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1. Physician and Non-Physician Practitioner

This section covers Medicaid services provided by all physician specialties, physician assistants, certified registered nurse anesthetists (CRNA), certified nurse midwife, and nurse practitioners as it relates to their licensure and scope of practice.

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

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

1.1 Provider Qualifications

Physicians and non-physician practitioners in any state are eligible to participate in the Idaho Medicaid Program. They must be licensed in the state where the services are performed and enroll as an Idaho Medicaid provider prior to submitting claims for services.

See *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

1.2 Eligible Participants

Participants with Medicaid Basic and Enhanced Plans are eligible to receive services. When billing for participants enrolled in other benefit plans, 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 Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on DXC Technology's Idaho Medicaid website.

1.2.1 Referrals

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's primary care case management (PCCM) model of managed care. If a participant is enrolled, a referral may be required from the participant's primary care physician (PCP) prior to rendering services. Prior Authorization may be required in addition to obtaining a referral. Information on the Healthy Connections program can be found in the *General Information and Requirements for Providers,* Idaho Medicaid Provider Handbook.

1.3 Covered Services and Limitations – General

1.3.1 Abortions

An abortion is the interruption or termination of pregnancy before the fetus is viable. Abortion is not considered a family planning service by CMS. The FP modifier should not be used for abortions.

Professional and facility services related to non-covered abortions such as pre and post-operative care, visits, facility fees, supplies, drugs including preventive antibiotics and Rho-GAM, anesthesia and laboratory tests are not reimbursable. Services that are reimbursable related to a non-covered abortion are pregnancy tests, pap smears, urinalysis, testing for sexually transmitted diseases and charges related to complications.

1.3.1.1 Induced Abortion

An induced abortion is a voluntary, or elective, surgical or medical termination to pregnancy. Idaho Medicaid only covers induced abortions in the case of rape or incest. Documentation must be attached to the claim as a requirement for payment. The only acceptable documentation is:

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

1.3.1.2 Medical Abortion

Medical abortions are an alternative to surgical procedures using prescription drugs to terminate a pregnancy. Only Mifeprex is covered for medical abortions. Mifeprex is an FDA approved drug for medical abortion through 10 weeks gestation. Mifeprex is billed with S0190 (Mifepristone oral 200mg) and S0191 (Misoprostol oral 200mcg). A prior authorization is required for all medical abortions.

The participant must receive a copy of the mifepristone medication guide and give informed consent before the drug is administered. Administration of the drug must be in a physician's office, a clinic or hospital under the supervision of a physician with a manufacturer's prescriber agreement. The physician must be able to determine and document the duration of the gestation and discern if the pregnancy is ectopic or not. The physician must be able to provide or arrange immediate necessary intervention including surgery and blood transfusion in the case of complications, incomplete abortion, infection or severe bleeding. Follow-up must include an ultrasound to ensure complete evacuation and a pregnancy test with a negative result. Mifepristone is not covered for any other indication.

Services rendered to a recipient for a medical abortion should be billed under a global period with code S0199. The global period is performed over an eighteen (18) day period and includes all office visits, pelvic ultrasounds, laboratory studies, urine pregnancy tests and recipient education.

Medical abortions are only covered in the case of rape, incest or to save the life of the mother. See Induced Abortion and Therapeutic Abortion for coverage requirements.

1.3.1.3 Spontaneous Abortion

A spontaneous abortion, otherwise known as a miscarriage, occurs when the fetus is lost before the 20th week of pregnancy without apparent cause. Services for a spontaneous abortion are covered.

1.3.1.4 Therapeutic Abortion

A therapeutic abortion is a surgical or medical abortion performed when the termination of a pregnancy is necessary to save the life of the mother. Documentation must be attached to claims when abortion was performed to save the life of the mother. A licensed physician must certify in writing that the woman may die if the fetus is carried to term. Under no circumstance are medical records a substitution for the physician's certification. The certification must also contain the name and address of the woman. A copy of the documentation should be provided

to the hospital for their billing purposes. Therapeutic abortions are also covered for the following:

(a) Blighted Ovum

A blighted ovum occurs when the embryo degenerates or is absent from the ova. Services are covered to remove a blighted ovum.

(b) Ectopic Pregnancy

An ectopic pregnancy is caused by implantation of the ovum outside the cavity of the uterus in the abdominal viscera, cervix, fallopian tubes, ovaries or peritoneum. Services for aborting an ectopic pregnancy are covered.

(c) Incomplete Abortion

Incomplete abortion is a pregnancy that is associated with vaginal bleeding, dilatation of the cervical canal, and passage of some but not all the products of conception. If the retained products become infected it is considered a septic abortion. Services for incomplete abortions are covered.

(d) Missed Abortion

Missed abortion is the prolonged retention of an embryo or fetus that died in the first twenty weeks of the pregnancy. It would include an empty gestational sac, blighted ovum, but not a spontaneous or induced abortion, or delivery. Services for a missed abortion are covered.

(e) Molar Pregnancy

Hydatidiform mole is a rare condition that occurs when the placenta undergoes degenerative cystic, edematous changes that resembles a cluster of grapes. Services are covered to treat a molar pregnancy.

(f) Septic Abortion

A septic abortion occurs when the lining of the uterus and products of conception become infected. Services for septic abortions are covered.

Sample Documentation for Abortions to Save the Life of the Mother

I, _____(Name of physician), attending physician to

_____(Name of participant), certify that in my professional judgment, allowing this participant's present pregnancy to be carried to term will endanger her life.

Date: _____

Signature of physician: _____

Name of participant: _____

Address of participant: _____

1.3.1.5 References: Abortions

(a) Case Law

Blackmun, H. A. & Supreme Court of The United States (1972). *U.S. Reports: Roe v. Wade, 410 U.S. 113*. https://www.loc.gov/item/usrep410113/.

O'Connor, S. D., Kennedy, A. M., Souter, D. H. & Supreme Court of The United States. (1991) U.S. Reports: Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833. https://www.loc.gov/item/usrep505833/.

Stewart, P. & Supreme Court of The United States. (1979) U.S. Reports: Harris v. McRae, 448 U.S. 297. https://www.loc.gov/item/usrep448297/.

(b) CMS Guidance

"Chapter 3 – Eligibility." *The State Medicaid Manual,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

"Chapter 4 – Services." *The State Medicaid Manual,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

State Medicaid Director Letter December 28, 1993. Center for Medicaid and State Operations, Department of Health and Human Services.

State Medicaid Director Letter February 12, 1998. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd021298.pdf.

State Medicaid Director Letter# 01-018. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd033001.pdf.

(c) Idaho Medicaid Publications

Information Release MA02-29 (2/1/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov.

"Reminder: Medicaid Coverage of Abortions." *MedicAide Newsletter,* February 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202018%20MedicAide.pdf .

(d) Regulations

"Abortion Procedures: Participant Eligibility." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 511. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Abortion Procedures: Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 514. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Abortions, 42 C.F.R. 441 Subpart E (1987). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part441-subpartE.pdf.

"Definitions." Social Security Act, Sec. 1905(a)(4)(c) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions." Social Security Act, Sec. 2110(a)(16) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title21/2110.htm.

Denial of Payment for Abortions Under Certain Conditions, Idaho Code 56-209c (1977). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209c/.

Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019. H.R. 6157 (2018). Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-115hr6157enr/pdf/BILLS-115hr6157enr.pdf.

Executive Order No. 13535: Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act, 3 C.F.R. 15599 (2010). Government Printing Office, https://www.govinfo.gov/content/pkg/FR-2010-03-29/pdf/2010-7154.pdf.

Interpretation of State Statutes and the State Constitution, Idaho Code 18-601 (2001). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch6/sect18-601/.

Limitations on coverage: Abortions, 42 C.F.R. 457.475 (2001). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec457-475.pdf.

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

Payment for Covered Outpatient Drugs, 42 U.S.C. §1396r–8 (1993). Government Printing Office, https://www.govinfo.gov/content/pkg/USCODE-2008-title42/pdf/USCODE-2008-title42-chap7-subchapXIX-sec1396r-8.pdf.

"Payments to States." Social Security Act, Sec. 2105(c) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title21/2105.htm.

1.3.2 Advanced Care Planning (ACP)

As of January 1, 2018, Idaho Medicaid will reimburse for advanced care planning under CPT® 99497 if provided for a minimum of 30 minutes, and CPT® 99498 for each additional 30 minutes. ACP may include Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, or Medical Orders for Life-Sustaining Treatment.

The service is voluntary and is only reimbursable if the participant elects to receive the counseling. It may be rendered by any physician or non-physician practitioner in any location. It may also be rendered by other staff provided they meet the minimum direct supervision requirements. ACP is billable separately from a global surgical period, an annual wellness visit or E&M. They are not billable on the same dates of service as a critical care E&M. Time spent on any other service or treatment is not billable as ACP. The Advance Directive form does not have to be completed to be eligible for reimbursement.

Documentation must be maintained of:

- The face-to-face encounter;
- The consent for counseling;
- The time the counseling began;
- The duration;
- The explanation of an advance directive; and
- Who was present at the counseling.

1.3.3 Allergy Injections

Reimbursement for office visits is included in the reimbursement for allergy injections. Office visits may only be billed if there is a separately identifiable service, such as treatment for an ear infection.

1.3.4 Consultations

Idaho Medicaid does not recognize or reimburse codes for consultation services (CPT® codes 99241– 99245 and 99251–99255), instead the appropriate evaluation and management code for office, other outpatient services, hospital or nursing facility should be billed for the services rendered. As Idaho Medicaid does not use consultation codes, more than one physician will be permitted to bill an initial visit.

1.3.4.1 References: Consultations

Revisions to Consultation Services Payment Policy, MLN Matters Number: MM6740 (11/08/2011). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6740.pdf.

Changes to Medicaid's Reimbursement of CPT Codes, Information Release MA10-07 (6/10/2010). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA10-07%20Consult%20Codes.pdf.

1.3.5 Durable Medical Equipment

Idaho Medicaid will allow ordering physicians that are also the supplier to meet documentation requirements in the medical record instead of writing a separate order. Physicians are still expected to be compliant with the Physician Self-Referral Law. Physicians acting as suppliers are required to follow the Supplier, Idaho Medicaid Provider Handbook, for these services.

1.3.5.1 References: Durable Medical Equipment

"Order Requirements When Prescribing Practitioner is also the Supplier and is Permitted to Furnish Specific Items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)." *MLN Matters MM10984, October 2018,* Centers for Medicare and Medicaid

Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10984.pdf.

1.3.6 Excluded and Non- Covered Services

For information regarding excluded and non-covered procedures, please see the *Excluded Services* section and the Non-Covered section in the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook portion of the handbook.

1.3.7 Evaluation and Management

Physicians and non-physician practitioners are required to use either the 1995 or 1997 evaluation and management (E&M) documentation guidelines to document E&M office and outpatient visits. Modifications to these guidelines include:

- Elimination of the requirement to document the medical necessity of a home visit instead of an office visit;
- Focusing documentation on changes and persisting problems since the last visit for established patients, provided the physician or non-physician practitioner indicate in the record the patient's medical record was reviewed and updated if necessary; and
- Clarification that practitioners do not need to re-enter the participant's chief complaint and history into the medical record if ancillary staff or the participant have already updated it. The practitioner only needs to indicate in the medical record that the information has been reviewed and verified.

1.3.7.1 References: Evaluation and Management

1995 Documentation Guidelines for Evaluation and Management Services. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf.

1997 Documentation Guidelines for Evaluation and Management Services. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf.

"2019 Evaluation and Management (E&M) Documentation Updates." *MedicAide Newsletter,* January 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202019%20MedicAide.pdf.

Evaluation and Management Services. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf.

"Summary of Policies in the Calendar Year (CY) 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List." *MLN Matters MM11063, November 2018,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11063.pdf.

1.3.8 Family Planning

Medicaid covers contraceptive supplies, including prescription diaphragms, intrauterine devices (IUDs), implants, injections, contraceptive patches, oral emergency contraceptives and oral contraceptives. Oral contraceptives are limited to a pharmacy, and a three-month supply. Medicaid does not pay a physician's office for take-home contraceptives. See Covered Services and Limitations – Surgery for information about Sterilizations.

Family planning services and supplies are excluded from co-pay requirements.

Family planning services, devices and prescriptions **must** be billed with the **FP modifier**, and an NDC if applicable. The FP modifier allows the State of Idaho to receive 90% federal reimbursement on family planning services. If the modifier is not utilized by providers, it may lead to a civil monetary penalty from the Medicaid Program Integrity Unit. Claims with multiple services should have the FP modifier only on lines for the family planning service. Evaluation and management services for family planning services should include the FP modifier as well. A Healthy Connections referral is not required for family planning if the service is billed with the FP modifier.

Reimbursement for an IUD insertion includes any fees for the office visit. A separate office exam may only be billed for treatment of an unrelated diagnosis. Attach modifier 25 to the evaluation and management code. Insertion is covered following a delivery including in an inpatient setting when billed by the physician or non-physician practitioner with the ICD-10-CM diagnosis Z30.430 and FP modifier. Insertion is not reimbursable inpatient for any other indication.

If Depo-Provera and Lunelle are used for any purpose other than contraception, or for dosages up to 100 mg, use J3490 (Unclassified Drug) and indicate the NDC, quantity dispensed, and units of measure.

1.3.8.1 References: Family Planning

(a) CMS Guidance

Medicaid Family Planning Services and Supplies, SHO#16-008 (6/14/2016). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.

(b) Idaho Medicaid Publications

"Intrauterine Device (IUD)." *MedicAide Newsletter,* August 2015. https://www.idmedicaid.com/MedicAide%20Newsletters/August%202015%20MedicAide.pdf.

"Reminder: Family Planning Services Require the FP Modifier." *MedicAide Newsletter,* September 2018. https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

Reporting Family Planning Services, Information Release MA03-63 (10/20/2003). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/ctl/ArticleView/mid/1942/articleId/1287/MEDICAID-INFORMATION-RELEASE-MA03-63.aspx.

"Use FP Modifier When Billing Family Planning Services." *MedicAide Newsletter,* September 2005. http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/Sept-Dec05.pdf.

(c) Regulations

"Definitions." Social Security Act, Sec. 1905(a)(4)(C) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Family Planning Services, 42 C.F.R. Sec. 441.20 (1978). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=9e86d8803a5fadabebd59dc1631eda45&mc=true&node=se42.4.441_120&rgn=div8.

"Family Planning." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 680 – 699. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Limitations on Premiums and Cost Sharing, 42 C.F.R. Sec. 447.56 (1978). Government Printing Office, https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=9e86d8803a5fadabebd59dc1631eda45&mc=true&n=sp42.4.447.a&r=SUBPART&ty=HTML#se42.4.447_156.

"Medicaid Outpatient Services Subject to Copayments." *IDAPA 16.03.18, "Medicaid Cost-Sharing,"* Sec. 320. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160318.pdf.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(23)(B) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

1.3.9 Focus Case Review

Services may also be covered under a focused case review on a case-by-case basis for participants of any age with a life threatening medical illness and no other available treatment options. See the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook section on Exceptions to Non-Covered and Excluded Services for information.

1.3.10 Diabetes Education and Training

The physician is responsible to furnish basic diabetic care and instruction to the participant and may not use a formally structured program, or a Certified Diabetes Educator (CDE), as a substitute. Physician responsibility includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of agents for glycemic management.

Additionally, Medicaid covers individual and group counseling for diabetes education and training. Counseling must be conducted in an American Diabetes Association (ADA) recognized Diabetes Education Program by Certified Diabetes Educators (CDE) in a physician's office or outpatient hospital. Services must be billed under the hospital or physician's clinic provider number. The billing provider must submit and maintain proof of the CDE's current diabetic counseling certification with DXC Technology provider enrollment.

1.3.10.1 Participant Eligibility

Participants are eligible that have:

- A recent diagnosis of diabetes within the past 90 days, and have not received prior diabetes education; or

- Uncontrolled diabetes manifested by two (2) or more fasting blood sugar levels of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar levels greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or
- Recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds.

1.3.10.2 Individual Diabetic Counseling

For reimbursement, bill these services with procedure code G0108 (1 Unit = 30 Minutes). Services must be face-to-face services between a CDE and the participant. Medicaid only allows 12 hours per participant every five years for individual counseling.

1.3.10.3 Group Diabetic Counseling

Group counseling is billed with procedure code G0109 (1 Unit = 30 Minutes). Group counseling is limited to 24 hours, per participant, every five years.

1.3.11 Immunization and Vaccines

Idaho Medicaid covers immunization and vaccines for all ages. Vaccine administration should conform to the Advisory Committee on Immunization Practices (ACIP) guidelines for vaccine use. The claim should include the following information:

- The CPT® or HCPCS code for the vaccine.
- The CPT® code that accurately reflects the administration of the vaccine(s).

If there is a significant, separately identifiable service performed at the time of the vaccine administration, an E/M visit may also be billed with modifier 25. Documentation in the participant's record must reflect the additional services rendered.

1.3.11.1 Vaccines for Children Under 19

The Vaccine for Children (VFC) program offers a free-vaccine program for children who have not reached their 19th birthday. When a free vaccine(s) is administered, the CPT® code for the vaccine should be billed with modifier SL at a zero-dollar amount ($0.00).

Provider purchased vaccines should only be administered when a free vaccine is not available. When a provider purchased vaccine(s) is administered, the CPT® code for the vaccine should be billed at the usual and customary rate. No modifier is required.

See the Wellness Examinations section for the complete schedule of age-appropriate health history and health screening services.

1.3.11.2 Vaccines and Third-Party Liability

Participants under the age of 19 are exempt from Third Party Liability requirements for vaccines and their administration. All other participants are subject to the requirements of the Third Party Recovery section in *General Billing Instructions*, Idaho Medicaid Provider Handbook. If the primary payer combines payment for the administration with the cost of the injectable, a separate administration fee may not be charged.

1.3.11.3 References: Immunization and Vaccines

ACIP Vaccine Recommendations and Guidelines. Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention, Department of Health and Human Services, https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Vaccines for Children Program, 42 C.F.R. Sec. 441.600 – 441.615 (2012). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=a223aa30cf80d5b379cb6048a56a9f90&mc=true&node=sp42.4.441.l&rgn=div6.

1.3.12 Injections Administered as Part of a Procedure

Medicaid will not pay the administration fee(s) when an injection is part of a procedure (i.e., allergy injections, therapeutic, and diagnostic radiology, etc.).

1.3.13 Laboratory Coverage

Some laboratory procedures may require a prior authorization, refer to the physician fee schedule found on the Medicaid Fee Schedule webpage for CPT® codes that always require a prior authorization, and the reviewing authority. If a clinical diagnostic test order does not require a signature, there must be signed medical documentation such as a progress note by the treating physician or non-physician practitioner. See the *General Billing Instructions*, Idaho Medicaid Provider Handbook for more information about requesting a prior authorization.

1.3.13.1 Physician Office Laboratories

Physicians can bill Medicaid for clinical diagnostic laboratory services they personally performed or supervised in their office. Those services are reimbursed at the rate established by Medicaid.

Physician office or group practice office laboratories must hold a current Clinical Laboratory Improvement Amendments (CLIA) certificate on file with DXC Technology before Medicaid will reimburse for testing performed in the physician office laboratories. Payments will be denied to any laboratory submitting claims for services or dates not covered by their CLIA certificate.

Physician-owned laboratories may not bill for tests sent to independent laboratories or pathology laboratories. Physicians are not eligible to bill Modifier 90. Medicaid only pays the actual provider of service.

1.3.13.2 Specimen Collection

An office visit cannot be billed when a participant comes in for a blood draw by a lab technician and does not see the physician or non-physician practitioner. The lab technician's cost is included in the lab procedure payment.

The physician's office may be compensated for the handling and conveyance of specimens from the participant in a place other than a physician's office, such as place of service 12 (Home) or 32 (Nursing Facility), to an independent laboratory when billed with procedure code 99001.

1.3.13.3 Pathology Laboratory Procedures

Certain pathology lab codes can be broken out into professional and technical components. When billed with place of service 21 (Inpatient), 22 (Outpatient), or 23 (Emergency), a 26 modifier is required, unless the procedure code says, *Supervision and Interpretation Only*. The hospital will bill for the technical component on its UB-04 claim form.

If a pathologist has their own office and equipment, they may bill and be paid for the complete test including those that cannot be broken out into the professional and technical components.

1.3.13.4 Blood Lead Screening

Federal regulation requires that a screening for lead poisoning be a component of an Early and Periodic Screening, Diagnosis, and Treatment screen. Centers for Medicare and Medicaid Services (CMS) policy requires a screening blood lead test for all Medicaid eligible children at 12 months and 24 months of age. Children between the ages of 24 months and 21 years of age, should receive a screening blood lead test if there is no record of a previous test.

Providers are required to report lead poisoning within three (3) working days in accordance with *IDAPA 16.02.10.380*. Lead poisoning may be diagnosed by symptoms, or a blood level of:

a. Ten (10) micrograms or more per deciliter (10 ug/dL) in adults eighteen (18) years and older; or
b. Five (5) micrograms or more per deciliter (5 ug/dL) in children under eighteen (18) years of age.

The Department of Health and Welfare (DHW) reimburses providers for lead testing (CPT® 83655) performed by a venous blood draw or by capillary test (CPT® 36416). Claims should be submitted with a diagnosis reflecting a wellness visit. DHW will provide a LeadCare Analyzer machine to providers at no cost. This machine tests for lead by a simple capillary test (finger prick). The results are available immediately. Please contact the Medical Care Unit at 1 (208) 364-1835 or see www.medunit.dhw.idaho.gov, for more information on lead screening.

1.3.13.5 Controlled Substance and Drug Testing

Testing for the presence of controlled substances and drugs is only covered when medically necessary for the treatment of a substance use disorder. The physician must be providing or coordinating treatment to order testing. Medical necessity is established with criteria set by CMS and their Idaho regional Medicare contractor, Noridian, in LCD L36707. Testing is not covered when court ordered, or as a condition of employment or probation unless incidental to established medical necessity.

1.3.13.6 Newborn Screening

Newborn screening kits are a covered benefit of the Idaho Medicaid Program. Use HCPCS procedure code S3620. All babies born in Idaho are required to receive screening. Test kits are ordered through the Idaho Newborn Screening Program and must be purchased in advance from this program provider:

Idaho Newborn Screening Program
450 West State Street, 4th floor
PO Box 83720
Boise, ID 83720-0036
1 (208) 334-4927

Follow-up testing for participants diagnosed with one of the 47 screened conditions can be done in a laboratory.

1.3.13.7 References: Laboratory Coverage

"Medical Documentation Signature Requirements." *Noridian Healthcare Solutions,* 27 July 2018, https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirements.

1.3.14 Nutritional Services

Nutritional services are available for children, and pregnant participants until the end of the month in which 60 days have passed from delivery. See the *Dietary and Nutritional Services*, Idaho Medicaid Provider Handbook for more information.

1.3.15 Physician-Administered Drugs (PAD)

Certain PAD require prior authorization by the Idaho Medicaid Pharmacy Unit. Please refer to the Fee Schedule on the DHW website. The pharmacy request forms can be found at www.medicaidpharmacy.idaho.gov. If there is no PA form listed for the specific drug given, use the Universal PA form. At the top of the form please write "Physician Administered Drug" so that your PA is directed to the correct authorizing entity.

1.3.15.1 Reporting National Drug Code (NDC) for Drugs Billed with HCPCS Codes

Federal mandates require that professional claims for drugs reported with HCPCS must include the appropriate NDC of the drug supplied, units dispensed, and basis of measurement for each HCPCS drug. This requirement applies to drugs with HCPCS codes, whether submitted electronically, on a paper CMS-1500 claim form, or as a Medicare cross-over claim.

The HCPCS drugs that require NDC information are listed in the current HCPCS Manual, *Appendix 1,* and are listed alphabetically by generic, brand, or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will not be accepted.

1.3.15.2 Compound Drugs

Paper Claims: Attach the NDC Compound Detail Attachment.
Electronic Claims: To designate the claim as a compound drug claim combining two or more ingredients (one of which is a covered Medicaid product), a compound indicator value of two (2) is required.

If one or more of the ingredients being billed is a non-covered item and the pharmacy has chosen to be paid for the covered ingredients only, use a submission clarification code equal to eight (8). This will post a zero payment to the non-covered ingredient(s) and process the rest of the covered ingredients to pay at the applicable allowed amount.

Required for All Compound Claims:

- National Drug Code for each individual ingredient
- Drug name and strength
- Quantity of each ingredient
- A unit of measure for each individual ingredient of the compound:
  - Each (EA)
  - Grams (GM)
  - Milliliters (ML, CC)
- Ingredient cost for each ingredient (if no value is entered, no payment will be made)

1.3.16 Prolonged Services

Prolonged services (CPT® 99354 or 99356) lasting less than 30 minutes, or services before or after direct patient care (CPT® 99358 or 99359) on a given date are not separately reportable, because the work involved is included in the evaluation and management codes.

1.3.17 Radiology

The complete radiology procedure may be billed without a modifier if the physician, or non-physician practitioner, owns the equipment, and supervises and interprets the procedure. If these requirements aren't met, the procedure must be broken down into professional and technical components.

1.3.17.1 Technical Component

The technical component is billed with a TC modifier, and includes charges for:

- Personnel
- Material, including usual contrast media* and drugs
- Film or xerograph
- Space, equipment, and other facility charges

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes with the appropriate HCPCS. Attach an invoice to your claim identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered. Because of the wide variations in costs to providers and the radioisotopes billed, this information is necessary to price each claim.

1.3.17.2 Professional Component

The professional component represents services of the physician (radiologist) to interpret and report on the procedure. Unless there is a procedure code for *Supervision and Interpretation Only,* identify a charge for the professional component using the modifier 26. This component is applicable in any situation in which the physician does not provide the technical component as described above.

1.3.18 Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If the prescription cannot be faxed, phoned, or electronically sent to the pharmacy, then providers must ensure that the prescription form meets all three of the following requirements:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Note: The intent of this requirement is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

1.3.18.1 References: Tamper Resistant Prescription Requirements

Tamper-Resistant Prescription Forms, Information Release MA07-21 (10/1/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho,

https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA07-21%20Tamper%20Resistant%20Presription%20Pads-signed.pdf.

State Medicaid Director Letter# 07-012. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081707.pdf.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007. P.L. 110-28 (2007). Government Printing Office, https://www.govinfo.gov/content/pkg/PLAW-110publ28/pdf/PLAW-110publ28.pdf.

1.3.19 Telehealth

Physicians and non-physician practitioners are eligible to receive reimbursement for telehealth services. See the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for covered services and requirements.

1.3.20 Tobacco Cessation

Effective January 1, 2014, tobacco cessation benefits are available to all eligible Medicaid participants, including those who are dually eligible for both Medicare and Medicaid. For more information, call the Medicaid Pharmacy Unit at 1 (208) 364-1829 or refer to the Medicaid Pharmacy program webpage.

1.3.21 Wellness Examinations

Routine well checks are an important part of preventive health services and are covered once every 365 days by Idaho Medicaid. Wellness examinations should include a review of possible opioid use to screen for opioid use disorder. Physical exams for sports participation, camp attendance, employment, driving licensure, admission to an educational institution, military recruitment, insurance coverage, paternity determination, adoption, immigration, or marriage are not considered medically necessary and are not covered by Idaho Medicaid. A non-covered physical may be rendered as incidental to a Medicaid-covered service, but only the Medicaid-covered service will be reimbursed, and no additional payment will be made for the physical exam.

Administrative exams that are required by Idaho Medicaid are a covered service. Examples of covered administrative exams are health risk assessments and preventive physical examinations for refugees entering the country and participants in the Developmental Disability program. Examinations and laboratories for refugee immigration should be billed with diagnosis Z02.89 (Encounter for other administrative examinations) and modifier U7.

1.3.21.1 Adult Wellness Exams

Adult wellness exams are annual preventive exams to assess the health status of adult participants. Participants are eligible for one exam 365 days after their last exam. The content of the exam is expected to be similar to an Annual Wellness Visit (AWV) through Medicare. Screenings are covered if they have received an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF). Elements of an adult wellness exam include:

- A health risk assessment;
- Review of medical and family history (including opioid use);
- A list of providers the participant receives services from;
- Measurement of weight, BMI and blood pressure;
- Survey of potential risk factors for depression and other mood disorders;
- Detection of cognitive impairment;

- A screening schedule aligned with USPSTF "A" and "B" recommendations;
- Review of risk factors;
- Personalized health advice;
- Laboratory and diagnostic orders; and
- Any necessary referrals to other medical professionals.

1.3.21.2 Child Wellness Exams

All children ages birth through 21 should receive regular wellness exams from their Primary Care Providers (PCPs). Baby and child wellness exams, immunizations or family planning services are excluded from co-pay, as specified in IDAPA 16.03.18 "Medicaid Cost Sharing." Federal law requires that the wellness exams include:

- Appropriate immunizations
- Appropriate vision and hearing testing
- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Health education including anticipatory guidance
- Laboratory tests as indicated in periodicity schedule

Idaho Medicaid has adopted the American Academy of Pediatrics (AAP) periodicity schedule as the recommended frequency for child wellness exams. If a child has not received the recommended care previously, the schedule should be brought up to date at the earliest possible time. This periodicity schedule has been replicated in the tables found in *Appendix A: Periodicity Schedule.*

If a PCP determines during a wellness exam or an interperiodic screen, (see IDAPA 16.03.09.580.01) that a child needs a medically necessary service or product that is not covered under the child's Medicaid benefits, the PCP should consult the Early Periodic Screening and Diagnostic and Treatment (EPSDT) benefit section of the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for coverage and prior authorization information.

Federal regulations require that all Medicaid eligible children are tested for lead poisoning at the age of 12 months and 24 months, as part of their wellness exam. Children over the age of 24 months up to 21 years of age should receive a screening blood lead test if there is no record of a previous test. See the Laboratory Blood Lead Screening section for more information.

Children younger than 37 months of age with a physical or mental condition that has a high probability of developmental delay are eligible for Early Intervention Services through the Infant Toddler Program. See the Early Intervention Services section of the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information.

Weight management is a covered benefit for children aged five years and older, with a BMI that falls in either the overweight, obese, or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. If a PCP determines a child may benefit from a weight management program and the child, they should review the *Preventive Health Assistance (PHA)* section of the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information.

1.3.21.3 Child Wellness Exam: Maternal Postpartum Depression Screening

Effective January 1, 2018, maternal postpartum depression screening may be billed for the mother of an infant under 12 months of age if a standardized screening instrument is used. Acceptable screening instruments are:

- Edinburgh Postnatal Depression Scale (EPDS);
- Patient Health Questionnaire – 9 (PHQ-9) Screener; and
- Beck Depression Inventory (BDI).

Claims should be billed under the infant's Medicaid ID number with G8431 for a positive depression screen or G8510 for a negative depression screen. No additional diagnosis codes should be added for this service. If a screening is positive for depression, mothers with:

- Active Medicaid coverage should be directed to contact OPTUM Idaho Member Line at (855) 202-0973 for assistance finding a provider;
- Other insurance should be directed to contact their carrier for a list of available providers; or
- No insurance should be directed to contact community resources in their area.

Reimbursement for the screening is limited to three (3) per infant.

1.3.21.4 Instrument-Based Ocular Screening

Medicaid covers instrument-based ocular screening (e.g. photo screening, automated-refraction) for all children three years of age and for children ages four to five years, who are unable to cooperate with routine acuity screening (e.g. intellectual disability, developmental delay and sever behavioral disorders). Ocular screening is only covered when completed by a physician or a non-physician practitioner.

1.3.21.5 Reimbursement for Examinations

Wellness exams must be billed with the Preventive Medicine CPT® Codes and appropriate ICD-10-CM diagnosis codes (**Z76.2**, **Z00.121, Z00.129**, **Z00.110** or **Z00.111**). The CPT® codes **96110** or **96111** should be billed when using a standardized tool (such as the Ages & Stages Questionnaire) to assess development and behavior. Exams for refugees entering the country are covered using ICD-10-CM code Z02.89 as the primary diagnosis and modifier U7 on the claim line. When an exam and/or report is required by Department of Health and Welfare (DHW) for an adult participant, including annual history and physical exams for adults living in an Intermediate Care Facility (for Developmentally Disabled)/Intellectually Disabled (ICF/ID) Facility, use ICD-10-CM code Z02.89 as the primary diagnosis.

1.3.21.6 References: Wellness Examinations

"Annual Wellness Visit." *MLN Booklet*, August 2018, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf.

"**Attention Pediatric Care Providers:** Postpartum Depressions Screening During an EPSDT Well-Child Visit as of January 1, 2018." *MedicAide Newsletter,* December 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf.

Refuge Medical Assistance – Medical Screening, 45 C.F.R. Sec. 400.107 (1989). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=0a34f4d3cf26941ec1bdafbbe551e398&mc=true&node=se45.2.400_1107&rgn=div8.

Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV), MLN Matters Number: SE18004 (08/28/2018). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18004.pdf.

USPSTF A and B Recommendations. U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

1.4 Covered Services and Limitations – Specialists

1.4.1 Cervical Cancer Screening

Cervical cancer screenings should be billed with Preventive Medicine CPT® Codes and the appropriate ICD-10-CM diagnosis code. Screening with cervical cytology (i.e. pap smear) is a covered benefit for female Idaho Medicaid participants between the ages of twenty-one (21) and sixty-five (65) every three (3) years. Female participants between thirty (30) and sixty-five (65) may instead receive high-risk human papillomavirus (hrHPV) testing every five (5) years with or without cervical cytology at the same visit (i.e. co-testing). Participants over the age of sixty-five (65) are covered for continued screenings if they have experienced spontaneous regression or management for a precancerous lesion within the past twenty (20) years.

Female participants diagnosed with a compromised immune systems, high-grade precancerous cervical lesion or cervical cancer, or exposure to diethylstilbestrol in utero may receive screenings outside of age and frequency limitations. Participants with a hysterectomy including removal of the cervix are not eligible for screening unless there are indications of a high-grade precancerous lesion or cervical cancer.

1.4.1.1 References: Cervical Cancer Screening

"Cervical Cancer: Screening." *U.S. Preventive Services Task Force,* 21 August 2018, https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening2.

1.4.2 Critical Care Services

Critical care includes the care of critically ill participants, in a variety of medical emergencies that requires the constant attention of the physician. Critical care is usually, but not always, given in a critical care area, such as the Coronary Care Unit, Intensive Care Unit, Respiratory Care Unit, or the Emergency Department.

The following services are included in the global reporting and billing of critical care when performed during the critical period by the physician providing critical care:

- Interpretation of cardiac output measurements.
- Interpretation of chest x-rays.
- Pulse oximetry.
- Blood gases and information data stored in computers (e.g., electrocardiogram [ECG]), blood pressure, hematologic data.

- Gastric intubation.
- Temporary transcutaneous pacing.
- Ventilator management.
- Vascular access procedures.

Other procedures that are not directly connected to critical care management (the suturing of laceration, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap, etc.) are not included in the critical care and should be reported separately.

1.4.3 Hyperbaric Oxygen Therapy

Hyperbaric Oxygen (HBO) therapy is a technique of delivering higher pressures of oxygen to the tissues. Two methods of administration are available including topical and systemic HBO therapy.

Topical HBO therapy is a technique of delivering 100% oxygen directly to an open, moist wound at a pressure slightly higher than atmospheric pressure. Topical HBO therapy is considered investigational and is not covered by Idaho Medicaid.

In systemic HBO, the patient is entirely enclosed in a pressurized chamber and breathes oxygen at a pressure greater than one atmosphere (the pressure of oxygen at sea level). Idaho Medicaid follows Medicare criteria found in National Coverage Determination (NCD) 20.29. Conditions not listed as covered in National Coverage Determination 20.29 are considered investigational and are not covered under the Medicaid Program.

1.4.4 International Normalized Ratio (INR) Monitoring Services

When providing test materials and equipment for home international normalized ratio (INR) monitoring under CPT® 93792, providers should bill HCPCS G0249. Idaho Medicaid is substituting HCPCS G0249 for 99070. Idaho Medicaid will not provide reimbursement for 99070 under these circumstances.

1.4.5 Obstetric Care

Obstetric (OB) care must be billed as a global charge unless the attending physician, or non-physician practitioner did not render all components of the care. Antepartum and postpartum care may only be billed separately from the delivery when the delivery is performed by a person outside the rendering provider's practice. Providers eligible for a global charge may not separately bill per-visit antepartum or postpartum visits.

The global charge includes antepartum, intrapartum and postpartum care, a cesarean section or vaginal delivery, with or without episiotomy, with or without forceps, or breech delivery. Prenatal diagnostic laboratory charges, such as a complete urinalysis, are not included in the global charge, and may be billed according to Laboratory Coverage. Any surgical procedures must also abide by the Covered Services and Limitations – Surgery section.

Charges for total OB care must be billed after the delivery using the date of delivery as the to and from date. When the Medicaid participant has active eligibility that begins on the date of delivery or any point prior, the global CPT® must be billed to Idaho Medicaid. Any previously collected payment from the participant for antepartum care must be reimbursed. The place-of-service on the claim should reflect where the delivery occurred. The initial office examination for diagnosis of a pregnancy may be billed separate from the total OB charges if that is the provider's standard practice for all OB participants. The initial examination must be identified as such and billed with the appropriate Evaluation and Management (E/M) CPT® code.

Claims for deliveries with a participant under the age of 13 will be denied. Providers may submit a claim review request and a request for Medicaid review of claim determination with medical documentation to demonstrate a pregnancy at a younger age. The process for requesting a review is detailed in the General Billing Instructions, Idaho Medicaid Provider Handbook.

See the Family Planning, Hysterectomy and Sterilization sections for information about providing these services at the conclusion of delivery and during the postpartum periods.

1.4.5.1 Abortions

Please, see the Abortions section under Covered Services and Limitations – General.

1.4.5.2 Antepartum Care

Antepartum care includes recording weight, blood pressure and fetal heart tones, routine dipstick urinalyses and maternity counseling. Providers that also provide intrapartum and postpartum services to the participant must bill a global charge per the main Obstetric Care section. They are not eligible to bill antepartum care.

Antepartum care may only be billed separately if the delivery and/or postpartum is provided by person outside of the physician or non-physician practitioner's practice. When billing for the first three visits, use the appropriate evaluation and management CPT® codes. When billing for four or more visits use CPT® codes 59425 (Antepartum care only;4-6 visits) and 59426 (Antepartum care only;7 or more visits), as appropriate, with one unit and the total charge for all visits on one line. Do not split out each visit after the third visit as they are bundled into these two codes. Claims should use the first date the participant was seen in both the **from** and **to** date fields. If billing a paper CMS-1500 claim form, note the date for each additional visit in field 19.

1.4.5.3 Dilation and Curettage (D&C)

All D&C procedures require documentation in the form of an operative report, emergency department report, or office notes. Please attach required documentation to claim for submission.

1.4.5.4 High Risk Pregnancy Case Management Services

High risk pregnancy case management services are available for coordination of in-home and community support services to pregnant people who are at risk of premature labor or congenital issues of the fetus. To make a referral, contact Telligen at 1 (866) 538-9510 and request Case Management Services.

1.4.5.5 Lactation Counseling

Medicaid reimburses for lactation counseling when provided by the physician, non-physician practitioner or certified lactation consultant. Providers may bill for these preventive services by utilizing the Preventive Medicine, Individual Counseling CPT® procedure codes (99401 – 99404) for one initial antepartum session within two weeks of the expected date of delivery and two postpartum visits within the first month of delivery. Lactation counseling is reimbursable in addition to services covered under the global billing.

(a) References: Lactation Counseling

"Medicaid Covers Services to Promote Breastfeeding." *MedicAide Newsletter,* November 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202014%20MedicAide.pdf.

1.4.5.6 Multiple Deliveries

Delivery of the first baby should be billed with the appropriate CPT® code (59400 or 59510), one (1) unit, and only the charges for the first delivery. Delivery of any additional babies should be billed with a delivery code (59409, 59514, 59612, or 59620), modifier 51 and 59, one (1) unit. All antepartum or postpartum care should be included in the delivery code for the first baby.

1.4.5.7 Postpartum Care

Postpartum care includes home, hospital and office visits, and contraceptive counseling until the end of the month in which 60 days have passed from delivery. Postpartum care (CPT® 59430) may only be billed separately if the delivery is provided by a physician from a different practice. All visits for postpartum care are bundled into one unit of 59430. Enter the first date the participant was seen for postpartum care in both the **from** and **to** date fields. Evaluation and management codes for postpartum visits is prohibited. See Family Planning for more information on contraceptive counseling.

(a) References: Postpartum Care

Pregnant Women Eligible for Extended or Continuous Eligibility, 42 C.F.R. Sec. 435.170 (2016). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=7551a61ff22258106db2d043c86b2816&mc=true&node=se42.4.435_1170&rgn=div8.

1.4.5.8 Presumptive Eligibility (PE) Services

Services are limited for participants covered by Medicaid under Presumptive Eligibility programs. T1023 may be billed for the PE determination. Please see the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information about billing requirements for these participants.

1.4.5.9 Resuscitation – Newborn

Resuscitation of the newborn infant is covered separately if billed under the child's name and Medicaid identification (MID) number.

1.4.5.10 References: Obstetric Care

"New Limitation on Claims for Deliveries." *MedicAide Newsletter,* March 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202019%20MedicAide.pdf.

1.4.6 Ophthalmology

Please see the *Eye and Vision Services Guidelines*, Idaho Medicaid Provider Handbook for ophthalmology services.

1.4.7 Oral Treatments

For participants up to the age of 21, physicians may provide in their office the application of topical fluoride varnish using CPT® 99188. Dentists should continue to bill services through the Idaho Smiles program.

1.4.8 Outpatient Cardiac Rehabilitation (CR)

Cardiac Rehabilitation (CR) in the outpatient setting is a medically supervised program with the goal of preventing future cardiac events. Effective April 1, 2015, CR is aligned with Medicare's policy.

1.4.8.1 Cardiac Rehabilitation: Eligible Participants

Outpatient cardiac rehabilitation is available for participants with a diagnosis of:

Covered Diagnoses for Cardiac Rehabilitation	
ICD-10-CM	**Description**
I20.1 – I20.9	Angina pectoris
I21.01 – I21.4	Acute myocardial infarction
I22.0 – I22.9	Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
I25.111 – I25.119	Atherosclerotic heart disease of native coronary artery with angina pectoris
I25.2	Old myocardial infarction
I25.5	Ischemic cardiomyopathy
I25.6	Silent myocardial ischemia
I25.700 – I25.812	Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris
I25.89	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unspecified
I50.22	Chronic systolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.812	Chronic right heart failure
I50.814	Right heart failure due to left heart failure
I50.82 – I50.89	Heart Failure
Z48.21	Encounter for aftercare following heart transplant
Z48.280	Encounter for aftercare following heart-lung transplant
Z48.812	Encounter for surgical aftercare following surgery on the circulatory system
Z94.1	Heart transplant status
Z94.3	Heart and lungs transplant status
Z95.1 – Z95.5	Presence of cardiac and vascular implants and grafts
Z96.89	Presence of other specified functional implants
Z98.61	Coronary angioplasty status
Z98.890	Other specified postprocedural states

1.4.8.2 Cardiac Rehabilitation: Coverage and Limitations

Cardiac Rehabilitation is only reimbursable for an eligible participant when provided by an eligible provider, and with adherence to all Medicaid requirements. A physician must be immediately available and accessible for medical consultations and emergencies at all times.

Covered Cardiac Rehabilitation CPT® Codes	
Code	**Description**

93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

Cardiac rehabilitation program sessions are limited to a maximum of two, one-hour sessions per day for up to 36 sessions, over a period of 36 weeks with the option for an additional 36 sessions over an extended period with prior authorization. Participation in another outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational. Intense Cardiac Rehabilitation is not covered.

CR can be provided in places of service:

- 11 – Office;
- 19 – Off Campus – Outpatient Hospital; and
- 22 – On Campus – Outpatient Hospital.

Programs that only offer supervised exercise training are not considered to be cardiac rehabilitation. Physical and/or occupational therapy are not medically necessary in conjunction with cardiac rehabilitation unless performed for an unrelated diagnosis.

1.4.8.3 References: Outpatient Cardiac Rehabilitation

Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage, 42 C.F.R. Sec. 410.49 (2009). Government Printing Office, https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=8a132797bc27d06231a3c664beb3bc2e&mc=true&n=pt42.2.410&r=PART&ty=HTML#se42.2.410_149.

"Chapter 32 – Billing Requirements for Special Services." *Medicare Claims Processing Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf.

Decision Memo for Cardiac Rehabilitation (CR) Programs - Chronic Heart Failure (CAG-00437N) (2/18/2014). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=270.

"**Local Coverage Article:** Outpatient Cardiac Rehabilitation." *Noridian Healthcare Solutions,* 25 March 2019, https://med.noridianmedicare.com/documents/10546/7933826/Outpatient+Cardiac+Rehabilitation+National+Coverage+Determination+%28NCD%29+Coverage+Article.

"Outpatient Cardiac Rehabilitation." *MedicAide Newsletter,* April 2015, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202015%20MedicAide.pdf

1.4.9 Psychiatric Care

Medicaid covers preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided by a psychiatrist in an inpatient or outpatient setting. A psychiatrist billing for these services will use their own physician provider number.

1.4.9.1 Inpatient Psychiatric Care

The QIO conducts concurrent review of all admissions to inpatient psychiatric facilities for Idaho Medicaid participants if care exceeds three days.

The Department of Health and Welfare (DHW) will only pay for medically necessary inpatient psychiatric hospital services in an Institute for Mental Disease (IMD) for participants under the age of 21 who have a current DSM diagnosis with substantial impairment in thought, mood, perception, or behavior. If a participant reaches age 21 while receiving services, treatment may continue until services are no longer required, or the participant reaches age 22.

See the QIO Idaho Medicaid Provider Manual for more information.

1.4.9.2 Outpatient Psychiatric Care

Effective September 1, 2013, Medicaid participants who are eligible for the basic plan are automatically enrolled in the Idaho Behavioral Health Plan to obtain outpatient behavioral health services administered by Optum Idaho. Physicians are not required to enroll as network providers to provide and bill for Medicaid-reimbursable outpatient psychiatric services.

1.4.9.3 Psychiatric Crisis via Telehealth

Physicians and psychiatric nurse practitioners may provide psychotherapy (CPT® 90839 and 90840) to participants in crisis via telehealth. The medical record of the participant must support a crisis service was provided for the full duration billed and demonstrate that an urgent assessment of the participant's mental state was necessary, and/or their health or safety was at risk. The participant must be in the room for the duration of the visit or a majority of the service, which is focused on the individual. 90839 is a stand-alone code not to be reported with psychotherapy or psychiatric diagnostic evaluation codes, the interactive complexity code, or any other psychiatry section code.

1.4.10 Skin Substitute Products

Skin substitute products are a covered benefit through Idaho Medicaid.

1.4.10.1 EpiCord® and EpiFix®

EpiCord® and EpiFix® are two of the many options for skin substitute products. These two products require a prior authorization by the Medical Care Unit. EpiCord® and EpiFix® are only considered medically necessary for the treatment of:

- A non-healing diabetic lower-extremity ulcer as demonstrated by standard wound care for two weeks or more with less than a 20% reduction in wound area; or the following ophthalmic indications:
- Corneal ulcers and melts;
- A persistent epithelial defect that with conservative treatment has failed to close completely within 5 days or decrease in size after 2 days;
- Neurotrophic keratitis;
- Pterygium repair; or
- Stevens-Johnson syndrome.

Codes	Description
Q4186	EpiFix®, per sq. cm
Q4187	EpiCord®, per sq. cm

Any other use is considered investigational and non-covered per IDAPA 16.03.09, "Medicaid Basic Plan Benefits."

1.4.10.2 References: Skin Substitute Products

"Criteria for Prior Authorization of EpiFix® and EpiCord®." *MedicAide Newsletter,* April 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf.

1.5 Covered Services and Limitations – Surgery

Some surgeries may require a prior authorization. Surgeries requiring a prior authorization require an authorization for both the professional component and the facility, but only a single request needs to be submitted for both.

Reconstructive and plastic surgery always require a prior authorization. See the Prior Authorization (PA) section for more information on determining if a procedure requires a prior authorization.

1.5.1 Surgical Global Fee Concept

Medicaid pays all surgical fees based on the global fee concept as defined by CMS and the Current Procedural Terminology (CPT®) Manual. The global surgical package includes all intra-operative services that are normally a usual and necessary part of the procedure. It also includes all medical and surgical services during the postoperative period to treat complications that do not require a return to the operating room. The following services are always included in the global fee payment for the procedure:

- Access to the site;
- Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia;
- Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of the procedure (including history and physical);
- Supplies, except those identified as exclusions by Medicare;
- Administration of fluids and drugs during the procedure;
- Immediate postoperative care, including dictating operative notes and talking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the post anesthesia recovery area;
- Postoperative visits and miscellaneous services related to the surgery; and
- Postoperative pain management provided by the surgeon.

If a provider, outside of the performing surgeon's practice, delivers part of the global components listed above, he/she must bill the appropriate CPT® code for the actual services delivered with the appropriate modifier.

1.5.1.1 References: Global Fee Concept

"Chapter 1 – General Correct Coding Policies." *National Correct Coding Initiative Policy Manual for Medicaid Services,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html.

Global Surgery Booklet. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf.

1.5.2 Health Acquired Conditions (HAC)

When submitting a claim to indicate a HAC, one of the following modifiers is required. All claims for HAC will be denied.

Modifier	Description
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

1.5.3 Modifiers – Surgical

Modifiers are mandatory in certain circumstances. Refer to the most recent Current Procedural Terminology (CPT®) Manual for specific guidance using modifiers. Anatomical modifiers are required when the procedure is unilateral (left arm/right arm). If the procedure is a unilateral code, and there is no more specific code available as with 28126 (Resection, single toe, each) or 28153 (Resection, head of phalanx, toe), it may be billed as many times as anatomically appropriate—for this example, ten times, with use of the appropriate modifier to identify each toe. In order to recognize assistant-at-surgery services provided by a physician assistant or nurse practitioner (mid-level practitioners), surgical codes should be billed under the mid-level practitioner number with an AS modifier.

The following surgical modifiers pay a percentage of the Idaho Medicaid fee schedule.

Modifier	Percentage of Fee Schedule	Modifier Description
54	80%	Surgical care only
55	20%	Post-op management only
58	100%	Staged or Related Procedure or Service By the Same Physician During the Postoperative Period
62	62.5% each	Two surgeons
78	80%	Unplanned return to operating room for a related procedure following initial procedure for related procedure during post-op period
80	20%	Assistant surgeon
81	20%	Minimum assistant surgeon
82	10%	Assistant surgeon when qualified resident surgeon not available
AS	20% of 85%	First assistant is a physician assistant, nurse practitioner, or clinical nurse specialist

1.5.3.1 Modifier 25

Modifier 25 is appended to an evaluation and management (E&M) code when a significant separately identifiable service is provided by the same physician or other qualified healthcare professional on the same day of the procedure or other service. E&M performed on the same date as a minor procedure are usually included in the payment for the procedure regardless of if the provider performing the E&M and surgeon are different. The service provided with a modifier 25 must be unrelated to the decision to have a surgery. The diagnoses for the E&M and procedure do not have to be different to qualify separately from the global.

1.5.3.2 Modifier 57

Modifier 57 (Decision for surgery) is appended to the E&M code when the decision for surgery is being made to perform a major procedure. This is regardless of whether both services were provided by the same or different providers.

1.5.3.3 References: Modifiers – Surgical

"Chapter 1 – General Correct Coding Policies." *National Correct Coding Initiative Policy Manual for Medicaid Services,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html.

"Modifier 25." *MedicAide Newsletter,* June 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202019%20MedicAide.pdf.

1.5.4 Hospital Admissions

If the surgery is elective or non-trauma, the hospital admission is included in the fee for surgery. If the surgery is the result of an emergency or trauma situation, the hospital admission can be paid in addition to the surgery. Indicate in field **24C** of the CMS-1500 claim form or in the electronic claim form emergency indicator when the admission is trauma or emergency related.

See Inpatient Stay Reviews for information on QIO requirements and penalties.

1.5.5 Anesthesiology

Anesthesia claims must include the CPT® anesthesia code for the surgical procedure that was performed on the participant.

Base units will be added by the system automatically and should not be billed separately. Units are equal to Medicare base units multiplied by fifteen (15). A list of Idaho Medicaid base units may be found in Appendix B. Anesthesia Base Units. Base units include preoperative evaluation, reviewing the participant's medical record, and post-operative visits.

Anesthesia time begins when the anesthesiologist physically starts to prepare the participant for the induction of anesthesia in the operating room, or equivalent area, and ends when the anesthesiologist is no longer in personal attendance. Units are equal to the total amount of time in one (1) minute increments, and any necessary modifiers. Only time spent in personal attendance in the room with the participant should be counted. The anesthesiologist may account for discontinuous time by adding time before and after interruptions of personal attendance. Documentation of personal attendance should be maintained as part of the participant's record.

Idaho Medicaid limits reimbursement for anesthesia procedures to once per day. The anesthesia start date is the only date that should be used. Do not date span. A repeat anesthesia procedure on the same day that 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.

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

Postoperative pain management is included in the surgeon's global payment when related to the procedure. An anesthesiologist may only render services if they are separate, medically necessary and the surgeon does not have the skill or experience for treatment. The surgeon is

responsible to document in the medical record the referral to the anesthesia practitioner, and why.

1.5.5.1 Certified Registered Nurse Anesthetist (CRNA)

Payments may be made directly to the CRNA under their individual provider number, or through an anesthesiologist group. The services of a CRNA may be billed on a UB-04 if the hospital has received an exemption from Medicare. The hospital must send Idaho Medicaid an application with a copy of the valid CRNA license and exemption attached. Exemptions must be updated annually.

1.5.5.2 Modifiers

Anesthesia Modifiers	
A repeat anesthesia procedure on the same day which is billed with the CPT® modifier **76** or **77** will be paid at $0.00.	
AA	Anesthesia services personally performed by an anesthesiologist. The AA modifier is used for all basic procedures
AD	Medical supervision by a physician, more than four concurrent anesthesia procedures.
P1	Normal healthy patient.
P2	Patient with mild systemic disease
P3	Patient with severe systemic disease
P4	Patient with severe systemic disease that is a constant threat to life
P5	Moribund patient who is not expected to survive without the operation.
QS	Monitored anesthesia care service (can be billed by CRNA or a physician). Modifier QS (Monitored Anesthesia Care) is for informational purposes. Please report actual monitoring time on the claim form. This modifier must be billed with another modifier to show that the service was personally performed or medically directed.
QX	CRNA service, with medical direction by a physician.
QZ	CRNA service, without medical direction by a physician.

1.5.5.3 References: Anesthesiology

(a) CMS Guidance

Anesthesia and Pain Management. Jurisdiction F – Medicare Part B. Noridian Healthcare Solutions.
https://med.noridianmedicare.com/web/jfb/specialties/anesthesia-pain-management.

Anesthesia Services Webinar. Noridian Healthcare Solutions, February 2016. Webinar.

"Chapter 2 – Anesthesia Services." *Medicaid NCCI Policy Manual,* Centers for Medicare and Medicaid Services, Department of Health and Human Services,
https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html.

"Chapter 12 – Physicians/Nonphysician Practitioners." *Medicare Claims Processing Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

"**Medicaid Program Integrity Unit:** Billing Anesthesia Services." *MedicAide Newsletter,* July 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202016%20MedicAide.pdf.

(b) Idaho Medicaid Publications

All Anesthesia Providers, Information Release MA02-24 (8/01/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/ctl/ArticleView/mid/1942/articleId/1226/MEDICAID-INFORMATION-RELEASE-200224.aspx.

Anesthesia Providers, Information Release MA02-19 (1/01/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/ctl/ArticleView/mid/1942/articleId/1221/Medicaid-Information-Release-MA0219.aspx.

Anesthesia Providers, Information Release MA04-01 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/ctl/ArticleView/mid/1942/articleId/1165/MEDICAID-INFORMATION-RELEASE-MA0401.aspx.

1.5.6 Circumcisions

Idaho Medicaid covers circumcisions only when medically necessary. Coverage is not available for religious or cultural reasons. Common medical reasons to have a circumcision is to protect against infections of the urinary tract and the foreskin, prevent cancer, lower the risk of getting sexually transmitted diseases and prevent phimosis. Prior authorization is not required. Claims billed with circumcision CPT® codes 54150, 54160, or 54161, and related charges are paid for one of the diagnosis codes listed below, or with documentation of medical necessity attached to the claim.

ICD-10 Diagnoses	Description
C60.0	Malignant neoplasm of prepuce
C60.8	Malignant neoplasm of overlapping sites of penis
C63.7	Malignant neoplasm of other specified male genital organs
C63.8	Malignant neoplasm of overlapping sites of male genital organs
C79.82	Secondary malignant neoplasm of genital organs
D07.61	Carcinoma in situ of scrotum
D07.69	Carcinoma in situ of other male genital organs
D29.0	Benign neoplasm of penis
N47.0 – N47.8	Disorders of prepuce
N48.0 – N48.29	Other disorders of penis
S31.21XA – S31.25XS	Open wound of penis
S38.221A – S38.222S	Amputation of the Penis
S39.848A – S39.848S	Other specified injuries of external genitals

1.5.6.1 References: Circumcisions

Change in Medicaid Coverage for Male Circumcision, Information Release MA05-22 (6/22/2005). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/ctl/ArticleView/mid/1942/articleId/1344/MEDICAID-INFORMATION-RELEASE-MA0522.aspx.

1.5.7 Hysterectomy

Medicaid only pays for a hysterectomy if the following criteria are met:

- Prior authorization (PA) approval by QIO is on file.
- Rendering the participant permanently incapable of reproducing was not the sole purpose of the surgery.
- Participant was advised both verbally and in writing that the hysterectomy would result in permanent sterility and that she will no longer be able to bear children.
- The Authorization for Hysterectomy form, or the sterilization form (HW0034 or HW0034S), must be signed by the participant, regardless of the participant's age or reproductive capabilities.

The Authorization for Hysterectomy form may be signed either before or after the surgery has been performed. If the form is signed after the surgery has been performed, the participant must sign a statement clearly stating that she was informed, both verbally and in writing, before the surgery was performed, that the hysterectomy would render her sterile. See the section titled *Sample Consent for Hysterectomy Form* for an example.

If using the sterilization form under Consent to Sterilization, the field for *operation known as* should be completed with "hysterectomy" and the form should be signed and dated by the participant.

1.5.7.1 Retroactive Eligibility – Hysterectomy

Medicaid may cover a hysterectomy that occurred during a period the participant was found to be retroactively eligible for. Instructions for retroactive eligibility in the *General Billing Instructions*, Idaho Medicaid Provider Handbook must be followed, and the physician must submit a written statement certifying that:

- The participant was informed before the operation that the procedure would render them sterile; or
- The participant was sterile before the hysterectomy; or
- The hysterectomy was necessary for a life-threatening emergency in which prior acknowledgement was not possible.

1.5.7.2 Sample Consent for Hysterectomy Form

I have been informed orally and in writing that the hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed.

Signature: _____

Patient's Medicaid ID number or birth date: _____

Date: _____

1.5.7.3 References: Hysterectomy

"Family Planning." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 680 – 699. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Sterilizations, 42 C.F.R. Sec. 441.250 – 441.259 (1978). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=47c1f1525b86b53c7b8d6a243bf8fd57&mc=true&node=sp42.4.441.f&rgn=div6.

1.5.8 Oral and Maxillofacial Surgery

An oral surgeon who is also enrolled as a dental provider, when performing medical surgical procedures is required to bill the appropriate CPT® code on the CMS-1500 claim form with their physician provider number and submit to DXC Technology.

Extractions must be billed under the provider's dental provider number to Idaho Smiles. Idaho Smiles may require authorization for some extractions. Please call Idaho Smiles provider services at 1 (855) 233-6262 for more information.

Claims for certain dental implants require the prior authorization documentation from Idaho Smiles be attached to the claim submitted to DXC Technology. These codes are identified on the Idaho Medicaid Numerical Fee Schedule.

1.5.9 Subcutaneous Cardiac Rhythm Monitor

Use of a subcutaneous cardiac rhythm monitor is only covered when a participant meets all the following criteria:

- Evidence of recurrent transient loss of consciousness (TLOC);
- A comprehensive evaluation with 30 days of noninvasive ambulatory cardiac monitoring that was unable to find a cause for TLOC, but cardiac arrhythmia is suspected; and
- There is likely to be a recurrence of TLOC within the battery life of the device.

Code	Description
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming

1.5.9.1 References: Subcutaneous Cardiac Rhythm Monitor

"Criteria for Subcutaneous Cardiac Rhythm Monitor." *MedicAide Newsletter,* April 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf.

1.5.10 Sterilization Procedures

Sterilizations (tubal ligations/vasectomies) do not require prior authorization from the Department or QIO; however, participant consent must be obtained with strict adherence to federal regulations. Claims will be denied if consent is not documented correctly. Providers may not bill the participant for errors related to completing the form.

An interactive sterilization consent form can be downloaded from the DXC Technology Medicaid website. The form is available in English (HW0034) and Spanish (HW0034S). Three copies are needed – one for the patient, one for the physician, and one is required to be attached to the claim. Although this form is not required to be used, any form that is submitted must have at a minimum all of the same information as the HW0034/HW0034S forms.

Sterilization claims must include the consent form and the ICD-10-CM code Z30.2

1.5.10.1 Informed Participant Consent

Prior to the procedure as specified in the Mandatory Waiting Time section, the participant must voluntarily sign and date the consent form in the presence of the person obtaining the consent. The participant must be at least 21 years of age, and mentally competent before signing. Consent does not qualify as informed if the participant is:

- In active labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other mind-altering substances.

(a) Interpreter's Statement

An interpreter must be provided to ensure that information is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped. An interpreter must also be provided if the participant does not understand either the language used on the consent form or spoken by the person obtaining the consent. Providers may bill Medicaid for reimbursement for oral or sign language interpreter services that they provide for participants. Interpreters may not bill Medicaid directly for their services.

See the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for additional information about billing interpretive services.

1.5.10.2 Mandatory Waiting Time

There must be a lapse of 30 days between the time the participant signs the consent form and the time the sterilization is performed. This allows the participant time to consider the decision to be sterilized. The form expires 180 days after the participant's signature if the procedure is not performed.

Date signed	Participant signs form. This does not count as the first day.
Day 1	Count begins, and 30 days must lapse. This counts as the first day.
Day 31	First day surgery can be performed.
Day 180	Last day surgery can be performed.

The sterilization may be performed 72 hours after the signature if premature delivery occurs or emergency abdominal surgery is required. The surgeon must certify the reason for the exception in paragraph two of the physician's statement of the consent form with either:

- The expected delivery date and provide written details of the premature delivery; or
- The emergency nature of the abdominal surgery.

1.5.10.3 Statement of Person Obtaining Consent

Before the participant signs and dates the consent form, they must be advised that federal benefits will not be withheld regardless of their decision to be sterilized or not to be sterilized. The person obtaining consent must certify that:

- The requirements on the consent form were verbally explained to the participant; and
- To the best of the witness' knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization.

The person obtaining consent may sign the form any time on or after the date the person giving consent signed the form. If the physician obtains the participant's signature, then the physician must sign both statements on the form, once as the person obtaining the consent and again as the physician performing the surgery.

If the person obtaining consent fails to complete the statement correctly, all claims regarding the sterilization, including physician, hospital, and anesthesiologist charges, may be denied. Corrections to the participant signature and signature date are not allowed.

1.5.10.4 Physician's Statement

The physician must sign the consent form certifying that the requirements per *IDAPA 16.03.09.681 Medicaid Basic Plan Benefits* have been fulfilled. The physician who performs the surgery does not need to be the physician who obtains the consent from the participant. However, the physician who performs the surgery must also sign the consent form.

The performing surgeon's signature must be obtained either within three days prior to surgery or any time after the surgery. A copy of the completed consent form must be submitted with the claim form. Failure to properly complete the physician's statement of the consent form will result in claim denial.

1.5.10.5 Sterilizations Incidental to Medical Procedure

Procedures, other than hysterectomies, performed for a purpose other than sterilization, but that result in sterilization, require attached chart notes and an operative report to the claim. Should the claim deny for lack of sterilization diagnosis code Z30.2, a claim review request as detailed in the *Claim Review Request* section of General Billing Instructions, Idaho Medicaid Provider Handbook, will be required for successful processing.

1.5.10.6 References: Sterilization Procedures

"Family Planning." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 680 – 699. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Sterilizations, 42 C.F.R. Sec. 441.250 – 441.259 (1978). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=47c1f1525b86b53c7b8d6a243bf8fd57&mc=true&node=sp42.4.441.f&rgn=div6.

1.5.11 Surgical Procedures for Weight Loss

Medicaid will cover bariatric surgeries, abdominoplasty, or panniculectomy when all conditions listed below are met.

- The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than 40, 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 a 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.

- Physicians and Hospitals practices must meet national medical standards for weight loss surgery.

1.5.11.1 Abdominoplasty or Panniculectomy

Abdominoplasty or panniculectomy is covered only with medical necessity, and a PA from the QIO. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for PA includes, but is not limited to:

- 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.

1.5.11.2 References: Surgical Procedures for Weight Loss

"Surgical Procedures for Weight Loss: Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 431 – 434. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

1.5.12 Transplants

The Department of Health and Welfare may purchase the following organ transplant services for participants with the Medicaid Enhanced Plan:

- Bone marrow;
- Corneas when efficacy has been demonstrated for the underlying condition;
- A heart, but not an artificial heart or ventricular assist device unless the participant is under 21;
- Intestines;
- Kidneys;
- A liver; and
- Lungs.

All transplants require a prior authorization by the QIO except cornea transplants. Re-transplants will be covered if the original transplant was performed for a covered condition. Services, supplies, medications, transportation, or equipment directly related to a non-covered transplant will not be covered by Medicaid.

The transplant costs for actual or potential living donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post operation recovery expenses associated with the donation. Payments for post operation expenses of a donor will be limited to the period of actual recovery.

See the *Hospital*, Idaho Medicaid Provider Handbook for eligible facility requirements.

1.5.12.1 References: Transplants

Organ Transplants, 42 C.F.R. Sec. 441.35 (1991). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec441-35.pdf.

"Organ Transplants." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 090 – 096. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160310.pdf.

1.6 Inpatient Stay Reviews

Idaho Medicaid contracts with a Quality Improvement Organization (QIO) to conduct review on a preadmission basis for selected diagnoses and procedures and a concurrent length of stay review on all hospital stays that exceed a specified number of days.

All inpatient admissions must be reviewed by the QIO if the stay exceeds three days, except for a qualifying cesarean delivery (admitting or principal diagnosis) which needs review if the stay exceeds four days. If the patient is not discharged by the end of the third day (count the day of the admission as day one), a review must be obtained on day four, and thereafter at intervals determined by the QIO. If the review due date falls on a weekend or a holiday, the review is due by the next business day.

The QIO performs retrospective reviews for services that were not reviewed in a timely manner (penalties may apply). Retrospective reviews may also be requested from the QIO for services requiring prior authorization (PA) and for admissions longer than three days when the patient receives retroactive eligibility.

The participant's physician or the treating facility may initiate the request for PA. Both providers are equally responsible for obtaining authorization. See procedures and instructions detailed in the QIO Provider Manual or contact the QIO.

1.6.1 Penalties

Medicaid assesses a penalty to physicians and hospitals for failure to obtain a timely QIO review instead of withholding total payment. Information on the penalty amounts are detailed in the *Medicaid Basic Plan Benefits, IDAPA 16.03.09.505 Physician Services - Provider Reimbursement and IDAPA 16.03.09.705.03 Inpatient Psychiatric Hospital Services - Provider Reimbursement; Physician Penalty Schedule,* available online or by calling the Department of Administration, Office of Administrative Rules at 1 (208) 332-1822.

1.7 Prior Authorization (PA)

When necessary, providers must request prior authorization before treatment using the appropriate CPT® code and/or ICD-10-PCS code. Requests for services provided to participants that received eligibility retroactively after the procedure will be considered on a case-by-case basis.

Refer to the physician fee schedule found on the Medicaid Fee Schedule webpage for CPT® codes that always require a prior authorization, and the reviewing authority. The most accurate way to determine the requirement for a prior authorization is by verifying eligibility through the provider's Trading Partner Account. ICD-10-PCS codes requiring a prior authorization from the Medical Care Unit or the QIO, Telligen, can be found in the Appendices of the Hospital, Idaho Medicaid Provider Handbook.

All surgical procedures on the QIO Select Pre-Authorization List of Diagnoses and Procedures require pre-authorization for inpatient and outpatient services through Telligen, Inc. The list is located in the QIO vendor's provider manual. For more information, please call at 1 (866) 538-9510, fax at 1 (866) 539-0365, or visit https://idmedicaid.telligen.com/.

The status of a prior authorization request for may be checked by providers online at the DXC Technology portal under "Authorization Status", using your NPI, or by contacting DXC Technology at 1 (866) 686-4272.

See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on prior authorization requirements.

1.8 Reimbursement

Idaho Medicaid reimburses physician and non-physician practitioner services on a fee-for-service basis except for services provided in Rural Health Clinics (RHC), Federally Qualified Health Clinic (FQHC), or Indian Health Services (IHS). Usual and customary fees are paid up to the Medicaid maximum allowance. Most non-physician practitioner services are reimbursed up to 85 percent of the allowed physician maximum. See the *Ambulatory Health Care Facility*, Idaho Medicaid Provider Handbook for information on encounter fees for services provided in an RHC, FQHC or IHS.

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

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

1.8.1 Site of Service Differential

Idaho Medicaid reduces physician and non-physician practitioner reimbursement when certain procedures are provided in a facility setting. For these procedure codes there is a 30 percent reduction for physicians, and a 40 percent reduction for non-physician practitioner, of the Idaho Medicaid fee schedule in the following places of service (POS):

- 02 Telehealth (Not recognized by Idaho Medicaid);
- 19 Outpatient Hospital-Off Campus;
- 21 Inpatient Hospital;
- 22 Outpatient Hospital;
- 23 Emergency Room – Hospital;
- 24 Ambulatory Surgical Center;
- 26 Military Treatment Facility;
- 31 Skilled Nursing Facility;
- 34 Hospice – Inpatient Care;
- 41 Ambulance – Land;
- 42 Ambulance – Air or Water;
- 51 Inpatient Psychiatric Facility;
- 52 Psychiatric Facility - Partial Hospitalization;
- 53 Community Mental Health Center;
- 56 Psychiatric Residential Treatment Center; and
- 61 Comprehensive Inpatient Rehabilitation Facility.

If the space and supplies are provided by the hospital, and are included in the hospital's cost settlement, the physician or non-physician practitioner can bill under his own provider number on the 1500 form, and there is a site of service deduction. The facility fees are billed by the hospital on their UB-04 form under the hospital provider number.

There is no site of service reduction if office space is rented from the hospital and the physician or non-physician practitioner provides his own supplies. The hospital cannot use the same space, etc. to bill for services under their hospital provider number.

Refer to CMS and their Idaho regional Medicare contractor, Noridian, for a list of codes the differential affects.

1.8.1.1 References: Site of Service Differential

"Site of Service Reduction List." *MedicAide Newsletter,* April 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf.

1.8.2 Physician Employees

Services provided by employees of a physician may not be billed directly to Idaho Medicaid. However, psychological testing services provided by a licensed psychologist or social worker who are employees of the physician, may be billed under the physician's provider number. This exception applies to testing only.

Occupational, Physical or Speech therapy services that are provided by a physician may be billed with that physician's provider number. If services are provided by a licensed therapist employed by the physician, the therapist must apply for a separate Medicaid provider number and the services billed with that number.

1.8.3 Misrepresentation of Services

Any representation that a service provided by a nurse practitioner, nurse midwife, licensed midwife, physical therapist, physician assistant, psychologist, social worker, or other non-physician professional was rendered as a physician service is prohibited. All provider types and specialties submitting claims, must bill using their own National Provider Identification (NPI) number. Idaho rule and policy requires payment be made only for claims submitted by the enrolled provider who is physically present (not simply on-site) and performing the service.

Examples of misrepresentation of services prohibited by Idaho Medicaid includes, but is not limited to:

- 'Incident to' billing of a non-physician NPI under physician NPI.
- Global billing when services are rendered by two different provider types in the same group practice.
- By any provider who is not an enrolled with Idaho Medicaid, under the NPI of any enrolled provider.
- Students or unlicensed aides of an Idaho Medicaid provider.
- Unenrolled subcontractors to an Idaho Medicaid provider.
- For supervision of services rendered by any other provider of medical services or supplies, whether or not enrolled with Idaho Medicaid.

1.8.3.1 References: Misrepresentation of Services

"Physician Services: Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 504. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

1.8.4 Out-of-Idaho Care

Out-of-state providers in the United States of America, who are enrolled in the Idaho Medicaid Program and have an active Idaho Medicaid provider number may render services to Idaho Medicaid participants without receiving out-of-state prior approval. All medical care provided outside the state of Idaho is subject to the same utilization review, coverage requirements, and restrictions as medical care provided within Idaho.

Idaho Medicaid does not cover services outside of the United States of America.

1.8.5 Locum Tenens and Reciprocal Billing Arrangements

Idaho Medicaid allows for physicians to bill for locum tenens and reciprocal billing arrangements. Arrangements may be made with one or more substitute physicians, and do not have to be in writing. The absent physician continues to bill and receive payment for the substitute physician's services as though they were performed by the absent physician.

Locum tenens and reciprocal billing arrangements are allowed when:

- The regular physician is unavailable to provide the services.
- The Medicaid participant has arranged or seeks to receive services from their regular physician.
- The regular physician identifies the services provided by a substitute physician by appending the appropriate modifier to the procedure code on claims.
- The regular physician maintains a record of each service provided by the substitute physician and their National Provider Identifier (NPI). Records must be available to DHW upon request.
- Services are not reported separately as substitute services for an operation and/or post-operative care covered by a global fee.

1.8.5.1 Locum Tenens Arrangements

Locum tenens arrangements occur when the substitute physician covers the regular physician during absences for illness, pregnancy, vacation, or continuing education. The regular physician pays the substitute physician for their services on a per diem, or similar fee-for-time basis. Locum tenens arrangements cannot exceed a period of 90 continuous days. The regular physician must use the Q6 modifier on claims for services provided by the substitute physician in a locum tenens arrangement.

1.8.5.2 Reciprocal Billing Arrangements

Reciprocal billing arrangements occur when the substitute physician covers the regular physician during occasional absences such as on-call coverage. The absent physician agrees to cover the substitute physician at a later time in exchange for their services. Arrangements are not to exceed a period of 14 continuous days. The regular physician must use the Q5 modifier on claims for services provided by the substitute physician in a reciprocal billing arrangement.

1.9 References: General

1.9.1 CMS Guidance

Active Local Coverage Determinations. Jurisdiction F – Medicare Part B. Noridian Healthcare Solutions. https://med.noridianmedicare.com/web/jfb/policies/lcd/active.

"Chapter 12 – Physicians/Nonphysician Practitioners." *Medicare Claims Processing Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

"Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Medicare National Coverage Determinations (NCD) Manual. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html.

"Non-Covered Services." *Noridian Healthcare Solutions,* 16 April 2018, https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered_statutorily_excluded.

1.9.2 Idaho Medicaid Publications

Basic Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/BasicBenchmark.pdf.

Enhanced Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/EnhancedBenchmark.pdf.

1.9.3 Regulations

"**Definitions**: Physician Services." Social Security Act, Sec. 1905(a)(5) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office, https://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

"Physician Services and Abortion Procedures." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 500 – 519. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Appendix A. Periodicity Schedule

If a child receives care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Key	
X	Should be performed
R	A risk assessment to be performed with appropriate action to follow, if positive
← or →	The range during which a service should be provided (with the X at the preferred age)
#	Indicates a note in Appendix A with additional information.

(a) Infancy Screening

Age [1]	Newborn [2,3]	3-5 [4] Days	By 1 Mo.	2 Mos.	4 Mos.	6 Mos.	9 Mos.
History							
Initial/Interval	X	X	X	X	X	X	X
Measurements							
Length/Height and Weight	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X
Weight for Length	X	X	X	X	X	X	X
Blood Pressure[5]	R	R	R	R	R	R	R
Sensory Screening							
Vision	R	R	R	R	R	R	R
Hearing	X[8]	X[9]	R	R	R	R	R
Development/Behavior Assessment							
Developmental Screening[8]							X
Developmental Surveillance[8]	X	X	X	X	X	X	
Psychosocial/Behavioral Assessment	X	X	X	X	X	X	X
Maternal Depression Screening			X	X	X	X	
Physical Examination[17]	X	X	X	X	X	X	X
Procedures[18]							
Newborn Blood	X[19]	X[20]	→	→			
Newborn Bilirubin	X						
Critical Congenital Heart Defect [22]							

Immunization[23]	X	X	X	X	X	X	X
Anemia [24]							
Lead [25]						R	R
Tuberculosis[27]			R			R	
Oral Health[32]						X	X
Fluoride Supplementation						R	R
Anticipatory Guidance[23]	X	X	X	X	X	X	X

Anticipatory Guidance During Infancy (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
Newborn	Family Readiness, Infant Behaviors, Feeding, Safety, Routine Baby Care
First Week	Parental (Maternal) Well-Being, Newborn Transition, Nutritional Adequacy, Safety, Newborn Care
1 Month	Parental (Maternal) Well-Being, Family Adjustment, Infant Adjustment, Feeding Routines, Safety
2 Month	Parental (Maternal) Well-Being, Infant Behavior, Infant-Family Synchrony, Nutritional Adequacy, Safety
4 Month	Family Functioning, Infant Development, Nutrition Adequacy and Growth, Safety
6 Month	Family Functioning, Infant Development, Nutrition and Feeding: Adequacy/Growth, Oral Health, Safety
9 Month	Family Adaptations, Infant Independence, Feeding Routine, Oral Health, Safety

(b) Early Childhood Screening

Age	12 Mos.	15 Mos.	18 Mos.	24 Mos.	30 Mos.	3 Yrs.	4 Yrs.
History							
Initial/Interval	X	X	X	X	X	X	X
Measurements							
Length/Height and Weight	X	X	X	X	X	X	X
Head Circumference	X	X	X	X			
Weight for Length	X	X	X				
Body Mass Index[5]				X	X	X	X
Blood Pressure[6]		R	R	R	R	X	X
Sensory Screening							
Vision[7]	R	R	R	R	R	X	X
Hearing	R	R	R	R	R	R	X

Age	12 Mos.	15 Mos.	18 Mos.	24 Mos.	30 Mos.	3 Yrs.	4 Yrs.
Developmental/Behavioral Assessment							
Developmental Screening[11]			X		X		
Autism Spectrum Disorder Screening[12]			X	X			
Developmental Surveillance	X	X		X		X	X
Psychosocial/Behavioral Assessment	X	X	X	X	X	X	X
Physical Examination[17]	X	X	X	X	X	X	X
Procedures[18]							
Immunization[23]	X	X	X	X	X	X	X
Anemia	X	R	R	R	R	R	R
Lead [25]	X or R[26]		R	X or R[26]		R	R
Tuberculosis [27]	R			R		R	R
Dyslipidemia [28]				R			
Oral Health[32]	X		X [1]	X	X	X	
Fluoride Varnish[34]			X				
Fluoride Supplementation[35]	R		R	R	R	R	R
Anticipatory Guidance	X	X	X	X	X	X	X

Anticipatory Guidance during Early Childhood (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
12 Month	Family Support, Establishing Routines, Feeding and Appetite Changes, Establishing a Dental Home, Safety
15 Month	Communication and Social Development, Sleep routines and Issues, Temper Tantrums and Discipline, Healthy Teeth, Safety
18 Month	Family Support, Child Development and Behavior, Language Promotion/Hearing, Toilet Training Readiness, Safety
24 Month	Assessment of Language Development, Temperament and Behavior, Toilet Training, Television Viewing, Safety
30 Month	Family Routines, Language Promotion and Communication, Promoting Social Development, Preschool Considerations, Safety
3 Year	Family Support, Encouraging Literacy Activities, Playing with Peers, Promoting Physical Activity, Safety
4 Year	School Readiness, Developing Healthy Personal Habits, Television/Media, Child and Family Involvement and Safety in the Community, Safety

(c) Middle Childhood Screening

Age[1]	5 Yrs.	6 Yrs.	7 Yrs.	8 Yrs.	9 Yrs.	10 Yrs.
History						
Initial/Interval	X	X	X	X	X	X
Measurements						
Height and Weight	X	X	X	X	X	X
Body Mass Index[5]	X	X	X	X	X	X
Blood Pressure[6]	X	X	X	X	X	X
Sensory Screening						
Vision[7]	X	X	R	X	R	X
Hearing	X	X	R	X	R	X
Developmental/Behavioral						
Developmental Surveillance	X	X	X	X	X	X
Psychosocial/Behavioral[13]	X	X	X	X	X	X
Physical Examination[17]	X	X	X	X	X	X
Procedures[18]						
Immunization[23]	X	X	X	X	X	X
Anemia	R	R	R	R	R	R
Lead [25]	R	R				
Tuberculosis [27]	R	R	R	R	R	R
Dyslipidemia Screening[28]		R		R	R	R
Oral Health[32]	X	X				
Fluoride Varnish[34]	X	X	X	X	X	X
Fluoride Supplementation[35]	R	R	R	R	R	R
Anticipatory Guidance[23]	X	X	X	X	X	X

Anticipatory Guidance during Middle Childhood (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
5 and 6 Year	School Readiness Mental Health Nutrition and Physical Activity Oral Health Safety

Anticipatory Guidance during Middle Childhood (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
7, 8, 9, and 10 Year	School Development and Mental Health Nutrition and Physical Activity Oral Health Safety

(d) Adolescence Screening

Age[1]	11 Yrs.	12 Yrs.	13 Yrs.	14 Yrs.	15 Yrs.	16 Yrs.	17 Yrs.	18 Yrs.	19 Yrs.	20 Yrs.	21 Yrs.
History											
Initial/Interval	X	X	X	X	X	X	X	X	X	X	X
Measurements											
Height and Weight	X	X	X	X	X	X	X	X	X	X	X
Body Mass Index[5]	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure[6]	X	X	X	X	X	X	X	X	X	X	X
Sensory Screening											
Vision[7]	R	X	R	R	X	R	R	R	R	R	R
Hearing	R	R	R	R	R	R	R	R	R	R	R
Developmental Surveillance[11]	X	X	X	X	X	X	X	X	X	X	X
Psychosocial/ Behavioral Assessment[13]	X	X	X	X	X	X	X	X	X	X	X
Tobacco, Alcohol or Drug Use	R	R	R	R	R	R	R	R	R	R	R
Depression Screening[15]	X	X	X	X	X	X	X	X	X	X	X
Physical Examination[17]	X	X	X	X	X	X	X	X	X	X	X
Procedures[18]											
Immunization[23]	X	X	X	X	X	X	X	X	X	X	X
Anemia[24]	R	R	R	R	R	R	R	R	R	R	R
Lead[25]	R	R	R	R	R	R	R	R	R	R	R
Tuberculosis[27]	R	R	R	R	R	R	R	R	R	R	R
Dyslipidemia Screening[28]	R	R	R	R	R	R	R	←	←	X	→
Se[19]											
Sexually Transmitted	R	R	R	R	R	R	R	R	R	R	R

Age[1]	11 Yrs.	12 Yrs.	13 Yrs.	14 Yrs.	15 Yrs.	16 Yrs.	17 Yrs.	18 Yrs.	19 Yrs.	20 Yrs.	21 Yrs.
Cervical Dysplasia Screening[31]											R
Fluoride Supplementation[35]	R	R	R	R	R	R					
Anticipatory Guidance[23]	X	X	X	X	X	X	X	X	X	X	X

Anticipatory Guidance during Adolescence (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
Each Year Age 11-21	Physical Growth and Development Social and Academic Competence Emotional Well-Being Risk Reduction Violence and Injury Prevention

(e) Notes from the Recommendations for Preventive Pediatrics Health Care, the American Academy of Pediatrics (AAP) and the American Association of Pediatric Dentistry (AAPD)

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within three to five days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Screening should occur per 'Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents.' Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age three years. (https://pediatrics.aappublications.org/content/140/3/e20171904)
7. A visual acuity screen is recommended at ages four and five years, as well as in cooperative three-year-olds. Instrument-based screening may be used to assess risk at

ages 12 and 24 months, in addition to the well visits at three through five years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).

8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible and follow up as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).

23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics (Iron chapter).
25. For children at risk of lead exposure, see 'Prevention of Childhood Lead Toxicity' and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention'.
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.* Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.*
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Appendix B. Anesthesia Base Units

Code	Base Units	Code	Base Units	Code	Base Units	Code	Base Units	Code	Base Units
00100	75	00400	45	00625	195	00846	120	00948	60
00102	90	00402	75	00626	225	00848	120	00950	75
00103	75	00404	75	00630	120	00851	90	00952	60
00104	60	00406	195	00632	105	00860	90	01112	75
00120	75	00410	60	00635	60	00862	105	01120	90
00124	60	00450	75	00640	45	00864	120	01130	45
00126	60	00454	45	00670	195	00865	105	01140	225
00140	75	00470	90	00700	60	00866	150	01150	150
00142	60	00472	150	00702	60	00868	150	01160	60
00144	90	00474	195	00730	75	00870	75	01170	120
00145	90	00500	225	00731	75	00872	105	01173	180
00147	60	00520	90	00732	90	00873	75	01180	45
00148	60	00522	60	00740	75	00880	225	01190	60
00160	75	00524	60	00750	60	00882	150	01200	60
00162	105	00528	120	00752	90	00902	75	01202	60
00164	60	00529	165	00754	105	00904	105	01210	90
00170	75	00530	60	00756	105	00906	60	01212	150
00172	90	00532	60	00770	225	00908	90	01214	120
00174	90	00534	105	00790	105	00910	45	01215	150
00176	105	00537	105	00792	195	00912	75	01220	60
00190	75	00539	270	00794	120	00914	75	01230	90
00192	105	00540	180	00796	450	00916	75	01232	75
00210	165	00541	225	00797	165	00918	75	01234	120
00211	150	00542	225	00800	60	00920	45	01250	60
00212	75	00546	225	00802	75	00921	45	01260	45
00214	135	00548	255	00810	75	00922	90	01270	120
00215	135	00550	150	00811	60	00924	60	01272	60
00216	225	00560	225	00812	45	00926	60	01274	90
00218	195	00561	375	00813	75	00928	90	01320	60
00220	150	00562	300	00820	75	00930	60	01340	60
00222	90	00563	375	00830	60	00932	60	01360	75
00300	75	00566	375	00832	90	00934	90	01380	45
00320	90	00567	270	00834	75	00936	120	01382	45
00322	45	00580	300	00836	90	00938	60	01390	45
00326	105	00600	150	00840	90	00940	45	01392	60
00350	150	00604	195	00842	60	00942	60	01400	60
00352	75	00620	150	00844	105	00944	90	01402	105

Code	Base Units
01404	75
01420	45
01430	45
01432	90
01440	120
01442	120
01444	120
01462	45
01464	45
01470	45
01472	75
01474	75
01480	45
01482	60
01484	60
01486	105
01490	45
01500	120
01502	90

Code	Base Units
01520	45
01522	75
01610	75
01620	60
01622	60
01630	75
01634	135
01636	225
01638	150
01650	90
01652	150
01654	120
01656	150
01670	60
01680	45
01682	60
01710	45
01712	75
01714	75

Code	Base Units
01716	75
01730	45
01732	45
01740	60
01742	75
01744	75
01756	90
01758	75
01760	105
01770	90
01772	90
01780	45
01782	60
01810	45
01820	45
01829	45
01830	45
01832	90
01840	90

Code	Base Units
01842	90
01844	90
01850	45
01852	60
01860	45
01916	75
01920	105
01922	105
01924	75
01925	105
01926	120
01930	75
01931	105
01932	90
01933	105
01935	75
01936	75
01951	45
01952	75

Code	Base Units
01953	15
01958	75
01960	75
01961	105
01962	120
01963	120
01965	60
01966	60
01967	75
01968	30
01969	75
01990	105
01991	45
01992	75
01996	45
01999	0

Appendix C. Physician and Non-Physician Practitioner, Provider Handbook Modifications

Version	Section/ Column	Modification Description	Date	SME
48.0	All	Published version	01/01/2020	TQD
47.9	Appendix C. Section Modifications	Renamed Physician and Non-Physician Practitioner, Provider Handbook Modifications. Removed all changes from list that occurred over three years ago.	12/30/2019	W Deseron K Duke
47.8	(e) Notes from the Recommendations for Preventive Pediatrics Health Care	Updated to match current guidance from AAP.	12/30/2019	W Deseron K Duke
47.7	1.7 Prior Authorization (PA)	New section.	12/30/2019	W Deseron K Duke
47.6	1.5 Covered Services and Limitations – Surgery	Moved text about prior authorizations to Prior Authorization (PA) section.	12/30/2019	W Deseron K Duke
47.5	1.4.5.Presumptive Eligibility (PE)/Pregnant Women (PW) Services	Renamed Presumptive Eligibility (PE). Removed PW program information.	12/30/2019	W Deseron K Duke
47.4	1.3.18 Tamper Resistant Prescription Requirements	New section. Moved from General Provider and Participant Information handbook.	12/30/2019	W Deseron K Duke
47.3	1.3.10.1 Participant Eligibility	Removed PW program requirement.	12/30/2019	W Deseron K Duke
47.2	1.3.9 Focus Case Review	New section.	12/30/2019	W Deseron K Duke
47.1	1.3.1.2 Medical Abortion	Added note of prior authorization requirement for Mifeprex to match claims processing.	12/30/2019	W Deseron K Duke
47.0	All	Published version	7/1/2019	TQD
46.25	1.7.1 Site of Service Differential	Updated list of places of service.	6/26/2019	W Deseron K Duke
46.24	1.5.12 Transplants	Added coverage for live organ donations, live liver transplants and lung transplants for over 21.	6/26/2019	W Deseron K Duke
46.23	1.5.10.5 Sterilizations Incidental to Medical Procedure	Clarified that hysterectomy is not considered a sterilization.	6/26/2019	W Deseron K Duke
46.22	1.5.9 Subcutaneous Cardiac Rhythm Monitor	Incorporating criteria from newsletter.	6/26/2019	W Deseron K Duke
46.21	1.5.8 Oral and Maxillofacial Surgery	Added information about prior authorizations required from Idaho Smiles.	6/26/2019	W Deseron K Duke
46.20	1.5.3.2 Modifier 57	New section. Clarifies use per NCCI Policy Manual.	6/26/2019	W Deseron K Duke
46.19	1.5.3.1 Modifier 25	New section. Clarifies use per NCCI Policy Manual.	6/26/2019	W Deseron K Duke
46.18	2.4.2 Complications	Section deleted.	6/26/2019	W Deseron K Duke
46.17	1.5.1 Surgical Global Fee Concept	Updated with content from NCCI Policy Manual.	6/26/2019	W Deseron K Duke
46.16	1.4.10 Skin Substitute Products	New section. Incorporating criteria for EpiCord(R) and EpiFix(R)	6/26/2019	W Deseron K Duke
46.15	1.4.9.3 Psychiatric Crisis via Telehealth	Incorporated coverage from Telehealth IR MA18-07.	6/26/2019	W Deseron K Duke
46.14	1.4.8 Cardiac Rehabilitation	Incorporated diagnoses , POS and CPT(R) codes.	6/26/2019	W Deseron K Duke

Version	Section/ Column	Modification Description	Date	SME
46.13	1.4.5.7 Postpartum Care	Clarified billing requirements for how and when to bill code.	6/26/2019	W Deseron K Duke
46.12	1.4.5.2 Antepartum Care	Clarified when code is billable.	6/26/2019	W Deseron K Duke
46.11	1.3.19.1 Adult Wellness Exams	Added elements of examination to align with Medicare.	6/26/2019	W Deseron K Duke
46.10	1.3.19 Wellness Examinations	Added CMS requirement for opioid use screening. Also instructions for refugee screening.	6/26/2019	W Deseron K Duke
46.9	1.3.12.14 Blood Lead Screening	Clarified that wellness visit diagnosis should be used on claims.	6/26/2019	W Deseron K Duke
46.8	1.3.12 Laboratory Coverage	Clarified documentation for tests that do not require orders.	6/26/2019	W Deseron K Duke
46.7	1.3.9. Diabetes Education	Clarified that participants with PW eligibility need a pregnancy related diabetic diagnosis.	6/26/2019	W Deseron K Duke
46.6	1.3.19.3 Child Wellness Exam: Maternal Postpartum Depression	Incorporated required screening tools from newsletter. Added referral for positive screening.	6/26/2019	W Deseron K Duke
46.5	1.3.7 Evaluation and Management	New section. Adds CMS guidance on documentation and elements.	6/26/2019	W Deseron K Duke
46.4	1.3.5 Durable Medical Equipment	New section with clarification on physicians ordering DME they supply.	6/26/2019	W Deseron K Duke
46.3	1.3.1 Abortions	New section with comprehensive abortion policy.	6/26/2019	W Deseron K Duke
46.2	1.2.1 Referrals	Removed reference to defunct IMHH program.	6/26/2019	W Deseron K Duke
46.1	1. Physician and Non-Physician Practitioner	Added glossary to the list of applicable documents.	6/26/2019	W Deseron K Duke
46.0	All	Published version	11/1/2018	TQD
45.1	All	Removed Molina references	11/1/2018	W Deseron E Garibovic
45.0	All	Published version	8/27/2018	TQD
44.11	2.8 References: General	Formatting references. Moved general references here.	8/27/2018	W Deseron E Garibovic
44.10	2.7 Reimbursement	Added information about encounter rates.	8/27/2018	W Deseron E Garibovic
44.9	2.5.8 Hysterectomy 2.5.10 Sterilization Procedures 2.5.11 Surgical Procedures for Weight Loss 2.5.12 Transplants 2.7.3 Misrepresentation of Services	Formatted reference section.	8/27/2018	W Deseron E Garibovic
44.8	2.4.4 Obstetric Care	Deleted extra blank lines from abortion document example. Added section on Lactation Counseling	8/27/2018	W Deseron E Garibovic
44.7	2.3.16 Wellness Examinations	Clarified coverage of exams for refugees. Moved maternal postpartum depression screening to ow	8/27/2018	W Deseron E Garibovic
44.6	2.3.12 Prolonged Services	99358 and 99359 are considered bundled in evaluation and management codes	8/27/2018	W Deseron E Garibovic
44.5	2.3.7 Immunization and Vaccines	Added reference section	8/27/2018	W Deseron E Garibovic

Version	Section/ Column	Modification Description	Date	SME
44.4	2.3.5 Family Planning	Clarified co-pay exemption, billing, importance of FP modifier and coverage for IUD after delivery	8/27/2018	W Deseron E Garibovic
44.3	2.3.3.1 References: Consultations	Formatted section and citations. Moved general references to general section	8/27/2018	W Deseron E Garibovic
44.2	2.2 Eligible Participants	New section. Direction to check eligibility and coverage	8/27/2018	W Deseron E Garibovic
44.1	2. Physician and Non-Physician	Added nurse midwife to list of covered providers. Listed applicable handbook sections	8/27/2018	W Deseron E Garibovic
44.0	All	Published version	7/26/2018	TQD
43.5	Appendix B Anesthesia Base Units	New section. Moved from anesthesiology.	7/26/2018	W Deseron E Garibovic
43.4	2.5.8 Hysterectomy	Added section about retroactive eligibility and references.	7/26/2018	W Deseron E Garibovic
43.3	2.5.6 Anesthesiology	Moved base units into Appendix B.	7/26/2018	W Deseron E Garibovic
43.2	2.4.4.3 Dilation and Curettage (D&C)	New section. Moved from Ambulatory Healthcare Facility handbook.	7/26/2018	W Deseron E Garibovic
43.1	2.3.16 Wellness Examinations	Updated with DD information and cost-sharing.	7/26/2018	W Deseron E Garibovic
43.0	All	Published Version	7/2/2018	TQD
42.1	All	Significant revisions	7/2/2018	W Deseron D Baker E Garibovic
42.0	All	Published version	4/20/2018	TQD
41.5	2.6.1 Certified Registered Nurse Anesthetist (CRNA) 2.6.2 Anesthesia Base Units	New sections	4/20/2018	W Deseron D Baker E Garibovic
41.4	2.6 Anesthesiology	Significant revisions	4/20/2018	W Deseron D Baker E Garibovic
41.3	2.7.1 Overview	Removed section	4/20/2018	W Deseron D Baker E Garibovic
41.2	2.1 Reimbursement	Added co-pays and prior authorization	4/20/2018	W Deseron D Baker E Garibovic
41.1	2.1 General Policy	Removed heading	4/20/2018	W Deseron D Baker E Garibovic
41.0	All	Published version	3/8/2018	TQD
40.4	2.13.3 Group Diabetic Counseling	Minor updates for clarity	3/8/2018	W Deseron D Baker E Garibovic
40.3	2.13.2 Individual Diabetic Counseling	Clarified requirements for reimbursement	3/8/2018	W Deseron D Baker E Garibovic
40.2	2.13.1 Participant Eligibility	Minor verbiage updates for clarity	3/8/2018	W Deseron D Baker E Garibovic
40.1	2.13 Diabetes Education and Training	Updates to group counseling information	3/8/2018	W Deseron D Baker E Garibovic
40.0	All	Published version	1/11/2018	TQD

Version	Section/ Column	Modification Description	Date	SME
39.16	2.33.3.2 Quality Improvement Organization (QIO) PA	Updated prior auth information	1/11/2018	W Deseron D Baker E Garibovic
39.15	2.33.1 Overview	Updated inpatient psychiatric information	1/11/2018	W Deseron D Baker E Garibovic
39.14	2.27.2 Inpatient Psychiatric Care	Significant revisions	1/11/2018	W Deseron D Baker E Garibovic
39.13	2.26.1 Reporting National Drug Code (NDC) for Drugs Billed with HCPCS Codes	Changed "will be denied" to "will not be accepted"	1/11/2018	W Deseron D Baker E Garibovic
39.12	2.25 Oral and Maxillofacial Surgery	Removed reference to ADA Dental Claim form	1/11/2018	W Deseron D Baker E Garibovic
39.11	2.20 Nutritional Services	Moved section; updates for clarity	1/11/2018	W Deseron D Baker E Garibovic
39.10	2.19.6 Newborn Screening	Changed section title; updates for clarity	1/11/2018	W Deseron D Baker E Garibovic
39.9	2.19.4 Special Services	Updated POS descriptions	1/11/2018	W Deseron D Baker E Garibovic
39.8	2.18 International Normalized Ratio (INR) Monitoring Services	New section	1/11/2018	W Deseron D Baker E Garibovic
39.7	2.16 Hyperbaric Oxygen Treatment	New section; moved from General Provider and Participant Information	1/11/2018	W Deseron D Baker E Garibovic
39.6	2.14.1 Instrument-Based Ocular Screening	Changed "mid-level" to "non-physician practitioner"	1/11/2018	W Deseron D Baker E Garibovic
39.5	2.7.2 Billing Anesthesia	Added information about time and post-op pain management; updates to base units	1/11/2018	W Deseron D Baker E Garibovic
39.4	2.7.1 Overview	Added documentation; removed information about second separate anesthesia session	1/11/2018	W Deseron D Baker E Garibovic
39.3	2.5 Advanced Care Planning (ACP)	New section	1/11/2018	W Deseron D Baker E Garibovic
39.2	2.2.1 Site of Service Differential	Minor updates for clarity; added reference to CMS and Noridian	1/11/2018	W Deseron D Baker E Garibovic
39.1	2.2 Reimbursement	Removed dual eligibility, QMB, and crossover information and referred to General Billing Instructions	1/11/2018	W Deseron D Baker E Garibovic
39.0	All	Published version	12/14/2017	TQD
38.1	2.17.1.11 Medical Necessity	Removed information specific to Medical Necessity Form	12/14/2017	W Deseron D Baker E Garibovic
38.0	All	Published version	11/16/2017	TQD
37.20	2.29.3.3 PA by the Medicaid Medical Care Unit	Updated resources	11/16/2017	W Deseron D Baker
37.19	2.29.1 Overview	Removed ICD-9 codes	11/16/2017	W Deseron D Baker
37.18	2.25.3 Modifiers	Added information for anatomical modifiers	11/16/2017	W Deseron D Baker

Version	Section/ Column	Modification Description	Date	SME
37.17	2.24.6 Diagnosis Codes	Removed ICD-9 codes	11/16/2017	W Deseron D Baker
37.16	2.21 Oral and Maxillofacial Surgery	Corrected Idaho Smiles phone number	11/16/2017	W Deseron D Baker
37.15	2.20 Oral Treatments	Replaced reference to D1206 and D1208 with new CPT® code	11/16/2017	W Deseron D Baker
37.14	2.18.8 Sterilizations Incidental to Medical Procedure	New section	11/16/2017	W Deseron D Baker
37.13	2.17.2.5 Diaphragm	Removed note about "morning-after pill"	11/16/2017	W Deseron D Baker
37.12	2.17.2.2 Intrauterine Device (IUD)	Removed information about Liletta and Mirena sharing J code	11/16/2017	W Deseron D Baker
37.11	2.16.7 Controlled Substance and Drug Testing	New Section	11/16/2017	W Deseron D Baker
37.10	2.14.1.1 Acupuncture 2.14.1.2 Biofeedback Therapy 2.14.1.3 Complications 2.14.1.4 Cosmetic Surgery 2.14.1.5 Fertility Related Services 2.14.1.6 Investigational/Unproven/Experimental Procedures 2.14.1.7 Laetrile Therapy 2.14.1.8 Naturopathic Services	Removed sections (content contained within General Provider and Participant Information)	11/16/2017	W Deseron D Baker
37.9	2.14 Excluded Services	Added reference to General Provider and Participant Information	11/16/2017	W Deseron D Baker
37.8	2.13.1 Wellness Exams for Children Up to the Age of 21 2.13.2 Wellness Physicals for Adults 21 Years and Over	Removed sections (content contained within General Provider and Participant Information)	11/16/2017	W Deseron D Baker
37.7	2.13 Examinations – Wellness	Updated for clarity	11/16/2017	W Deseron D Baker
37.6	2.9 Emergency Department	Removed reference to visit limits for non-HC participants	11/16/2017	W Deseron D Baker
37.5	2.6.1.1 Billing Anesthesia	Added information about base units	11/16/2017	W Deseron D Baker
37.4	2.4.6.2 Reciprocal Billing Arrangements	Updated section title and all content	11/16/2017	W Deseron D Baker
37.3	2.4.6.1 Locum Tenens Arrangements	Updated section title and all content	11/16/2017	W Deseron D Baker
37.2	2.4.6 Locum Tenens and Reciprocal Billing Arrangements	Updated section title and all content	11/16/2017	W Deseron D Baker
37.1	2.2 Reimbursement	Updated verbiage regarding participant billing	11/16/2017	W Deseron D Baker
37.0	All	Published version	9/7/2017	TQD
36.1	2.22 Physician-Administered Drugs (PAD)	Removed reference to PAD list and added reference to Fee Schedule	9/7/2017	E Garibovic
36.0	All	Published version	6/5/2017	TQD
35.1	2.23.2 Inpatient Psychiatric Care	Added statement regarding authorization—for clarity only, no policy change	6/5/2017	W Deseron D Baker E Garibovic
35.0	All	Published version	3/29/2017	TQD
34.1	2.21 Oral and Maxillofacial Surgery	Updated dental vendor information	3/29/2017	C Loveless
34.0	All	Published version	3/23/2017	TQD

Version	Section/ Column	Modification Description	Date	SME
33.1	2.18 Sterilization Procedures Overview 2.18.2 Waiting Time Exceptions	Moved reference to sterilization consent form from 2.18.2 to 2.18	3/23/2017	D Baker E Garibovic