

3 Service Coordination Guidelines

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3.1 General Policy

3.1.1 Definition

Note: New rules for service coordination were approved upon close of the 2009 legislative session. Please refer to the Idaho Administrative Rules Web site for the most recent final published rules.

Service coordination services are delivered by qualified providers to assist Medicaid participants who are unable, or have limited ability, to gain access to coordinate or maintain service on their own or through other means. See *Medicaid Enhanced Plan Benefits, Service Coordination-Provider Reimbursement*, for rules regarding service coordination.

Service coordination services are limited to the following targeted populations:

- Adults receiving Developmental Disabilities services or Home and Community Based DD Waiver services.
- Adults receiving services related to Severe and Persistent Mental Illness (SPMI).
- Individuals who are eligible for personal care services or adults who are eligible for Home and Community Based Waiver Services for the aged and physically disabled.
- Children age birth to three (0-3) who qualify for early intervention services through the Idaho Infant Toddler Program.
- Children age three through the month of their 21 birthday (please see Section 3.2 for the eligibility requirements for children's service coordination).

Service coordination is a brokerage model of case management and does not include the provision of direct services.

Service coordination consists of the following functions:

- **Assessment**—Evaluation of the participant's ability to gain access to needed services; coordinate or maintain those services; and identify services and supports the participant needs to maintain his/her highest level of independence in the community. Assessment of a participant's needs consists of information gathering and activities required of the service coordination as necessary to write the service plan. (For assessment requirements see *IDAPA 16.03.10.727.01 a-c*)
 - The plan of service must include documentation of the participant choice between waiver services and institutional placement, the participant's or legal guardian's signature and the signature of the service coordination for the participant.
 - At least annually, the plan must be revised, updated, and service authorized based upon changes in the participant's needs.
- **Plan Development**—Plan development allows for hourly payment for developing a plan. As a paid service, the plan developer is the service coordinator. The plan developer is chosen by the participant and assists with facilitating the person-centered planning meeting, writing the plan of service, and any subsequent plan modifications (addendums).
- **Referral and Related Activity**—Finding, arranging, and assisting the participant to maintain services, supports and community resources identified on the service plan; advocating for the unmet needs of the participant; and encouraging independence.
- **Monitoring and Follow-up Activities**—Assisting the participant and family/guardian to coordinate and retain services; assure the consistently and non-duplication between services; and assure participant satisfaction by making adjustments in the plan when necessary.
- **Crisis Assistance**— See *Section 3.4 Crisis Service Coordination* for more information.

Face-to-Face Contact—Service coordinators must have face-to-face contact with the participant, legal guardian, or provider who can verify the participant's well being and whether services are being provided

according to the written plan at least every 90 days. These visits should be written into the plan. The plan must also identify additional frequency, mode of contact, and the person who is contacted. Mental health service coordinators must have face-to-face contact with each participant every month.

When it is necessary for a service coordinator to complete the face-to-face visits with a child, or participant who is not his/her own guardian, without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to contact with the participant. Paraprofessionals should also conduct any meetings with the participant with the parent or legal guardian present, or contact the parent or legal guardian prior to contact with the participant.

Service coordinators do not have to be available on a 24-hour basis, but must include on the written plan what the participant, families, and providers should do in an emergency situation.

3.1.2 Payment

Medicaid reimburses all service coordination services on a fee-for-service basis. Providers are paid in increments of 15 minutes.

A service coordinator can only be reimbursed for the amount of time worked and must not bill for more than four billing units per hour.

3.1.3 Non-Covered Services

- Service coordination does not include the provision of direct service.
- Medicaid does not pay for service coordination activities that duplicate services or payments for the same purposes.
- Medicaid does not pay for ongoing service coordination delivered prior to the completion of a services coordination plan.
- Services provided to a group of participants are not covered.
- Medicaid does not pay for service coordination when the participant is incarcerated.
- Medicaid does not pay for service coordination for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments, transporting the participant, or documenting services.
- Medicaid does not pay for activities that are an integral component of another covered Medicaid service.
- Medicaid does not pay for activities that are integral to the administration of foster care programs.
- Medicaid does not pay for activities that are integral to the administration of another non-medical program.

3.1.4 Service Limitations

Service coordination services for all of the different populations have different limitations and they are as follows:

- Service coordination for adults receiving services for mental illness is limited to 20 units/month (5 hours/month).
- Service coordination for individuals eligible to receive personal care services or age/disabled waiver services is limited to 32 units/month (8 hours/month).
- Service coordination for children is limited to 18 units/month (4.5 hours/month).
- Service coordination for adults receiving developmental disability services is limited to 18 units/month (4.5 hours/month).

Medicaid does not pay for service coordination services provided to participants who are inpatients in a nursing facility, ICF/MR, or hospital, except in the following circumstances:

- During the last 14 days of an inpatient stay less than 180 days (when claims for reimbursement are submitted after the participant's discharge and placement); or
- During the last 60 days of an inpatient stay of 180 days or more (when claims for reimbursement are submitted after the participant's discharge and placement).
- Additionally, services are reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission, and also on the day of discharge from a medical institution if the service is provided after discharge.

3.1.5 Payment Limitations

Participants are only eligible for one type of service coordination. If they qualify for more than one type, the participants must choose one.

Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities.

Payment for service coordination is allowed for:

- Activities related to the development of the participant's plan (assessment, plan development, conducting person-centered planning meetings, and modification and addendums to service plans).
- Face-to-face contact (ongoing with a 90 day requirement).
- Two-way communications with the participant, service providers, family, primary care givers, legal guardians, and other interested parties.
- Referral and related activities associated with obtaining needed services as identified in the service coordination plan.
- Monitoring and follow-up activities, including formal reviews of progress, necessary to ensure the plan is implemented and that it addresses the participant's need.
- Provision of crisis assistance.

Payment for a paraprofessional is allowed for:

- Face-to-face contact (a paraprofessional *may not* develop a plan, complete the 90 day face-to-face requirement, or conduct the person-centered planning meeting).
- Two-way communications with the participant, service providers, family, primary care givers, legal guardians, and other interested parties.
- Referral and related activities associated with obtaining needed services as identified in the service coordination plan.
- Monitoring and follow-up activities necessary to ensure the plan is implemented and that it addresses the participant's needs. (Paraprofessionals may not modify the plan or complete addendums.)
- Provision of crisis assistance.

Only the Infant Toddler Network can be reimbursed for service coordination provided to children age 0-3.

3.1.6 Determining How to Bill Units for 15-Minute Timed Codes

Several CPT codes used for evaluations, therapy modalities, procedures, and collateral contacts specify that 1 unit equals 15 minutes. Providers bill procedure codes for services delivered using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes. Two units should be billed when the interaction with the participant or collateral contact is greater than or equal to 23 minutes but less than 38 minutes. Time intervals for larger numbers of units are as follows:

3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes

6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for less than 8 minutes. The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review. The above schedule of times is intended to provide assistance in rounding time into 15 minute increments for billing purposes. It does not imply that any minute until the eighth should be excluded from the total count as the timing of active treatment counted includes all time. The beginning and ending time of the treatment must be recorded in the participant's medical record with the note describing the treatment. **(For additional guidance please consult CMS Program Memorandum Transmittal AB-00-14.)**

3.1.7 Participant Choice

A participant must have freedom of choice when selecting from the service coordinators available to him/her. The service coordinator cannot restrict the participant's choice of other health care providers.

3.1.8 Record Requirements

The following documentation must be maintained by the provider as required in *IDAPA 6.03.10.728.03.a-j Service Coordination – Procedural Requirements*:

- Name of the participant.
- Name of agency and person providing service.
- Date, time and POS.
- Documentation of eligibility.
- A copy of the assessment and service plan signed by participant or legal representative and the plan developer. Mental health service coordination plans must also be signed by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law (or as indicated in each specific program rule). The service coordinator must also document that a copy of the plan was given to the participant or legal representative. Plan must be updated and authorized when required, but at least annually.
- Description of the service provided signed by the person who delivered the service.
- Documented review of progress toward each service plan goal.
- Assessment of the participant's need for targeted service coordination and other services as the participant's needs change.
- Informed consent.
- Documentation of the participant's, family's, or guardian's satisfaction with service.
- For adults with mental illness, documentation to support authorization of crisis assistance beyond the monthly limitation. See *IDAPA 16.03.10.728.03.j Crisis Assistance Documentation for Adults With Severe and Persistent Mental Illness* for detailed description of the content of the documentation.

3.1.9 Prior Authorization (PA)

Some service coordination services require prior authorization. When a service is prior authorized, the approval is valid for one year from the authorized date unless otherwise indicated.

For HC participants, PA will be denied if the requesting provider is not the primary care provider (PCP) or a referral has not been obtained. An HC referral is not required for service coordination services for individuals receiving personal care or A&D waiver services.

For more information on prior authorization, see *Section 2.3.2 Medicaid Prior Authorization (PA)*.

Service coordination for adults with mental illness does not require PA for the first five hours of service each month. Providers must document the need for service coordination in the participant's records. See *Section 3.4.2 Crisis Assistance for Adults with Severe and Persistent Mental Illness*.

Service coordination for individuals eligible to receive PCS or A&D waiver services requires two PAs from RMS. They are as follows:

- The participant must be approved by RMS for service coordination. RMS will authorize the assessment and service plan development.
- Based on the Individual Community Support Plan (ICSP), RMS authorizes hours of ongoing service coordination.

Service coordination for adults with developmental disabilities requires PA in accordance with *IDAPA 16.03.10.507 Behavioral Health Prior Authorization (PA)* through *515 Behavioral Health – Quality Assurance and Improvement*. The service coordinator must update the approved plan for service coordination at least annually.

Plan development for adults with developmental disabilities occurs during person centered planning. The Person-Centered Planning team includes:

- The participant.
- The plan developer, and/or service coordinator, if chosen, by the participant.
- The guardian, family, or current service providers, unless specifically excluded by the participant.
- Others identified by the participant.

The plan is based on a person-centered, Idaho Department of Health and Welfare (IDHW) approved planning and assessment process. It describes the specific types, amounts, frequency, and duration of Medicaid-reimbursed services to be provided. It lists all support and service needs to be met by the participant's family, friends, other community resources, and the providers of services, when known.

The plan of service must include documentation of the participant's choice between waiver services and institutional placement, the participant's or legal guardian's signature, and the signature of the service coordination for the participant.

At least annually, the plan must be revised, updated, and service authorized based upon changes in the participant's needs.

Plan Development. Plan development allows for hourly payment for plan development. As a paid service, the plan developer is the service coordinator. The plan developer is not a paraprofessional. The plan developer is chosen by the participant and assists with facilitating the person-centered planning meeting, writing the plan of service, and any subsequent plan modifications (addendums).

- **G9007 Plan Development, DD Waiver.** Plan development must be prior authorized and is billed in 15-minute unit increments with the limitation of 48 units (12 hours) per calendar year.
- **G9012 Plan Development, Children.** Plan development for children must be prior authorized and is billed in 15-minute unit increments with the limitation of 24 units (6 hours) per year. The plan developer is responsible for writing the plan of service and completing any subsequent plan modifications (addendums). The Regional Children's DD Program must approve the service coordination plan.

- **G9001 Plan Development, PCS, or Adult A&D Waiver Participants.** Plan development for adults eligible to receive PCS or A&D waiver services must be prior authorized and is billed in 15-minute unit increments with the limitation of 24 units per year.
- **H0031 Plan Development, Mental Health.** Plan development for service coordination for adults receiving services related to severe and persistent mental illness must be prior authorized and is limited to 24 units per year.

3.1.10 Procedure Codes

All service coordination service must be billed using the appropriate HCPCS codes.

Note: Some service codes require you to bill them with a designate modifier code.

Service Type and Service	HCPCS Code	Description	Limitations
Adult DD Service Coordination			
DD Service Coordination	G9002	1 unit=15 minutes	18 units/month (G9002 and G9002-HM combined)
DD Service Coordination—Paraprofessional	G9002-HM	1 unit=15 minutes	18 units/month (G9002 and G9002-HM combined)
DD Plan Development	G9007	1 unit=15 minutes	48 units/year
Children's Service Coordination			
Children's Service Coordination	G9002	1 unit=15 minutes	18 units/month (G9002 and G9002-HM combined)
Children's Service Coordination Paraprofessional	G9002-HM	1 unit=15 minutes	18 units/month (G9002 and G9002-HM combined)
Children's Plan Development	G9012	1 unit=15 minutes	24 units/year
PCS Service Coordination			
PCS Service Coordination	G9002	1 unit=15 minutes	32 units/month (G9002 and G9002-HM combined)
PCS Service Coordination—Paraprofessional	G9002-HM	1 unit=15 minutes	32 units/month (G9002 and G9002-HM combined)
PCS—Plan Development	G9001	1 unit=15 minutes	24 units/year
Mental Health Service Coordination			
MH Service Coordination	T1017	1 unit=15 minutes	32 units/month
MH Service Coordination Plan Development	H0031	1 unit=15 minutes	24 units/year

Crisis Intervention Service Coordination (All Specialties)			
Crisis Intervention by the Service Coordinator (DD, Children's, MH, and PCS)	H2011	1 unit=15 minutes	As authorized
Crisis Intervention by the Paraprofessional (DD, Children's, and PCS only)	H2011-HM	1 unit=15 minutes	As authorized

3.1.11 Place of Service (POS) Codes

Enter the appropriate numeric code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- 03** School
- 11** Office
- 12** Home
- 22** Outpatient hospital
- 23** Emergency Room: hospital
- 31** Skilled nursing facility
- 32** Nursing facility
- 33** Custodial care facility
- 53** Community mental health center
- 54** Intermediate care facility/mentally retarded (ICF/MR)
- 71** Public health clinic
- 99** Other unlisted facility

3.1.12 Diagnosis Codes

Enter the appropriate primary ICD-9-CM diagnosis code for the participant's condition in field **21** on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

Exception: Use diagnosis code **V604** - No Other Household Member Able to Render Care, as the primary diagnosis code for personal care case management.

3.2 Service Coordination Eligibility

Participants identified below who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for the mentally retarded are eligible for service coordination.

Adults with a developmental disability, as defined in *Section 66-402 of Idaho Code* and *IDAPA 16.03.10.501 Developmental Disability Determination Standards – Eligibility* through *503 Developmental Disability Determination – Test Instruments*, are eligible for service coordination if they:

- Are 18 years of age or older; and
- Are diagnosed with a developmental disability; and
- Have impairments that result in substantial functional limitations in three or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency; and
- Need a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated.
- Require and choose assistance to adequately access services and supports necessary to maintain their independence in the community.

Individuals who receive personal assistance services are eligible for service coordination if they:

- Are adults or children who have been approved to receive state plan personal care services; or
- Are adults who have been approved to receive aged and disabled home and community based waiver services; and
- Require and choose assistance to access services and supports necessary to maintain their independence in the community.

Adults with severe and persistent mental illness are eligible for service coordination if they:

- Are 18 years of age or older; and
- Have a severe and persistent mental illness with a diagnosis identified in *IDAPA 16.03.10.725.02.a-b*.
- Have functional limitations due to a mental illness identified in *16.03.10.725.03.a-h*.
- Have a history of using high cost medical services including hospital services with frequent exacerbations of mental illness.

Children, from birth through the month of their third birthday (0-3), are eligible for early intervention services through the Idaho Infant Toddler Program.

Children 3-21 are eligible for service coordination if they:

- Are identified by a physician or other practitioner of the healing arts during a well-child check as needing service coordination services; and
- Have one of the following:
 - Development delay or disability.
 - Special health care needs requiring medical and multidisciplinary habilitation or rehabilitation service to prevent or minimize a disability.
 - Severe emotional disorder (SED), as defined in the Children's Mental Health Services Act in *Section 16-2403* of the Idaho Code.
- Have one or more of the following problems associated with their diagnosis:
 - The condition has resulted in a level of functioning below normal age level in one or more life areas such as school, family, or community.

Note: Only participants enrolled in the Medicaid Enhanced plan are eligible for service coordination services.

3.3 Provider Qualifications

3.3.1 Service Coordinator Qualifications

All service coordinators must be employees or contractors of an agency that has a valid provider agreement with DHW.

- Agencies that hire employees must meet all requirements for an agency as listed in the general provider agreement, including the requirements for workers' compensation and general liability insurance.
- An agency is a business entity that provides management, supervision, and quality assurance for service coordination, and it includes at least two (2) individuals, one (1) supervisor, and a minimum of one (1) supervisor and one (1) service coordinator.
- Agencies may not provide both service coordination and direct service to the same Medicaid participant, except when service coordinators work with children or when participants receive services for adults with mental illness. (16.03.10.727.08).

All service coordinators must pass a DHW criminal history and background check, and, at a minimum, have a bachelor's degree in the human services field from a nationally accredited university or college or be a licensed professional nurse (RN). In addition to this educational requirement, service coordinators must have 12 months of supervised work experience with the population that is being served.

If an individual meets the education or licensing requirements as stated above, but does not have the required supervised work experience, the individual may be supervised by a qualified service coordinator while gaining the required work experience.

3.3.2 Paraprofessional Qualifications

Paraprofessionals are adults at least age 18, who have a minimum of a high school diploma or its equivalency, *and* must have at least 12 months of supervised work experience with the population being served. All paraprofessionals must pass a DHW criminal history and background check, and must be supervised by a qualified service coordinator supervisor.

Paraprofessionals assist qualified service coordinators with implementing service coordination plans, except for participants with a mental illness. Paraprofessionals cannot be identified as the service coordinator for a participant; paraprofessionals may not be supervisors.

3.3.3 Supervision of Service Coordination

Agencies must provide supervision to all service coordinators and paraprofessionals. The agency must clearly document each supervisor's ability to address concerns about the services provided by employees and contractors under their supervision. A supervisor used to meet this requirement may not be a paraprofessional.

Agency supervisors must have at least one of the following qualifications:

- Have a master's degree in a human services field from a nationally accredited university or college, and have 12 months of supervised work experience with the population being served.
- Have a bachelor's degree in a human services field from a nationally accredited university or college, and have 24 months of supervised work experience with the population being served.
- Be a licensed professional nurse (RN), and have 24 months of supervised work experience with the population being served.

Additionally, for mental health service coordination, the supervisor must have obtained the required supervised work experience in a mental health treatment setting with the serious and persistent mentally ill population.

3.4 Crisis Service Coordination

Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to service providers, or direct skill-building services. When crisis services meet the criteria for service provision, they may be requested retroactively when submitted to the Department within 72 hours of being provided.

3.4.1 Crisis Assistance for Adults Receiving Developmental Disability Services

Crisis hours must be prior authorized for adults receiving developmental disability services. The service coordinator may request crisis hours after providing 4.5 hours of service coordination in a month that meet the definition of a crisis. Crisis assistance must be based on community crisis supports found in the IDAPA Administrative Rules.

3.4.2 Crisis Assistance for Adults with Severe and Persistent Mental Illness

For adults who receive services related to serious and persistent mental illness, initial crisis assistance is limited to 3 hours per calendar month without prior authorization. Additional crisis services beyond the 3 hours may be authorized if the need meets all of the following criteria:

- The participant is at imminent risk of re-institutionalization within 14 days following discharge from a hospital, institution, jail, or nursing home.
- The participant experiences symptoms of psychiatric decomposition that prohibits them from gaining or coordinating services.
- The participant has already received the maximum number of monthly hours allowed for service coordination, and no other crisis assistance is available under other Medicaid mental health services or psychosocial rehabilitation services.

Crisis service requests must be submitted to DHW the next business day that follows the beginning of the crisis or be prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis.

The process to request crisis hours for adults with severe and persistent mental illness follows:

Step 1 Complete the request for additional services coordination hours form.

Step 2 Attach the service coordination assessment, treatment plan, and applicable documentation that supports the need for the services.

Step 3 Fax the request to the Office of Mental Health and Substance Abuse at:
(208) 334-0766 or **(866) 467-1549**

3.4.3 Adults with Serious and Persistent Mental Illness: Personal Assistance Services Crisis Assistance

For participants who receive service coordination related to personal assistance services, crisis services must be prior authorized, and may be used after eight (8) hours of service coordination have already been provided in one month.

3.4.4 Children's Crisis Assistance

For children, crisis hours must be prior authorized by the Regional Children's DD Program and may be requested by the service coordinator after 4.5 hours of service coordination have been provided in a month. The participant's needs must meet the definition of a crisis as an unanticipated event or circumstance that places the participant at risk of hospitalization, loss of housing, loss of employment or income, incarceration, or physical harm to self or others.

Should a child require service coordination beyond the 4.5 hour/month limit for circumstances that do not rise to the level of a crisis, additional units may be requested under Early & Periodic Screening, Diagnosis & Treatment (EPSDT).

3.5 Claim Billing

3.5.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.5.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission, General Billing Information*, for more information.

3.5.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior authorization (PA) numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the transaction.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) information with HCPCS and CPT codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3 of the Physician Guidelines* for more information.

Electronic crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.5.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006.

3.5.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean; use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format; note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year; refer to specific instructions for field **24A**.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted; if the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements; total each claim separately.
- Be sure to sign the form in the correct field; claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments; stack the attachments behind the claim.
- Do not fold the claim form(s); mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.5.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.5.3.3 Completing Specific Fields of CMS-1500

Consult the Use column in the following table to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.

9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked yes.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items 9a-9d .
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	Other ID	Required if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier 1D followed by the referring physician's 9-digit Idaho Medicaid provider number. For Healthy Connections participants, enter the qualifier 1D followed by the 9-digit Healthy Connections referral number. Note: The HC referral number is not required on Medicare crossover claims.
17b	NPI Number	Not Required	Enter the referring provider's 10-digit NPI number. Note: The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003, becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.

24C	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an X .
24D 1	Procedure Code Number	Required	Enter the appropriate five character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21 .
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, see <i>Section 1.6 Child Wellness Exams</i> for more information.
24I	ID. Qualifier	Required if Legacy ID	Enter qualifier 1D followed by the 9-digit Idaho Medicaid provider number in 24J .
24J	Rendering Provider ID Number	Required if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the 1D qualifier was entered in 24I . Note: If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID Number field. Note: Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Include documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See <i>Section 1.1.4 Signature-on-File Form</i> for more information.
33	Provider Name and Address	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. Note: If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33A	NPI Number	Desired but not required	Enter the 10-digit NPI number of the billing provider. Note: NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Other ID	Required	Enter the qualifier 1D followed by the provider's 9-digit Idaho Medicaid provider number. Note: All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.5.3.4 Sample Paper Claim Form

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____																													
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSCOT Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$ _____ 29. AMOUNT PAID \$ _____ 30. BALANCE DUE \$ _____									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH. # () a. NPI _____ b. _____																			

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