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2. Physician Assistants and Advanced Practice Nursing Providers

2.1. Introduction

2.1.1. General Policy
This section covers Medicaid services provided by midlevel practitioners as deemed appropriate by the Department of Health and Welfare (DHW). Midlevel practitioners include certified registered nurse anesthetists, physician assistants, certified nurse midwives, and nurse practitioners.

2.1.2. Prior Authorization (PA)
Claims for services requiring PA will be denied if the provider did not obtain a PA from the authorizing authority.

For Healthy Connections (HC) participants, prior authorization will be denied if the requesting provider is not the primary care provider and a referral is not on file.

2.1.3. Place of Service (POS) Codes
Idaho Medicaid follows national place of service codes. Refer to the Current Procedural Terminology (CPT) Manual. Enter the appropriate numeric code in the POS field on the CMS-1500 claim form or in the appropriate field on the electronic claim form.

2.1.4. Reimbursement
Medicaid reimburses midlevel practitioner services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

Idaho Medicaid will reimburse the lowest of the following rates:
- Provider’s actual charge for the service.
- Medicaid’s established maximum allowable reimbursement from its pricing file for the service. Most mid-level reimbursement is 85% (percent) of the physician fee schedule as posted on the DHW website.

2.1.4.1. Site of Service Differential
For dates of service on or after 9/1/2014, Medicaid will pay a site of service differential of 60% of the rate on file for claims billed with a place of service:

- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room - Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 31 Skilled Nursing Facility
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility - partial hospitalization
- 61 Comprehensive Inpatient Rehabilitation Facility
For a complete list of Site of Service Reduction codes, see the Medicaid Fee Schedule website.

If a person is eligible for both Medicaid and other insurance(s), Medicaid’s payment for services will be calculated according to the “Lesser Of” methodology.

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

2.1.5. Procedure Codes
Idaho Medicaid follows national procedure codes as listed in the most current version of:
- Healthcare Common Procedure Coding System (HCPCS).
- International Classification of Diseases 10th Revision Clinical Modification (ICD-10-CM).

If a provider bills with a non-specific procedure code and Medicaid determines another code more accurately describes the procedure, the claim may be denied.

2.1.6. Telehealth Services
Telehealth services provided by Advanced Practice Registered Nurses who are enrolled as Healthy Connections primary care providers are reimbursable if provided in accordance with the Idaho Medicaid Telehealth Policy and applicable handbooks.

2.1.7. Interpretive Services
Medicaid covers interpretive services provided to assist participants who are deaf or who do not speak or understand English when receiving a Medicaid service. Refer to the Idaho Medicaid Interpretive & Sign Language Services policy for more information.

2.2. CRNA Services Policy
2.2.1. Covered Services

Payments may be made directly to the Certified Registered Nurse Anesthetists (CRNA) under their individual provider numbers.

When a CRNA provides services through hospitals or anesthesiologist groups, the hospital or group may bill Medicaid for the CRNA. To enroll as a participating CRNA, the hospital or group must send Idaho Medicaid an application with a copy of the valid CRNA license attached.
2.2.2. **Anesthesia Time**

Anesthesia time begins when the CRNA physically starts to prepare the participant for the induction of anesthesia in the operating room and ends when the CRNA is no longer in constant attendance.

Medicaid does not pay for supervision of anesthesia services. The provider who administers the anesthesia, either a physician or a CRNA, is paid 100% (percent) of the allowed amount for the procedure.

2.2.3. **Billing Instructions**

Enter the CPT anesthesia code for the surgical procedure that was performed on the participant, the total amount of time in one (1) minute increments, and any necessary modifiers from the [CMS 1500 Instructions](#).

Idaho Medicaid limits reimbursement for anesthesia procedures to once per day. A repeat anesthesia procedure on the same day which is billed with the CPT modifier 76 or 77 will be considered included in the original payment. Medicaid considers that a second separate session of anesthesia has occurred when a patient is returned to surgery after spending time in another unit of the hospital. In these cases, Medicaid will reimburse both CPT anesthesia codes plus the total time for both sessions, with adequate documentation.

2.2.4. **Modifiers**

Up to four modifiers may be used at one time. Refer to the [CMS 1500 Instructions](#) for valid modifiers.

2.3. **Physician Assistant, Certified Nurse Midwife, and Nurse Practitioner Services Policy**

2.3.1. **Overview**

State-licensed physician assistants, certified nurse midwives, and nurse practitioners are eligible to participate in the Idaho Medicaid Program. They must obtain an Idaho Medicaid provider number from Idaho Medicaid.

All eligible midlevel practitioners must submit an application for provider enrollment to Idaho Medicaid for approval before billing for services rendered to Idaho participants. See [General Provider and Participant Information](#), for more information on provider enrollment.

2.3.2. **Misrepresentation of Services**

Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other non-physician professional as a physician service is prohibited.

2.3.3. **Out-of-State Care**

Out-of-state providers who are actively enrolled in the Idaho Medicaid program may render services to Idaho Medicaid participants without receiving special out-of-state prior approval.

All medical care provided outside the state of Idaho is subject to the same utilization review, prior authorization, coverage requirements, and restrictions as medical care provided within Idaho.
2.3.4. **Surgery Assistant**

Modifier AS is used when a physician assistant, nurse practitioner, or clinical nurse specialist serves as first assistant at surgery. Idaho Medicaid pays 20% of the mid-level reimbursement of 85% of the Physician Fee Schedule for modifier AS.

2.3.5. **Medical Policy Limitations**

2.3.5.1. **Elective Treatment**

Prior authorization is required for certain medical and surgical procedures. Additional information detailing those procedures that require prior authorization is online at www.medunit.dhw.idaho.gov, or you can contact the Idaho Medicaid Medical Care Unit at 1 (208) 364-1839.

2.3.5.2. **Injectable Vitamins**

Payment for injectable vitamin therapy must be supported by the diagnosis of pernicious anemia. Injectable vitamin therapy is limited to the following:

- Vitamin B12 and its analogues.
- Vitamin K and its analogues.
- Folic acid.
- Vitamin B12 mixtures, folic acid, and iron salts in any combination.

2.3.6. **Coverage Limits**

2.3.6.1. **Wellness Examinations**

**Wellness Physicals - Adults 21 Years and Over:**

Adult preventive medicine procedures will be limited to one per rolling year. Evaluation and Management procedures will not be paid if billed by the same provider on the same day as a preventive medicine procedure for participants over age 21. Bill the appropriate preventative medicine examination procedure code for the participant’s age as listed in the Current Procedural Terminology (CPT) Manual, or see the CMS 1500 Instructions for service codes.

Special reports and pre-employment physicals for individuals age 21 and older are not covered by Idaho Medicaid.

A health risk assessment/preventive physical examination for an adult that is required by DHW is a covered service, including annual history and physical exams for adults living in an ICF/ID facility. Use the appropriate CPT codes with the ICD-9 or ICD-10 primary diagnosis code based on dates of service. For more information on which ICD version to use, refer to ICD-9 and ICD-10 Diagnosis Billing Requirements.

**Wellness Physicals for Children up to the Age of 21**

Health risk assessment/physicals for children are covered based on child wellness exams (also referred to as EPSDT) periodicity requirements. See the “Wellness Exams” section of the General Provider and Participant Information handbook and the General Billing Instructions handbook for more information.
Interperiodic screens are covered when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screens may occur in children if there are indications that a previously diagnosed illness or condition may have become more severe or changed significantly, so that further examination is medically necessary.

Physical exams for any other purpose are not considered medically necessary.

2.3.6.2. **Cosmetic Surgery**
Cosmetic surgery is not covered by Medicaid unless the surgery is reconstructive and has been prior authorized by DHW.

2.3.6.3. **Bariatric Surgery for Weight Loss**
Medicaid will cover bariatric surgeries when conditions listed below are met, as defined in Medicaid Basic Plan Benefits, IDAPA 16.03.09.431 – 434:

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

2.3.6.4. **Abdominoplasty or Panniculectomy**
Abdominoplasty or panniculectomy is covered only with PA from the QIO. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for prior authorization includes, but is not limited to, the following:

- Photographs of the front, side, and underside of the participant’s abdomen.
- Documented treatment of the ulceration and skin infections involving the panniculus.
- Documented failure of conservative treatment, including weight loss.
- Documentation that the panniculus severely inhibits the participant’s walking.
- Documentation that the participant is unable to wear a garment to hold the panniculus up.
- Documentation of other detrimental effects of the panniculus on the participant’s health such as severe arthritis in the lower body.
2.3.6.5. **Unproven/Questionable Procedures**
New procedures of unproven value and established procedures of questionable current usefulness as identified by the U.S. Public Health Service and which are excluded by the Medicare program are excluded from payment by Medicaid.

2.3.6.6. **Non-Covered Procedures**
Non-covered services for Medicaid include, but are not limited to, the following.

- Acupuncture
- Naturopathic services
- Biofeedback therapy
- Fertility related services
- Laetrile therapy

2.3.6.7. **Complications from Other Non-Covered Procedures**
The treatment of complications, consequences, or repair of any excluded medical procedure is not covered. Medicaid may authorize treatment if the resultant condition is determined by Medicaid to be life threatening.