare, Inc. Claims should not be submitted to Gainwell Technologies for services, including encounters, with a primary behavioral health or substance use disorder diagnosis code listed in the Behavioral Health and Social Services, Idaho Medicaid Provider Handbook.

Indian Health Services are encouraged to enroll with Magellan. They are not required to do so and may continue to bill Gainwell Technologies for all services. Behavioral health and substance use disorder services may not be billed to both Gainwell Technologies and Magellan.

An Indian Health or Tribal 638 Clinic may bill a mental health encounter for services provided to a Medicaid participant with a substance use diagnosis when provided by a certified Alcohol/Drug Counselor with an Idaho Board of Alcohol/Drug Counselor Certification (IBADCC). Substance Use 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 as 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 the participant is 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 FHQC 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


(b) Idaho State Plan


(c) **State Regulations**


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. Virtual Care Services

Virtual care services provided as an encounter by a facility are reimbursable if the services are delivered in accordance with the Virtual Care Services section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.
4.13. Vaccinations

If a participant sees an encounter eligible healthcare professional, vaccine administration is included as part of the encounter rate, even if no other service is provided. The vaccine and administration CPT® must be listed under the encounter code for billing. When the vaccine is free to the provider, then the SL modifier must be included. If the participant does not see an encounter eligible health professional, the vaccine administration rate should be billed as fee-for-service, using the vaccine and administration codes. Fee-for-service reimbursement is paid at the provider’s usual and customary fee up to the Medicaid maximum allowance listed in the Numerical Fee Schedule.

See the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook for more information about vaccines and immunizations including age and other requirements.

4.13.1. References: Vaccinations

(a) Idaho Medicaid Publications


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 Authorization
See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on prior authorizations.
6. Documentation

All providers are required to generate records at the time the service is delivered and to maintain documentation to support reimbursement for services. Individual services may have additional documentation requirements. General requirements for documentation and signatures can be found in General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, including standard retention requirements. Records limited to checklists with attendance/appointments, procedure codes, and units of time are insufficient to meet this requirement. Documentation must be signed and dated by the person delivering the service with their name clearly printed. 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 immediately upon request by Department personnel acting in their official capacity. Services delivered without adequate documentation are not eligible for reimbursement. Providers should only submit records for utilization management when requested by the Department. Documentation sent unsolicited, or not for a service requiring prior authorization, may not be reviewed by the Department. Unreviewed documentation does not constitute approval or authorization of a service.

6.1. References: Documentation

6.1.1. State Regulations


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 if 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 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. Idaho Medicaid is the primary payer for the following third-party insurers as they are exempt from third-party liability:

- 6243 SHASTA ADMIN SERVICES-INDIAN HEALTH
- 6233 HEALTHCARE MGT ADMIN - AN/AI

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


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) CMS Guidance


(b) Federal Regulations


(c) Idaho Medicaid Publications


(d) Idaho State Plan


(e) State Regulations


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. 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 Medicare payments for residents.

(a) References: FQHC Residents

(i) Federal Regulations

(ii) Idaho State Plan
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 per year.

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

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

This table lists the last three (3) years of changes to this handbook as of the publication date.

<table>
<thead>
<tr>
<th>Version</th>
<th>Section/Column</th>
<th>Modification Description</th>
<th>Publish Date</th>
<th>SME</th>
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<td>6.0</td>
<td>All</td>
<td>Published version</td>
<td>07/01/2024</td>
<td>TQD</td>
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<td>5.13</td>
<td>7.3. Overpayments and Underpayments</td>
<td>Clarifies interest calculation.</td>
<td>06/27/2024</td>
<td>W Deseron M Hanifen</td>
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<td>5.12</td>
<td>7.2.3. Managed Care Supplemental Payments</td>
<td>Deleted section.</td>
<td>06/27/2024</td>
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<td>5.11</td>
<td>7.2. FQHC/RHC Reimbursement</td>
<td>Added mental health as separate category.</td>
<td>06/27/2024</td>
<td>W Deseron M Hanifen</td>
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<td>5.10</td>
<td>7.1. Indian Health Service Reimbursement</td>
<td>Added secondary payers to Medicaid.</td>
<td>06/27/2024</td>
<td>W Deseron M Hanifen</td>
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<td>5.9</td>
<td>6. Documentation Requirements</td>
<td>Renamed Documentation. Updated to standard language.</td>
<td>06/27/2024</td>
<td>W Deseron M Hanifen</td>
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<td>5.8</td>
<td>5. Prior Authorization</td>
<td>Deleted content and subsections to point to the general handbook.</td>
<td>06/27/2024</td>
<td>W Deseron M Hanifen</td>
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<td>5.7</td>
<td>4.13. Vaccinations</td>
<td>Clarified SL modifier requirement.</td>
<td>06/27/2024</td>
<td>W Deseron M Hanifen</td>
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<td>5.6</td>
<td>4.12. Telehealth Services</td>
<td>Renamed Virtual Care Services.</td>
<td>06/27/2024</td>
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<td>5.5</td>
<td>4.7. Mental Health Services</td>
<td>Updated from Optum to Magellan.</td>
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<td>5.4</td>
<td>4.1. Encounters</td>
<td>Updated to reflect latest State Plan Amendment. Clarified when encounters are denied.</td>
<td>06/27/2024</td>
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<td>5.3</td>
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<td>New Section.</td>
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<td>5.2</td>
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<td>5.1</td>
<td>IHS, FQHC and RHC Services</td>
<td>Updated to standard language regarding regulations and requesting public records.</td>
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| 4.6     | 4.5. Family Planning   | Cleaned up language.                                   | 08/02/2023    | W Deseron
|         |                        |                                                         |               | E Garibovic                 |
| 4.5     | 4.1. Encounters        | Updated professionals eligible for an encounter.       | 08/02/2023    | W Deseron
|         |                        |                                                         |               | E Garibovic                 |
| 4.4     | 3.1. Referrals         | Removed redundant language.                            | 08/02/2023    | W Deseron
|         |                        |                                                         |               | E Garibovic                 |
| 4.3     | 3. Eligible Participants | Changed participant to individual.                     | 08/02/2023    | W Deseron
|         |                        |                                                         |               | E Garibovic                 |
| 4.2     | 2.2. Federally Qualified Health Center | Added reference to Indian Self-determination Act. | 08/02/2023    | W Deseron
|         |                        |                                                         |               | E Garibovic                 |
| 4.1     | 1.4. Telligen, Inc.    | Removed fax number.                                    | 08/02/2023    | W Deseron
|         |                        |                                                         |               | E Garibovic                 |
| 4.0     | All                    | Published version                                       | 11/18/2022    | TQD                          |
| 3.1     | 1.2 Provider Relations Consultants | Updated contact phone numbers for PRCs | 11/18/2022    | A Boparai
|         |                        |                                                         |               | M Payne
|         |                        |                                                         |               | J Kennedy-King              |
| 3.0     | All                    | Published version                                       | 6/17/2022     | TQD                          |
| 2.1     | 1.2 Provider Relations Consultants | Updated to add Region 9 contact information | 6/14/2022     | G Branscum
|         |                        |                                                         |               | M Payne
|         |                        |                                                         |               | J Kennedy-King              |