

3 Waiver Services for Adults with Developmental Disabilities (DD) and Idaho State School and Hospital (ISSH) Waiver Participants

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3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided through the Waiver Services Programs for Adults with Developmental Disabilities (DD Waiver), and the Idaho State School and Hospital (ISSH Waiver). These programs are provided as deemed appropriate by the Department of Health and Welfare (DHW). This section addresses the following:

- Participant eligibility.
- Record keeping.
- Payment.
- Prior authorization (PA).
- Third party recovery.
- Claims billing.
- Waiver services policy.
- Specific waiver services:
 - Adult day care.
 - Assisted non-medical transportation services.
 - Behavior consultation/crisis management services.
 - Chore services.
 - Environmental modification services.
 - Home-delivered meals services.
 - Nursing services.
 - Personal emergency response system services.
 - Residential habilitation services.
 - Respite care services.
 - Specialized medical equipment and supplies services.
 - Supported employment services.

See *Section 1.4 Benefit Plan Coverage* for more on participant eligibility

Note: Waiver services are covered for Medicaid Enhanced Plan participants.

Each provider service subsection in this handbook describes the service, payment, and diagnosis, place of service (POS) and procedure codes for that service.

Note: DD/ISSH Waiver services are covered for Medicaid Enhanced Plan participants.

3.1.2 Participant Eligibility

Idaho Medicaid provides health coverage for qualified adults and children. Medicaid only reimburses for treatment rendered while the participant was eligible for Medicaid benefits. Eligibility for DD Waiver and ISSH Waiver is defined in *IDAPA 16.03.10.702 DD/ISSH Waiver Services – Coverage And Limitations*.

3.1.3 Record Keeping

3.1.3.1 Medical Record Contents

The Department of Health and Welfare requires all providers to meet the documentation requirements listed in the provider enrollment agreement and IDAPA rules. Providers must generate and maintain all records in hard copy format to fully document the extent of services submitted for Medicaid reimbursement.

3.1.3.2 Medical Record Retention

Providers must retain records to document services submitted for Medicaid reimbursement for at least five years after the date of service for auditing purposes.

3.1.4 Payment

Medicaid reimburses DD and ISSH waiver services on a fee-for-service basis. Prior Authorization (PA) based upon guidelines established by DHW must be obtained prior to billing for waived services.

For the DD and ISSH waivers, check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho Medicaid's primary care case management (PCCM) model of managed care. If a participant is enrolled, certain guidelines must be followed to ensure reimbursement for providing Medicaid-covered services.

Reimbursement is subject to review to insure that billed services were rendered. The review also determines that the services were provided in accordance with the Medicaid Provider Enrollment Agreement and additional terms waiver provider agreement(s), *IDAPA 16.03.10 Medicaid Enhanced Plan Benefits*, and the requirements of this handbook. Payment of services is subject to recoupment when it is determined that the service was not properly provided.

See *Section 1.5 Healthy Connections* for more information.

3.1.5 Prior Authorization (PA)

Regional Medicaid Services (RMS) or designee must PA all services reimbursed by Medicaid under the DD Waiver and ISSH Waiver programs before the payment of services. All PA numbers must be included on the claim or the authorized service will be denied.

For HC participants on the DD or ISSH waiver, PA will be denied if the requesting provider is not the primary care provider (PCP) or a referral has not been obtained.

Approved PAs are valid for one year from the date of PA by the RMS Unit unless otherwise indicated. PA for services authorizes an Idaho Medicaid provider to perform Medicaid covered services for an eligible Medicaid participant but does not guarantee payment.

Note: The Medical Care Unit, DME is responsible for the PA of certified medical equipment and supplies for the DD/ISSH Waiver.

3.1.6 Third Party Recovery

See *Section 2 Third Party Recovery*, for information regarding DHW policy on billing all other third party resources before submitting claims to Medicaid.

3.1.7 Change of Provider Information

If the provider has a change of name, address, or telephone number, immediately notify EDS Provider Enrollment in writing at:

EDS
PO Box 23
Boise, ID 83707
Fax: (208) 395-2198

Note: Indicating updated provider information on a claim form is not acceptable.

3.2 Waiver Services Policy

3.2.1 Overview of Policy for Waiver Programs

Waiver services are covered for Medicaid Enhanced Plan participants.

3.2.1.1 DD Waiver and ISSH Waiver Overview

DD Waiver and ISSH Waiver services are part of the Community Supports for People with Developmental Disabilities Program. Currently, Idaho has two waivers for persons with developmental disabilities:

- A waiver for any individual at least 18 years of age who meets intermediate care facility for the mentally retarded (ICF/MR) level of care requirements.
- A waiver for adolescents 15 through the month of their 18th birthday who are discharging from ISSH, meet ICF/MR level of care, and have chosen to receive community based services.

Services, provider qualifications, record requirements, etc., are the same for both waivers.

For a participant to be eligible for either waiver, the RMS unit or designee must determine that the participant meets all of the following criteria:

- Requires services due to a developmental disability that significantly limits mental or physical function or independence in three of seven life skill areas and has been determined to meet the categorical criteria for mental retardation in the state of Idaho or has been determined to have a related condition.
- Is capable of being maintained safely and effectively in a non-institutional setting.
- Would need to reside in an ICF/MR in the absence of such services.

3.2.2 Place of Service (POS) Codes

Participants may choose to receive DD Waiver or ISSH Waiver services in the following settings, depending on the service. Check the POS codes for each service under each respective waiver:

12 Home

99 Other (Community)

3.2.2.1 Place of Service (POS) Exclusions

The following living situations are specifically excluded as a personal residence:

- Licensed, skilled, or intermediate care facility; certified nursing facility (NF); or hospital.
- Licensed intermediate care facility for the mentally retarded (ICF/MR).
- Licensed residential and assisted living facility.

3.2.3 Plan of Service

All services must be provided based on a written plan of service.

3.2.3.1 Plan Development

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, DHW 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 a legal guardian's signature (if applicable), and the signature of the service coordinator for the participant.

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

3.2.3.2 Service Supervision

The plan includes all Medicaid allowable services and supports, and all natural or non-paid services and supports. See *IDAPA 16.03.10.703* for a description of services for DD and ISSH Waivers.

3.2.4 Provider Qualifications

The plan includes all Medicaid allowable services and supports, and all natural or non-paid services and supports. See *IDAPA 16.03.10.703 DD/ISSH Waiver Services – Coverage And Limitations*, for a description of services for DD and ISSH Waivers.

3.2.5 Important Billing Instructions

Dates of service must be within the Sunday through Saturday calendar week on a single detail line on the claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday. Failure to comply with the Sunday through Saturday billing will result in claims being denied. In addition, one detail line on a DD or ISSH claim form cannot span more than one calendar month. If the end of the month falls in the middle of a week two separate detail lines must be used.

Example: August 2001 Billing

The last week in August 2001, begins Sunday, August 26, 2001, and ends Saturday, September 1, 2001. Two separate detail lines must be entered on the claim form for this week. One detail line will have service dates of 08/26/2001 through 08/31/2001. The second detail line will have service dates of 09/01/2001 through 09/01/2001. **Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim detail line as long as the same quantity of services have been provided each day.**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			Aug. 1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	Sept. 1

3.2.6 Adult DD Care Management

Care management for adults with developmental disabilities, is outlined in *IDAPA 16.03.10.507 Behavioral Health Prior Authorization (PA) through 515 Behavioral Health – Quality Assurance And Improvement*. IDAPA rules are available online at:

<http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm>

3.2.7 Community Crisis Supports

Community crisis supports is a service available to adults with developmental disabilities.

Community crisis supports includes intervention for participants in crisis situations to ensure their health and safety or prevent hospitalization or incarceration of a participant.

Community crisis supports may include:

- Loss of housing, employment, or reduction of income.

- Risk of incarceration.
- Risk of physical harm.
- Family altercation or other emergencies.

A community crisis supports provider is the choice of the participant and may be billed by service coordinators, plan developers or plan monitors (must meet service coordinator qualifications as described in *IDAPA 16.03.10.700 Developmental Disability Agencies* through *736 Service Coordination –Provider Reimbursement*), and all DD and ISSH Waiver providers except:

- Specialized Medical Equipment Agencies.
- Non-Medical Transportation Providers.
- Personal Emergency Response Agencies.
- Home Delivered Meal Providers.
- Chore Services.
- Environmental modification services.
- Supported employment services.

Community crisis supports is limited to a maximum of 20 hours per crisis for a period of five consecutive days. Services may not exceed 20 hours per crisis.

The Regional Care Manager will review and authorize each crisis service to make determination for appropriateness and financial reimbursement. Providers must get either a written or verbal approval for community crisis supports prior to billing.

Providers must identify on the Crisis Authorization Worksheet the factors contributing to the crisis and develop a proactive strategy that will address the factors that result in crisis.

3.2.8 Medical Care Evaluation for Assessment

The Care Management Program includes an assessment process which includes the requirement for a history and physical examination and referral from the physician (the participant's HC PCP, if applicable) for adults with developmental disabilities.

History and physicals for adults will be reimbursed by Medicaid when it is a Medicaid program requirement. When billing for history and physical exams for developmentally disabled adults that have been requested by the Medicaid program, use the following CPT codes:

- **99450** for history and physical examinations to complete the Medical Care Evaluation form.
- **99080** for completion of the Medical Care Evaluation form from a record review.

Use the diagnosis code **V70.3** - Other medical examination for administrative purposes.

3.2.9 Plan Development

Plan development allows for hourly payment for plan development. This service must be provided by a service coordinator. The plan developer is chosen by the participant and may be reimbursed for participation in facilitating the person-centered planning meeting, writing the plan of service, and any subsequent plan addendums.

G9007 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.

3.2.10 Plan Monitoring

Plan monitoring allows for hourly payment for monitoring of the plan when the participant does not have a service coordinator. Plan monitors are chosen by the participant. They must monitor the plan at least

every 30, 60, or 90 days as identified on the plan of service. Plan monitoring is limited to eight hours per year.

Plan monitoring must include all of the following:

- Review of the plan of service in a face-to-face contact with the participant to identify current status of programs and changes if needed.
- Contact with service providers to identify barriers to service provision.
- Discussion with the participant about satisfaction regarding quality and quantity of service.
- Provider status reviews and completion of plan monitor summary when the plan has been in effect for 6 months and at the annual plan.

3.2.11 Procedure Codes

Use the 5-digit HCPCS procedure code. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Community Crisis Supports	H2011	<i>Intervention for participant in crisis situations.</i> (See Information Release 2003-89). Service is limited to a maximum of 20 hours per crisis for five consecutive days. Service may not exceed 20 hours per crisis.
Medical Care Evaluation – History & Physical Examinations	99450	<i>History and physical examinations to complete the Medical Care Evaluation form</i> Use diagnosis code V70.3 - Other medical examination for administrative purposes.
Medical Care Evaluation – Completion of Evaluation from Record Review	99080	<i>Completion of the Medical Care Evaluation form from a record review</i> Use diagnosis code V70.3 - Other medical examination for administrative purposes.
Plan Development	G9007	<i>Plan Development</i> Limited to 12 hours per year. 1 Unit = 15 minutes PA required.
Plan Monitoring	G9012	<i>Plan Monitoring.</i> Must occur at least every 30, 60, or 90 days as identified on the plan of service. Limited to eight hours per year. 1 Unit = 15 minutes PA required.

3.3 Adult Day Care Services

3.3.1 Service Description for DD and ISSH Waivers

Adult day care for adults with developmental disabilities is a structured day program, outside the home of the participant that offers one or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the Plan of Service.

Note: Adult day care services are covered for Medicaid Enhanced Plan participants.

3.3.2 Provider Qualifications

All providers of this service when delivered in a DDA must be employed by an agency.

Adult day care may be provided by one of the following:

- Developmental Disability Agency.
- Nursing Facility.
- Licensed Residential Facility.
- Assisted Living Facility.
- Certified Family Home (affiliated with a Residential Habilitation Agency).
- Residential Habilitation Agency.

Providers of adult day care who are not one of the above must meet the fire/life safety requirements of a certified family home or Developmental Disability Agency.

Providers of adult day care must:

- Demonstrate the ability to communicate and deal effectively, assertively and cooperatively with a variety of people.
- Be a high school graduate or have a GED or demonstrate the ability to provide services according to the Plan of Service.
- Be free of communicable disease.
- Pass a criminal history check.
- Demonstrate knowledge of infection control methods.
- Agree to practice confidentiality in handling situations that involve waiver participants.
- And any other requirements identified in the Medicaid Provider Agreement.

3.3.3 Service Locations

Adult day care may be provided in the following locations:

Home: Adult day care services provided in a home environment other than the participant's primary residence, must meet the standards for home certification identified in *IDAPA 16.03.19 Rules Governing Certified Family Homes*, and health standards identified in *IDAPA 16.04.11 Developmental Disabilities Agencies (DDA)*.

Facility: Day care services provided in a facility must meet building and health standards identified in *IDAPA 16.04.11 Developmental Disabilities Agencies (DDA)*.

3.3.4 Payment

Medicaid reimburses waiver services on a fee-for-service basis. All adult day care must be prior authorized by DHW or its designee before being rendered and must be the most cost effective way to meet the needs of the participant.

Adult day care cannot exceed 30 hours per week either billed alone or in combination with developmental therapy, or occupational therapy.

3.3.5 Diagnosis Codes

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

3.3.6 Place of Service (POS) Codes

Adult day care services can only be provided in the following POS:

12 Home (Certified Family Home-not the residence of the participant)

99 Community (DDA)

Enter this information in field **24 B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.3.7 Procedure Code

Use the following 5-digit HCPCS procedure code with the required modifier for all adult day care. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Adult Day Care	S5100 U8 Modifier Required	<i>Day Care Services, adult; per 15 minutes.</i> The limit of hours for adult day care is 30 hours per week billed alone or in combination with Developmental Therapy and Occupational Therapy.

3.4 Assisted Non-Medical Transportation Services

3.4.1 Service Description for DD Waiver and ISSH Waiver

Assisted transportation services are non-medical transportation services used by a participant to access community services and other waiver or waiver-related services required by the plan of service. This service is in addition to medical transportation services and does not replace them. Waiver transportation is limited to 1800 miles per year.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized.

Note: Non-medical Transportation waiver services are covered for Medicaid Enhanced Plan Benefits participants.

3.4.2 Provider Qualifications

Providers of assisted transportation services must possess a valid driver's license, valid vehicle insurance, comply with all applicable state laws, and be enrolled as a Medicaid transportation provider. Waiver transportation may be provided by a commercial, agency or individual transportation provider.

3.4.3 Payment

Payment for non-medical Waiver transportation waiver services is reimbursed at the per-mile rate established by Medicaid. Participants receive a PA notice that identifies the procedure codes that have been approved and are to be used for billing.

3.4.4 Diagnosis Codes

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic transaction.

3.4.5 Place of Service (POS) Code

Non-medical transportation can only be provided in the following POS:

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.4.6 Procedure Codes

Use the five-digit HCPCS procedure code with the required modifier when billing non-medical transportation services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
DD/ISSH Non-Medical Transportation By agency or individual transportation provider	A0080 U8 Modifier Required	<i>Non-emergency transportation, per mile-vehicle provided by volunteer (individual or organization), with no vested interest</i> Note: This service may be provided by an agency or individual transportation provider and is paid at two different rates. 1 Unit = 1 mile The maximum units allowed per year are 1800. PA required
DD/ISSH Non-Medical Transportation By commercial transportation provider	A0080 U8 and SE Modifiers Required	<i>Non-emergency transportation, per mile-vehicle provided by volunteer (individual or organization), with no vested interest</i> 1 Unit = 1 mile The maximum units allowed per year are 1800. PA required

3.5 Behavior Consultation/Crisis Management (BC/CM) Services

3.5.1 Service Description for DD Waiver and ISSH Waiver

Behavior consultation and crisis management services are services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development to providers related to the needs of a participant. This service requires the provider to meet directly with the participant.

Note: BC/CM services are covered for Medicaid Enhanced Plan participants.

3.5.2 Provider Qualifications

3.5.2.1 Behavior Consultation and Crisis Management (BC/CM) Providers

DD Waiver and ISSH Waiver providers of this service must work in one of the following situations:

- In a provider agency capable of supervising the direct service.
- Under the direct supervision of a licensed psychologist or Ph.D. in special education with training and experience in treating severe behavioral problems, and training and experience in applied behavioral analysis.

DD Waiver and ISSH Waiver providers must have or be one of the following:

- Have a Master's degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study.
- Be a licensed pharmacist.
- Be a qualified mental retardation professional (QMRP).

3.5.2.2 Emergency Intervention Technicians

Emergency intervention technicians for the ISSH/DD Waiver must:

- Meet qualifications of a residential habilitation direct care provider as identified in IDAPA 16.04.17 Rules Governing Residential Habilitation Agencies and IDAPA 16.03.10.705 DD/ISSH Wavier Services – Provider Qualifications And Duties.
- Have at least one year of experience working directly with adults with developmental disabilities who exhibit severe maladaptive behaviors that may cause harm to themselves or others.
- Be supervised by a QMRP or clinician.

3.5.3 Payment

Medicaid reimburses BC/CM services on a fee-for-service basis. All services must be authorized prior to payment and must be the most cost-effective way to meet the needs of the participant. The Department of Health and Welfare or its designee authorizes all services for the DD and ISSH waivers. The PA number must be included on the claim or the claim will be denied.

3.5.4 Diagnosis Codes

Enter the ICD–9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or the appropriate field of the electronic claim form.

3.5.5 Place of Service (POS) Codes

BC/CM services can only be billed for the following POS:

- 11 Office
- 12 Home

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.5.6 Procedure Codes

All BC/CM claims must use one of the following five-digit HCPCS procedure codes with the required modifier when billing. The units must be entered in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Behavioral Consultation/Crisis Management - Psychiatrist	H2019 U8 and AG Modifiers Required	<i>Therapeutic Behavioral Services</i> 1 Unit = 15 minutes
Behavior Consultation/Crisis Management - QMRP	H2019 U8 Modifier Required	<i>Therapeutic Behavioral Services</i> 1 Unit = 15 minutes
Emergency Intervention Technician	H2019 U8 and HM Modifiers Required	<i>Therapeutic Behavioral Services</i> Limited to 96 units per calendar month. 1 Unit = 15 minutes

3.6 Chore Services

3.6.1 Service Description for DD Waiver and ISSH Waiver

Chore services include heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary, and safe environment. This service is limited to services provided in a home rented or owned by the participant.

Chore activities include, but are not limited to:

- Washing windows and walls.
- Moving heavy furniture.
- Shoveling snow to provide safe access outside the home.
- Chopping wood when wood is the participant's primary source of heat.
- Tacking down loose rugs and flooring.
- Professional electrical or plumbing services.

These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for these services. This includes when no other relative, caretaker, landlord, community volunteer/agency, or third party payer is capable of or responsible for their provision.

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Note: Chore services are covered for Medicaid Enhanced Plan participants.

3.6.2 Provider Qualifications

Providers of chore services must be skilled in the type of service to be provided and demonstrate the ability to provide services according to the plan. Chore service providers who provide direct care or services must successfully complete DHWs criminal history background check process.

3.6.3 Provider Responsibilities

3.6.3.1 Chore Services - Skilled

Skilled chore services require a provider to have a license or other certification to perform services such as electrical work and plumbing. These services require three written bids for the cost of the service over \$1,500.00. If the cost of the service is over \$1,500.00, see *Section 3.6.4 Payment*.

3.6.3.2 Chore Services - Unskilled

Unskilled chore services are those routine activities including, but not limited to, washing windows, shoveling snow, or chopping wood. No certification or license is required to perform these services.

3.6.4 Payment

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. All chore services must be authorized by DHW or its designee before payment and must be the most cost-effective way to meet the needs of the participant.

The rates will be either the cost of the service up to \$1,500.00 or the lowest of three written bids if the cost exceeds \$1,500.00 or no more than \$8.00 per hour.

3.6.5 Diagnosis Codes

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.6.6 Place of Service (POS) Code

Chore services can only be provided in and billed with the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.6.7 Procedure Codes

Use one of the following 5-digit HCPCS procedure codes for all chore service claims. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Chore Services – Skilled	S5121 U8 Modifier Required	<i>Chore Services, per diem</i> 1 Unit = 1 service Cost of service up to \$1,500.00 or lowest of three bids. Not to exceed \$8.00 per hour.

3.7 Environmental Accessibility Adaptations (Modifications) Services

3.7.1 Service Description for DD Waiver and ISSH Waiver

Environmental modifications (accessibility adaptations) are interior or exterior physical adaptations to the home owned or rented by the participant, identified on the participant's ISP, and necessary to ensure the health, welfare, and safety of the individual. The modifications enable the participant to function with greater independence in the home and, without which, the participant would require institutionalization. This service is not available to CFH owners.

Such adaptations may include:

- Installation of ramps and lifts.
- Widening of doorways.
- Modification of bathroom and kitchen facilities.
- Installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant.

Note: Environmental modification services are covered for Medicaid Enhanced Plan participants.

Note: Provider responsibilities, payment information, and diagnosis, place of service and procedure codes can be found in *Section 3 Durable Medical Equipment Guidelines*.

3.7.2 Provider Qualifications

All providers of service must have a valid provider agreement with DHW. RMS monitors performance under this agreement in each region. Environmental modification providers must:

- Demonstrate the skills necessary to provide the service identified on the plan.
- Be approved by RMS or DHW designee.

Environmental modification services must comply with requirements and permits of the city, county, or state in which the modifications are made. The provider must demonstrate that all modifications, improvements, or repairs will be made in accordance with local and state housing and building codes.

3.7.3 Procedure Codes

Service	HCPCS	Description
Environmental Accessibility Adaptations (Environmental Modifications) For DD/ISSH Waiver	S5165 U8 Modifier Required	<i>Home Modifications; per service</i> Actual cost of three competitive bids for items over \$1500.00 including labor

3.8 Home Delivered Meal Services

3.8.1 Service Description for DD Waiver and ISSH Waiver

Home delivered meals are designed to promote adequate nutrition through the provision and home delivery of one to two meals per day. Home delivered meals are limited to participants who:

- Rent or own their home.
- Are alone for significant parts of the day.
- Have no regular service providers for extended periods.
- Are unable to prepare a balanced meal.

Note: Home delivered meal services are covered for Medicaid Enhanced Plan participants.

3.8.2 Provider Qualifications

Services of home delivered meals under this section may only be provided by an agency capable of supervising the direct service and must meet the following requirements:

- Ensure that each meal meets one third of the Recommended Daily Allowance as defined by the Food and Nutrition Board of National Research Council of the National Academy of Sciences.
- Maintain registered dietitian documented review and approval of all menus, menu cycles, and any changes or substitutions.
- Ensure that the meals are delivered on time.
- Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest USDA Grade for each specific food served.
- Provide documentation of current driver's license for each driver.
- Be licensed and inspected as a food establishment by the district health department.
- Deliver the meals in accordance with the plan for services in a sanitary manner and at the correct temperature for the specific type of food.

3.8.3 Payment

Medicaid reimburses DD and ISSH Waiver services on a fee-for-service basis.

3.8.4 Diagnosis Codes

Environmental modification services must comply with requirements and permits of the city, county, or state in which the modifications are made. The provider must demonstrate that all modifications, improvements, or repairs will be made in accordance with local and state housing and building codes.

3.8.5 Place of Service (POS) Code

Home delivered meals services can only be billed in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.8.6 Procedure Codes

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Home Delivered Meals (DD/ISSH)	S5170 U8 Modifier Required	<i>Home Delivered Meals, including preparation; per meal</i> This service is restricted to 14 meals per week. No more than two meals per day are allowed.

3.9 Nursing Services

3.9.1 Service Description for DD Waiver and ISSH Waiver

Nursing services include nursing oversight and skilled nursing services. Regional Medicaid Services (RMS) or DHW designee must PA all nursing oversight and skilled nursing services for DD or ISSH Waiver participants before service delivery. The authorization will indicate the hours of service per day and the number of days per week, or visits per month. Nursing services guidelines are available through RMS.

Note: Nursing waiver services are covered for Medicaid Enhanced Plan participants.

3.9.1.1 Skilled Nursing Services

Skilled nursing services include the provision of hands-on nursing services or treatments to eligible participants who need skilled nursing services. The medical needs of the participant must be of such a technical nature that the Idaho Nursing Practices Act requires a licensed nurse to provide the services. Nursing services provided by a licensed practical nurse (LPN) may require oversight by a licensed registered nurse (RN). Such services include but are not limited to the following:

- Nasal Gastric Tubes - NG tubes include the insertion and maintenance of NG tubes and participant feeding activities with or without the use of a feeding pump; An RN or LPN must perform this service.
- Volume Ventilators - The maintenance of volume ventilators includes associated tracheotomy care when necessary; An RN or LPN must perform this service.
- Intravenous Therapy/Parenteral Nutrition - Maintenance and monitoring of an IV site and administration of IV fluids and nutritional materials that require extended time periods to administer; An RN or LPN must perform this service.
- Tracheotomy and Oral/Pharyngeal Suctioning - Sterile suctioning and cleansing of the participant's airway and removal of excess secretions from the mouth, throat and trachea; only an RN may perform this service.

3.9.2 Provider Qualifications

Nursing services may only be provided by an RN or LPN. Nursing service providers must have a signed provider agreement on file with the Idaho Medicaid Program. Nursing oversight services may only be provided by an RN.

3.9.3 Provider Responsibilities

- Evaluate changes of condition.
- Notify the physician and plan monitor immediately of any significant changes in the participant's physical condition or response to the service delivery.
- Provide services in accordance with the nursing POC and the waiver plan of service.
- Maintain records of care given to include the date, time of start and end of service delivery, and comments on participant's response to services delivered.
- In the case of an LPN, skilled nursing providers, and other non-licensed direct care providers, document that oversight of services by a RN is in accordance with the Idaho Nurse Practice Act and the Rules, Regulations, and Policies of the Idaho Board of Nursing.
- An RN can provide either oversight or skilled nursing services.

3.9.3.1 Nursing Plan of Care (POC)

All nursing oversight and skilled nursing services provided must be on a nursing POC. The nurse is responsible for the nursing POC based upon:

- The nurse's assessment and observation of the participant.

- The orders of the participant's physician.
- The ISP.
- Information elicited from the participant.

The nursing POC must include all aspects of the medical care necessary to be performed, including the amount, type and frequency of such services. Certain services can be delegated by an RN. When nursing services are delegated to a non-licensed residential habilitation provider, the type, amount of supervision and training to be provided must be included in the plan.

3.9.3.2 Nursing Plan of Care (POC) Update

The nursing POC must be revised and updated based upon treatment results or as necessary to meet the participant's changing medical needs, but at least annually. A copy of the plan must remain in the participant's home.

3.9.3.3 Record Keeping

Service records must be maintained on each participant receiving nursing services for a period of five years. The record must be maintained in the participant's home. After every visit the provider will enter, at a minimum:

- The date and time of visit. The date is given in MMDDCCYY format:

Examples:

02/10/2005 8:00 a.m. – 11:15 a.m.

11/24/2005 10:30 a.m. – 3:15 p.m.

- The length of visit in decimal form.

Example: A visit of three hours and 15 minutes is entered as 3.25 hours.

- The services, supervised or skilled observation provided during the visit.
- A statement of the participant's response to the services including any changes noted in the participant's condition.
- Any changes in the POC authorized by the ISP as a result of changes in the participant's condition.
- Signature of the individual providing services, including their professional designation.

3.9.4 Payment

Medicaid reimburses DD and ISSH Waiver services on a fee-for-services basis.

3.9.5 Diagnosis Codes

Enter the appropriate ICD-9-CM code for the primary diagnosis in field **21** of the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.9.6 Place of Service (POS) Codes

Nursing oversight and skilled nursing services can only be billed for the following POS:

- 11** Office
- 12** Home
- 99** Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.9.7 Procedure Codes

All claims must use one of the following 5-digit HCPCS procedure codes when billing nurse oversight and private duty nursing services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.9.7.1 DD/ISSH Waiver

Service	HCPCS	Description
Nursing Oversight - Independent RN Visit	T1001 U8 and TD Modifiers Required	<i>Nursing Assessment/Evaluation</i> 1 Unit = 1 visit
Nursing Oversight - Agency RN Visit	T1001 U8 and TD Modifiers Required	<i>Nursing Assessment/Evaluation</i> 1 Unit = 1 visit
Private Duty Skilled Nursing - RN - Independent	T1000 U8 Modifier Required	<i>Private Duty/Independent Nursing Services – Licensed</i> 1 Unit = 15 minutes
Private Duty Skilled Nursing - LPN - Agency	T1000 U8 and TE Modifiers Required	<i>Private Duty/Independent Nursing Services – Licensed</i> 1 Unit = 15 minutes
Private Duty Skilled Nursing - RN - Agency	T1000 U8 and TD Modifiers Required	<i>Private Duty/Independent Nursing – Licensed</i> 1 Unit = 15 minutes
RN Oversight of LPN Visits	T1001 U8 Modifier Required	<i>Nursing Assessment/Evaluation</i> 1 Unit = 1 visit

3.10 Personal Emergency Response System (PERS) Services

3.10.1 Service Description for DD Waiver and ISSH Waiver

Personal emergency response system (PERS) services are provided to monitor the participant's safety and/or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems.

PERS services are limited to participants who:

- Rent or own their home.
- Are alone for significant parts of the day.
- Have no regular caretaker for extended periods of time.
- Would otherwise require extensive routine supervision.

Note: PERS services are covered for Medicaid Enhanced Plan participants.

Note: Provider responsibilities, payment information, and diagnosis, place of service and procedure codes can be found in *Section 3 Durable Medical Equipment Guidelines*.

3.10.2 Provider Qualifications

Providers of PERS must demonstrate that the devices installed in a participant's home meet Federal Communications Commission standards, Underwriter's Laboratory standards, or equivalent standards. Providers must be able to provide, install, and maintain the necessary equipment and operate a response center capable of responding on a 24-hour a day, 7-day per week basis.

3.10.3 Procedure Codes

All claims must use one of the following five-digit HCPCS procedure codes when billing PERS services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.10.3.1 DD/ISSH Waivers

Service	HCPCS	Description
Personal Emergency Response System – Installation Fee	S5160 U8 Modifier Required	<i>Emergency response system; installation and testing</i>
Personal Emergency Response System – Monthly Rate	S5161 U8 Modifier Required	<i>Emergency response system; service fee per month (excludes installation and testing)</i>

3.11 Residential Habilitation (RES/HAB) Services

3.11.1 Service Description for DD Waiver and ISSH Waiver

Residential Habilitation services consist of an integrated array of individually tailored services that assist eligible participants in living successfully in their own home, apartment, with their family, or in a CFH. Components of residential habilitation include skills training, personal assistance, and habilitation as listed in *IDAPA 16.03.10.705 DD/ISSH Waiver Services-Provider Qualifications And Duties* and for *IDAPA 16.04.17 Rules Governing Residential Habilitation Agencies*.

Note: RES/HAB waiver services are covered for Medicaid Enhanced Plan participants.

3.11.1.1 Personal Assistance Services

Personal assistance services support the participant in daily living activities, household tasks, and other routine activities the participant or primary, unpaid caregivers are unable to accomplish.

3.11.1.2 Skills Training

Skills training involves teaching participants, family members, substitute caregivers, or a participant's roommates or neighbors to perform activities to enhance participant independence and to carry out or reinforce habilitation training. Skills training is provided to encourage and accelerate development in independent daily living skills, such as housekeeping, meal preparation, dressing and personal hygiene, taking medication, money management, socialization, mobility, and other therapeutic programs.

3.11.1.3 Residential Habilitation (RES/HAB) Services

Residential habilitation services are aimed at assisting the participant to acquire, retain or improve their ability to reside as independently as possible in the community and maintain the family unity, if appropriate.

RES/HAB services include training in one or more of the following areas:

- Personal direction.
- Money management.
- Daily living skills.
- Socialization.
- Mobility.
- Behavior shaping and management.

3.11.2 Supported Living

Supported living is a type of RES/HAB. Supported living is defined as one, two, or three participants living in their own home or apartment who require staff assistance, or one or two participants who live in the home of a non-paid family member and require staff assistance.

The home is considered to be the participant's own home when it is owned or rented by the participant. The home is defined to be owned or rented by the participant(s) when the mortgage, lease, or rental agreement is held by the participant(s) with supporting documentation of such. When two or three participants share a home or apartment, the staff may also be shared.

3.11.3 Certified Family Home (CFH)

When RES/HAB is delivered in the home of the provider, the home must be a CFH. A CFH is defined in *IDAPA 16.03.19 Rules Governing Certified Family Homes*:

A home certified by DHW to provide care to one or two adults, who are unable to reside on their own and require activities of daily living, protection and security, and need encouragement toward independence.

A CFH may be granted an exception to the two resident limit if approved by RMS. With an approved exception, the CFH may provide care and supervision to three or four residents. These providers are reimbursed to deliver RES/HAB as outlined on the participant's plan of service.

3.11.4 Program Coordination

Program coordination is a function under RES/HAB. Program Coordination is defined as development, implementation, coordination, and evaluation of personal assistance, habilitation, and skills training provided for the participant as components of RES/HAB developed by a QMRP and delivered by a RES/HAB provider. Agencies providing oversight of RES/HAB must employ a program coordinator.

Program coordinators must have the following qualifications:

- Education and experience to meet the criteria established for qualifying as a QMRP for DD and ISSH Waiver participants.
- Experience in writing skills-training programs.
- Skill in individualized strategy development and implementation to assist the participant in meeting wants and needs within the scope of RES/HAB.

Core Functions of the Program Coordinator include the following:

- Face to face contact with direct service provider(s) and/or participant regarding oversight, supervision, and provision of RES/HAB.
- Implementation plan development.
- Evaluation, analysis, and/or revision of implementation plans.
- Phone contacts specific to RES/HAB services identified on the ISP.
- Attendance at participant meetings specific to RES/HAB services identified on the ISP.
- Emergency contact specific to RES/HAB services identified on the ISP.

3.11.5 Provider Qualifications

Residential habilitation must be provided by an agency certified by DHW as a RES/HAB services provider under *IDAPA 16.04.1, Rules Governing Residential Habilitation Agencies* or by a CFH provider who affiliates with a RES/HAB agency for oversight, training and quality assurance. Residential habilitation agencies must be capable of supervising the direct services provided.

RES/HAB providers who provide direct services to DD or ISSH Waiver participants must meet the following requirements:

- Be at least 18 years of age.
- Have a high school diploma or GED, or demonstrate the ability to provide services according to an ISP.
- Have current CPR and first aid certifications.
- Complete an approved Assistance with Medications course prior to assisting with participant medications.
- Be free from communicable diseases.
- Pass a criminal background check.
- Have documentation of universal precautions training.
- Participate in an orientation program provided by the agency prior to performing services including the purpose and philosophy of services, service rules, policies and procedures, proper conduct in relating to participants, handling of confidential and emergency situations that involve the participant,

participant rights, methods of supervising participants, working with individuals with developmental disabilities, and training specific to the needs of the participant.

- Have appropriate certification or licensure, if required, to perform tasks that require certification or licensure.

3.11.6 Provider Responsibilities

3.11.6.1 Training

The provider agency is responsible for training the direct service provider in general education areas of developmental disability for DD Waiver/ISSH Waiver participants. These training requirements are outlined in *IDAPA 16.03.10.705 DD/ISSH Waiver Services – Provider Qualifications And Duties*. All skill training for direct service staff must be provided by a QMRP. The provider agency must provide supervision to meet the participant's needs.

A QMRP with demonstrated experience in writing skill-training programs must develop skill-training programs for DD/ISSH Waiver participants. The program coordinator and/or QMRP must be employed by the RES/HAB Agency.

Additional training requirements for direct service providers must be completed within six months of employment or affiliation with RES/HAB agency and must include at a minimum:

- Instructional techniques: Methodologies for training in a systematic and effective manner.
- Managing Behaviors: Techniques and strategies for teaching adaptive behaviors.
- Feeding.
- Communication.
- Mobility.
- Activities of daily living.
- Body mechanics and lifting techniques.
- Housekeeping techniques, and maintenance of a clean, safe, and healthy environment.

The RES/HAB agency is responsible to provide on-going training specific to the needs of the participant as needed.

3.11.6.2 Certified Family Home (CFH) Provider Affiliation for DD and ISSH Waiver

Certified family home providers must be affiliated with a RES/HAB agency. Certified family home providers receive oversight, training, and quality assurance from the RES/HAB agency. A fee is paid to RES/HAB agencies for these services for CFH providers affiliating with the agency.

Agencies must maintain adequate documentation to support the date, times, amounts, and types (including contents) of training, oversight, and quality assurance services provided. This documentation includes telephone contacts and direct contacts with both the provider and participant.

3.11.6.3 Record Keeping

A RES/HAB provider must maintain a standardized RES/HAB service record for each participant receiving RES/HAB services. Residential habilitation agency QMRP program coordinators are responsible for establishing a standardized format for record keeping that includes all required information.

A copy of the record is maintained in the participant's home, unless RMS authorizes another site. After every visit, document the following information:

- The date and time of visit. The date is given in MMDDCCYY format:

Examples:

02/10/2005 8:00 a.m. – 11:15 a.m.

11/24/2005 10:30 a.m. – 3:15 p.m.

- The length of visit in decimal form.

Example: A visit of three hours and 15 minutes is entered as 3.25 hours.

- A statement of the participant's response to the services including any changes noted in the participant's condition.
- Any changes in the support plan authorized by RMS as a result of changes in the participant's condition or skill level.
- The participant's signature on the service record, unless RMS determines the participant is unable to sign.

3.11.6.4 Records Maintenance

To provide continuity of services, when a participant moves, selects a different provider, or changes service coordinators, all of the foregoing participant records will be delivered to and held by RMS until a new service coordinator assumes responsibility.

When a participant is no longer involved in the Waiver Services Program, copies of all the records are retained by RMS as part of the participant's closed record. Provider agencies must retain participant records for those to whom they provide services for five years following the last date of service.

3.11.6.5 Change in Participant Status

It is the responsibility of the RES/HAB provider to notify the plan monitor for DD and ISSH Waiver participants when there is a significant change in the participant's circumstances including accident, injuries, and health related activities.

3.11.6.6 Change of Provider Information

If the provider has a change of name, address, or telephone number, immediately notify EDS in writing. Indicating updated provider information on a claim form is not acceptable and the appropriate changes cannot be made.

Send corrections to:

**EDS
Provider Enrollment
PO Box 23
Boise, ID 83707
Fax: (208) 395-2198**

3.11.7 Payment

Medicaid reimburses RES/HAB services on a fee-for-service basis.

3.11.8 Diagnosis Code

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or the appropriate field of the electronic transaction.

3.11.9 Place of Service (POS) Codes

RES/HAB services can only be billed for the following POS:

- 12** Home (CFH, participant's own home, or home of unpaid family)
- 99** Other (Community) *This code should only be used when the participant receives hourly supported living to access the community. All other RES/HAB should be coded as, Home.*

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.11.10 Procedure Codes

Bill all RES/HAB claims using one of the following 5-digit HCPCS procedure codes. Enter this information in field **24D** on the CMS-1500 or in the appropriate field of the electronic claim form.

3.11.10.1 Billing Restrictions

Hourly procedure codes cannot be billed on the same date of service as daily procedure codes.

3.11.10.2 Supported Living - Agency ISSH/DD Waiver

Service	HCPCS	Description
Individual Supported Living Services- individual or group living arrangement one to three participants	H2015 U8 Modifier Required	<i>Comprehensive Community Support Services; per 15 minutes</i> (24-hour/day unavailable under hourly services) for participants who live in their own home or apartment or live with a non-paid caregiver. This code requires PA. 1 Unit = 15 minutes
Group Supported Living Services - agency Two or Three Participants	H2015 U8 and HQ Modifiers Required	<i>Comprehensive Community Support Services; per 15 minutes</i> Supported living for two or three participants who live in their own home or apartment or live with a non-paid caregiver. This code requires PA. 1 Unit = 15 minutes 24 hour/day unavailable under hourly serviced.
Daily Supported Living Services High Support: Participants must meet the SIB-R Support levels of Pervasive, Extensive, or Frequent Evaluation is case by case using the high support criteria	H2022	<i>Community Based Services, per diem</i> 24 hours per day support and supervision. Provided through a blend of 1:1 and group staffing.
Daily Supported Living Services Intense Support: Participants require intense one-on-one supports. Evaluation is case by case using the intense support criteria	H2016	<i>Comprehensive Community Support Services, per diem</i> 24 hours per day support and supervision. Typically requires 1:1 staffing but requests for blend of 1:1 and group staffing will be reviewed on a case-by-case basis.

3.11.10.3 Certified Family Home (CFH) - Agency Affiliation Fee

Service	HCPCS	Description
Agency - Certified Family Home Affiliation Fee DD & ISSH Waivers	0919B	<i>Agency - Certified Family Home Affiliation Fee</i> 1 Unit = 1 day.

3.11.10.4 Certified Family Home (CFH) – Independent

Service	HCPCS	Description
Certified Family Home –Daily one to two Participants	S5140 U8 Modifier Required	<i>Foster Care - Adult; per diem</i> 1 Unit = 1 day

3.12 Respite Care Services

3.12.1 Service Description for DD Waiver and ISSH Waiver

Respite care services provided under the DD and ISSH Waivers are services provided on a short-term basis because of the absence of persons normally providing non-paid care. These services may be provided in locations identified on the ISP.

While receiving respite care services, the participant cannot receive other duplicative waiver services. No room and board payment may be made as part of respite services. Respite care services are limited to participants who reside with non-paid caregivers.

Note: Respite care waiver services are covered for Medicaid Enhanced Plan participants.

3.12.2 Provider Qualifications

Providers of respite care services must meet the following minimum qualifications:

- Meet qualifications prescribed for the type of services to be rendered, for instance RES/HAB providers, or must be an individual selected by the waiver participant and/or the family or guardian.
- Have received care-giving instructions about the needs of the participant for whom the service will be rendered.
- Demonstrate the ability to provide services according to an ISP.
- Have good communication and interpersonal skills and the ability to deal effectively, assertively, and cooperatively with a variety of people.
- Be willing to accept training and supervision by a provider agency or primary caregiver of services.
- Be free of communicable diseases.
- Respite care service providers who provide direct care or services must successfully complete DHWs criminal history background check process.

3.12.3 Payment

Medicaid reimburses waiver services on a fee-for-service basis. All respite care must be authorized by RMS for DD and ISSH Waiver participant prior to payment.

3.12.4 Diagnosis Codes

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.12.5 Place of Service (POS) Codes

Respite care services can only be in the following POS:

- 12** Home
- 99** Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.12.6 Procedure Codes

Use one of the following 5-digit HCPCS procedure codes when billing respite care services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.12.6.1 DD and ISSH Waivers

Service	HCPSC	Description
Respite-Hourly	T1005 U8 Modifier Required	<i>Respite Care Services, up to 15 minutes</i> 1 Unit = 15 minutes. Maximum of six hours per day or 24 units.
Respite-Daily	S9125 U8 Modifier Required	<i>Respite Care, In the Home, per diem</i> 1 Unit = 1 day

3.13 Specialized Medical Equipment and Supplies Services

3.13.1 Service Description for DD Waiver and ISSH Waiver

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the ISP. The equipment and supplies must enhance the participants' daily living, and enable them to control and communicate within their environment. This also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the State Plan.

Items covered under DD/ISSH-Waiver are in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items that are of no direct medical, adaptive, or remedial benefit to the participant. All items must meet applicable standards of manufacture, design, and installation, including Underwriter's Laboratory (UL), Federal Drug Administration (FDA), and Federal Communication Commission (FCC) standards. Items available under the Medicaid program may only be billed by a medical vendor provider.

Note: Specialized medical equipment and supplies waiver services are covered for Medicaid Enhanced Plan participants.

Note: Provider responsibilities, payment information, and diagnosis, POS and procedure codes can be found in *Section 3 Durable Medical Equipment Guidelines*.

3.13.2 Provider Qualifications

Providers of specialized medical equipment and supplies purchased under this service must:

- Be an authorized dealer of equipment that meets UL, FDA, or FCC standards when applicable.
- Must provide the specific product when applicable (i.e. medical supply businesses or organizations that specialize in the design of the equipment).

Specialized medical equipment items over \$500.00 require three competitive bids.

3.13.3 Place of Service (POS) Codes

Specialized medical equipment can only be provided in the following POS:

11 Office

12 Home

3.13.4 Procedure Codes

Use the following five-digit HCPCS procedure codes when billing specialized medical equipment. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.13.4.1 DD and ISSH Waivers

Service	HCPCS	Description
Specialized Medical Equipment	E1399 U8 Modifier Required	<i>Durable Medical Equipment, Miscellaneous</i>

3.14 Supported Employment Services

3.14.1 Service Description for DD Waiver and ISSH Waiver

Supported employment is competitive work in an integrated work setting for participants with the most severe disabilities for whom competitive employment has not traditionally occurred. Supported employment is also available for participants when competitive employment is interrupted or intermittent as a result of a severe disability. It assists participants who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work.

Supported employment does not include services provided by the Idaho Division of Vocational Rehabilitation (IDVR) such as evaluation, work adjustment, and job site selection.

Note: Supported employment waiver services are covered for Medicaid Enhanced Plan participants.

3.14.2 Provider Qualifications

Supported employment services must be provided by an agency that is capable of:

- Supervising the direct service.
- Meeting accreditation standards of the Commission on Accreditation of Rehabilitation Facilities or Rehabilitation Services Accreditation System, Accreditation Council, or other comparable standard.
- Meeting requirements to be a Medicaid provider.

3.14.3 Provider Responsibilities

The provider is responsible for supported employment services, including long term maintenance or job coaching to support the participant at work.

3.14.4 Payment

Medicaid reimburses DD and ISSH Waiver services on a fee-for-service basis.

3.14.5 Diagnosis Codes

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.14.6 Place of Service (POS) Code

Supported employment services can only be billed in the following POS:

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.14.7 Procedure Codes

Use the following 5-digit HCPCS procedure code when billing supported employment services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.14.7.1 DD/ISSH Waiver

Service	HCPCS	Description
Supported Employment	H2023 U8 Modifier Required	<i>Supported Employment, per 15 minutes</i> The maximum allowable units per week are 160. 1 Unit = 15 minutes

3.15 Claim Billing

3.15.1 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.

3.15.2 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*, for more information.

3.15.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, 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 claims.

Referral number: A referral number is required on an electronic HIPAA 837 Professional claim 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 claim. A PA number can be entered at the header or at each detail of the claim.

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

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

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* in the *Physician Guidelines*, for more information.

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

3.15.3 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

3.15.3.1 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.

3.15.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.15.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column 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. There is no need to complete any other fields. 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.

Field	Field Name	Use	Directions
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 Healthy Connections 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.

Field	Field Name	Use	Directions
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 EPSDT</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.

3.15.3.4 Sample Paper Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA																																																	
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"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										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)										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					CITY					STATE																																												
ZIP CODE					TELEPHONE (Include Area Code) () ()					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"/> <i>If yes, return to and complete item 9 a-d.</i>																																							
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)										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. EPSOT Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																							
1										2										3										4										5										6									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. 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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