



From the Idaho Department of Health and Welfare, Division of Medicaid

May 2004

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Distributed by the Division of Medicaid Department of Health and Welfare State of Idaho

Prior Authorizations – Institutional, Professional and Dental Claims

For services that require a prior authorization number, the provider obtains this number from the appropriate authorizing agency (Regional Medicaid Services, Transportation, Qualis Health, Dental). Enter the prior authorization number in the correct field according to the claim type that is being billed. Refer to the Idaho Medicaid Provider Handbook for more specific billing information.

Electronic Billing

Providers using PES software may add enough zeros to the beginning of the prior authorization number to make it 8 (eight) digits. In any case, do not add the extra zeros to the end of the PA number; it will cause the claim to deny. Example: 654321 becomes 00654321.

Paper Billing

Providers that are billing on paper put the prior authorization number exactly as it is given on the prior authorization letter in the appropriate field on the paper claim form. When paper claims are processed in the system, zeros are automatically added to the beginning of the number so that providers do not have to do this.

Idaho Healthcare Conference 2004

This is a reminder that the annual Idaho Healthcare Conference will be taking place throughout the month of May in six locations. Registration is free for all Idaho providers and begins at 8:00 a.m. in all locations. Classes begin at 8:30 a.m. Please review the April 2004 MedicAide newsletter for specific class descriptions. Locations are listed below:

Clarkston, WA

Tuesday, May 4, 2004 Quality Inn 700 Port Dr., Clarkston, WA

Post Falls

Wednesday, May 5, 2004 Templins Resort 414 E. First Avenue, Post Falls, ID

Boise

Wednesday, May 12, 2004 DoubleTree Inn Riverside 2900 Chinden Blvd., Boise ID

Idaho Falls

Tuesday, May 18, 2004 Shilo Inn 780 Lindsay Blvd., Idaho Falls, ID

Pocatello

Wednesday, May 19, 2004 Pond Student Building, #14 Idaho State University 1065 S. 8th St., Pocatello, ID

Burley

Thursday, May 20, 2004 **Burley Convention Center** 800 N. Overland Ave., Burley, ID

MedicAide May 2004

April 1, 2004

MEDICAID INFORMATION RELEASE 2004-22

TO: Prescribing Providers, Pharmacists, Pharmacies, Hospitals,

and Long-Term Care Facilities

FROM: Paul Swatsenbarg, Deputy Administrator

SUBJECT: NEW PRIOR AUTHORIZATION CRITERIA FOR TRIPTAN DRUG CLASS

Drug/Drug Class: TRIPTAN

Implementation Date: Effective for dates of service on or after May 1, 2004

Idaho Medicaid is implementing an Enhanced Prior Authorization Program for select therapeutic classes including the identification of preferred agents. The Enhanced Prior Authorization Program (EPAP) is designed to provide Medicaid participants the most effective drug at the right price. Beginning May 1, 2004, triptans will be the next drug class to have new prior authorization requirements:

Enhanced Prior Authorization drug class	Preferred Agent(s)	Non-preferred Agents^
• TRIPTAN	 Imitrex[®] Zomig[®] Zomig ZMT[®] Maxalt[®] Maxalt MT[®] 	 Amerge[®] Frova[®] Relpax[®] Axert[®]

^{*}Use of non-preferred agents must meet prior authorization requirements

Point-of-service pharmacy claims will be routed through an automated system to apply PA criteria specifically designed to assure effective drug utilization. Through this process, therapy will automatically and transparently be approved for those patients who meet the system approval criteria. For those patients who do not meet the system approval criteria, contact the Medicaid Drug Prior Authorization help desk at (208) 364-1829 or fax a PA request form to (208) 364-1864 to initiate a review and potentially authorize claims. To assist in managing patients affected by these changes, Medicaid will be sending in a separate mailing a list to prescribing providers of their patients who are currently receiving therapy and whose claims for these drugs will be affected.

The Enhanced PA Program and drug class specific PA criteria are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. The determination of medications considered preferred within a drug class is based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes in comparison with other therapeutically interchangeable alternative drugs. A secondary consideration is cost.

In the coming months additional therapeutic drug classes will be added to the Enhanced Prior Authorization (EPAP) program. Please watch future information releases and the Medicaid Pharmacy website at www.idahohealth.org for details.

As always, your support is critical to the success of this Medicaid Pharmacy initiative. Our goal is to partner with you to provide quality, cost-effective health care to your patients. Questions regarding the Prior Authorization program may be referred to Medicaid Pharmacy at (208) 364-1829.

¹ Specific Prior Authorization criteria and fax forms for all drug classes may be obtained from the Department of Health and Welfare Pharmacy Program website at: http://www.idahohealth.org

Medicaid

Enhanced Prior Authorization Program

Drug Class Listing

Effective May 2004

Ca	ox-2s*
Preferred Agents	Non-preferred Agents^
Vioxx	Bextra
	Celebrex
Proton Pu	mp Inhibitors
Preferred Agents	Non-preferred Agents^
Prevacid [®] Aciphex [®] Prilosec OTC [®]	Protonix [®] Nexium [®] Prilosec [®] Omeprazole – various generics
Tri	Þ tans
Preferred Agents	Non-preferred Agents^
Imitrex [®]	Amerge [®]
Zomig®	Frova®
Zomig ZMT [®]	Relpax [®]
Maxalt [®]	Axert [®]
Maxalt MT®	

^{*}Entire Cox-2 drug class requires prior authorization and non-preferred agents require additional PA criteria for approval

Information Releases on Web

To obtain a copy of any current information release, please check the DHW website at **www2.state.id.us/dhw** and select **Medicaid**.

[^]Use of non-preferred agents requires prior authorization approval

March 19, 2004

MEDICAID INFORMATION RELEASE 2004-24

TO: Hospital Administrators

FROM: Kathleen Allyn, Deputy Administrator

SUBJECT: NOTICE OF 2004 MEDICAID RATES FOR SWING-BED DAYS AND ADMINISTRATIVELY

NECESSARY DAYS (AND)

Effective for dates-of-service on or after January 1, 2004, Medicaid will pay the following rates:

Swing-Bed Day \$172.28 Administratively Necessary Day (AND) \$142.02

If you have already billed for swing-beds days since 01/01/04, please submit corrected claim adjustments to EDS in order to receive reimbursement with the new rate listed above.

If you have any questions concerning the information contained in this release, please contact Sheila Pugatch, Senior Financial Specialist for the Bureau of Medicaid Policy, at (208) 364-1817.

Thank you for your continued participation in the Idaho Medicaid Program.

April 1, 2004

MEDICAID INFORMATION RELEASE MA04-25

TO: Physicians, Nurse Practitioners, Physician Assistants, Rural Health Clinics,

Federally Qualified Health Centers, and Indian Health Clinics

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: E CODES

As you are aware, providers are required to use the International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1, 2 and 3 for medical claim billing to Idaho Medicaid. Included in these code sets are E codes, which are supplementary classification of external causes of injury and poisoning (E800-E999). The purpose of these codes is to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. These codes are intended to be used in addition to a code from one of the main chapters of ICD-9-CM. Medicaid has not previously allowed these codes to be used on professional claims.

With the advent of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all standard code sets are permitted to be used in electronic billing of health claims. Providers may now use E codes when billing Medicaid as long as the code is not in the primary, secondary, or tertiary position on the claim form. When E codes are used in a primary, secondary, or tertiary position, the claim will deny.

If you have any questions regarding this information, please call Jan Uren at 208-364-1854.

Thank you for your continued participation in the Idaho Medicaid Program.

April 1, 2004

MEDICAID INFORMATION RELEASE #MA04-26

TO: DD Plan Developers, Developmental Disabilities Agencies,

DD/ISSH Waiver Service Providers

FROM: Paul Swatsenbarg, Deputy Administrator

SUBJECT: Changes for Behavioral Health Care Management for Adults with a Developmental Disability for dates of service on or after April 1, 2004.

1. Prior-Authorization by dollars rather than units.

- 2. Prior-Authorization for Medical Social History performed by a DDA.
- 3. Contents and Distribution of the ISP Packet.
- 4. Billing for Plan Development (G9007) and Plan Monitoring (G9012).
- 5. Modifications to the Durable Medical Equipment and Specialized Medical Equipment, DME/SME Guidelines.
- 6. Modifications to the Guidelines for Authorization of Medical Transportation.

1. Prior-Authorization by cost rather than units.

Adult DD Services will no longer be prior authorized by units. Prior authorization will be entered by the cost of the service in dollar amounts. The PA notice sent to providers will identify the total dollar amount authorized for the plan year. Providers will need to bill services according to frequency described on the ISP, to insure that authorized dollar amounts are not used up before the end date of the ISP. Prior authorization will be based on the costing sheet calculation for each service for the full plan year. This will provide flexibility for participants and providers to accommodate unique or special circumstances.

2. Prior-Authorization for Medical Social History performed by a DDA.

A Developmental Disabilities Agency may complete and be reimbursed for a Medical Social History that conforms to the requirements of IDAPA 16.04.11 (Rules Governing Developmental Disabilities Agencies. A Medical Social History will not be authorized in order to evaluate the need for psychotherapy. Participants assessed by the Independent Assessment Provider under IDAPA 16.03.13. will have a Medical, Social and Developmental History completed by the Assessor that will be available to the DDA as required by (IDAPA 16.04.11.800.01.b.). DDAs should utilize the information in that document to minimize duplicative efforts to complete a Medical/Social History Evaluation.

3. Contents and Distribution of an ISP packet.

An ISP packet should include the following information:

- Medical Care Evaluation Form
- Health and Well Being Form
- Residential Habilitation Program Coordination Plans for both Certified Family Home or Supported Living, and
- All ISP forms.

The information in the ISP packet must be provided to the Department to authorize the services on the ISP.

Distribution: Plan Developers are responsible for the distribution of the ISP documents as requested from the identified providers on the ISP.

4. Two ways to bill for Plan Development (G9007) and Plan Monitoring (G9012).

An agency that provides plan development and plan monitoring may choose between two options to bill for these services. The agency must adopt one method for all claims.

- 1. Delineate the service by each date of service as a separate line item on the claim.
- 2. Use a date span within the same month for the date of service. The units and dollars will reflect the total amount within the date span. Documentation of the daily activity must be documented within the agencies progress notes for each day of service delivery.

5. Modifications to DME/SME Guidelines.

- When it is determined that the participant needs any medical equipment or supplies during the participant's negotiated budget meeting/person centered planning meeting, the Plan Developer will consult with the medical equipment vendor to determine whether the requested equipment/supplies are covered under Medicaid's DME and require prior authorization.
- If prior authorization is not required, you may select a Medicaid DME vendor through the person centered planning team process and consult with that vendor for the price and appropriate code. Use the vendor "quote" for the cost of the DME supply or equipment on the ISP and submit the plan to the Assessor. The Assessor will use the participant profile to validate the cost.
- If prior authorization is required, the request including the procedure codes and prices is submitted by the medical equipment vendor to the DME unit in the Care Management Bureau.
- To assure the authorization is completed by the DME unit, the Plan Developer must get a valid price from the vendor and obtain a copy of the AIM prior authorization notice prior to putting the supply or equipment on the ISP.
- The authorization must be completed by the DME unit prior to the ISP being submitted. The Plan Developer must submit a copy of the prior authorization notice along with the ISP to the Assessor.

The guidelines are attached.

6. Modifications to Guidelines for Authorization of Medical Transportation.

- Plan Developers will work with Commercial Transportation providers to identify the mileage and amount (miles per week) authorized.
- For participants with an adult DD ISP, the Medical Transportation unit will contact the appropriate Assessor with any questions.
- The Assessor will contact the appropriate Medical Transportation specialist with any questions regarding medical transportation requests.

The guidelines are attached.

If you have any questions concerning the information contained in this release, please contact Jean Christensen by phone at 208-364-1828 or e-mail: christej@idhw.state.id.us.

Thank you for your continued participation in the Idaho Medicaid Program.

GUIDELINES FOR PLAN DEVELOPERS, DEPARTMENT STAFF AND ASSESSORS FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES (DME) SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SME) FOR DD AND ISSH WAIVER PARTICIPANTS

PLAN DEVELOPERS AND DEPARTMENT STAFF

Plan Developers are responsible for assisting individuals requesting developmental disabilities services to obtain needed medical equipment and supplies and to submit plan of service authorization requests and addendum for costing. The following guidelines are to assist the Plan Developer in assuring these services for the participant are authorized and captured in the ISP in the most expedient manner.

It is important to remember that if the participant you are providing services to is enrolled with the Healthy Connections Program, a primary care provider referral is necessary for Medicaid reimbursement of Durable Medical Equipment and Supplies (DME) or Specialized Medical Equipment and Supplies (SME). You are responsible for assuring that this referral is obtained prior to requesting Medicaid reimbursement for DME or SME.

STATE PLAN DURABLE MEDICAL EQUIPMENT (DME)

When you have determined that the participant needs any medical equipment or supplies during the participant's negotiated budget meeting/person centered planning meeting, the Plan Developer will consult with the medical equipment vendor to determine whether the requested equipment/supplies are covered under Medicaid's DME and require prior authorization.

- Copies of DME rules are available through the IDAPA rules 16.03.09.106.
- Refer to the DME provider handbook for items requiring prior authorization from the DME specialist in the Department. If there are questions call 1-866-205-7403.
- If you know the procedure code for the item you may call EDS at 383-4310 or 1-800-685-3757.
- If the equipment/supplies are not covered under the State Plan and the individual is either receiving or applying for waiver services, you should follow the procedure for Specialized Medical Equipment and Supplies (SME) listed below.
- If requests for non-covered equipment and/or supplies are submitted to DME Specialists, they
 will automatically consider any equipment/supplies under SME and refer the request to the appropriate Assessor for processing.
- Once you determine that the equipment/supplies are covered under Medicaid, please use the following protocol for submitting the plan of service that include DME:
 - If no prior authorization is required, you may select a Medicaid DME vendor through the person centered planning team process and consult with that vendor for the price and appropriate code. DME suppliers are listed in the yellow pages in your region under "Medical Equipment and Supplies." Use the vendor "quote" for the cost of the DME supply or equipment on the ISP and submit the plan to the Assessor. The Assessor will use the participant profile to validate the cost.
 - If prior authorization is required, the request including the procedure codes and prices is submitted by the medical equipment vendor to the DME unit in the Care Management Bureau.
 - To assure the authorization is completed by the DME unit, the Plan Developer must

get a valid price from the vendor and obtain a copy of the AIM prior authorization notice prior to putting the supply or equipment on the ISP.

- The authorization must be completed by the DME unit prior to the ISP being submitted. The Plan Developer must submit a copy of the prior authorization notice along with the ISP to the Assessor.
- You may need to assist the vendor *(the vendor must be an Idaho Medicaid DME provider)* in obtaining any needed additional information to be submitted to the assessor.
- If there are questions in regards to DME authorizations, contact the DME unit in the Care Management Bureau.

If a participant is currently living in an ICF/MR or is applying for waiver services and will need either DME or SME immediately upon discharge/approval onto the DD or ISSH waiver, the needed items may be requested by the vendor prior to discharge/approval. However, the actual authorization cannot be given until the participant is discharged.

The authorization of the plan and/or the discharge from the facility should not be delayed waiting for authorization of DME or SME unless the equipment is essential to their discharge into the community. If the person cannot be discharged without the equipment, validation that the authorization will occur must be done prior to that discharge.

For DME supplies not requiring prior authorization from the DME unit, the Plan Developer should attempt to get the prices from the available lists, DME Medicaid Care Management, medical equipment vendor or the Voice Response System 1-800-685-3757, and submit the plan to the Assessor with an estimate of the costs.

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SME) - DD AND ISSH WAIVERS ONLY

- Prior to requesting SME the Plan Developer or service coordinator (TSC) must first attempt to
 access these services through all other resources. In addition, the Plan Developer or service coordinator must provide documentation from a professional validating the need of the requested
 equipment specific to the participant.
- SME does not include convenience items or devices to assist the provider in fulfilling their responsibilities as outlined in Rule due to a disability or deficit of the provider.
- The procedure code used to bill Specialized Medical Equipment and Supplies is E1399.
- Requests for SME supplies will come through the Assessor for review on the ISP.
- This code cannot be used to bill for Durable Medical Equipment or for participants that are not eligible for services on the DD or ISSH waivers.
- If there are questions in regards to SME on the ISP, contact the Assessor.

SELECT AN IDAHO MEDICAID VENDOR

- If the only vendor for the SME is not an Idaho Medicaid DME vendor they will have to become a vendor prior to requesting authorization for services.
- The vendor should contact the Assessor to apply for SME provider status or EDS to apply for DME vendor status.
- To provide DME, the provider must enroll type 014 with the specialty of 137 or 138.
- To provide DME and SME you may enroll as specialty 137 or 138.

- To provide services under the waiver vender definition, you must enroll as specialty 141.
- The Plan Developer must submit documentation of efforts to find other funding and/or natural/informal supports to the Assessor in their region.
- If technical assistance is needed to determine the type of information needed to justify the need for DME or in processing the request for DME, please contact the DME Specialist in Medicaid using the information below.

DME Specialists, Care Management Bureau

 Address:
 Phone Number:
 FAX Number:

 PO Box 83720
 1-800-352-6044
 1-866-205-7403

 Boise, Idaho 83720-0036
 1-866-205-7403

Dorrie Phillips

Perinatal PA

- Apnea monitor
- Bili lights
- Oximeter
- Breast pumps

DME Claims Adjudication

Communication Devices

Excess Supplies

Nutritional Supplies

Miscellaneous

Home Health

Cille Lasley

Wheelchair PA

Walker PA

AIM UAT

Creditable Health Insurance

Determination

Gait Trainers

Standers

Hospice Program

Linda Schrock

Diabetic Supplies

- Insulin pumps
- Supplies in excess
- Glucose monitors

Steve Brown

CPAP/BIPAP PA

Vest PA

Semi-Electric Bed and Mattress

Wound Vac PA

Ventilators

CPM Machines

Elastometric Devices

Bathroom Equipment

Dee Patterson

Bone Growth Simulator PA TENS Units PA Hearing Aids

- Once you select a vendor who can provide the needed item, the vendor must submit a request form for prior authorization along with the following documentation:
 - Name of item (product), including make and model
 - Retail price of item
 - Vendor's cost of item (quote) or manufacturer's pricing sheet if the code is manually priced
 - Medical Necessity documentation will include a description of the item, why needed, functional abilities, what less costly means of meeting the medical need have been considered and the reasons each would not meet the medical need, and how it will be used.
- For questions concerning policy issues and SME contact: Regional Assessor

ASSESSOR

DME

- All requests for DME will be reviewed by the Assessor as part of the overall cost of the ISP using the following tools:
 - Participant profile
 - Medicaid Fee Schedule on www.idahohealth.org
 - DME Equipment and Supply Cost list
- The Plan Developer is responsible for obtaining the appropriate cost, code and copy of the prior authorization notice prior to the submission of the ISP.
- The Assessor can use the profile to validate DME supplies or equipment cost from past years expenditures when relevant.
- Any request denied by the DME unit must not be included in the plan submitted to the Assessor for review.
- If a DME supply requires prior authorization from the DME unit, a copy of the prior authorization notice must be submitted with the ISP to the Assessor. Any ISP's with DME requiring prior authorization not accompanied with a notice will be taken off the plan and will not be considered part of the cost. The Assessor will notify the Plan Developer when this occurs.

SME

- The Assessor will prior authorize the SME request as part of their plan of service authorization process.
- The Assessor will rule out a DME request by using the DME code list and Medicaid Fee Schedule.
- If the Assessor is unsure about the SME request, contact the DME specialist to clarify the request.

GUIDELINES FOR AUTHORIZATION OF MEDICAL TRANSPORTATION

- 1. All requests for Medical Transportation (by an individual or agency transporter) over 21 miles will come to the Transportation unit for review, and authorization in AIM. (Business as usual). Commercial transporters must prior authorize ALL trips regardless of mileage.
- 2. The Behavioral Health unit will provide a list of adults with developmental disabilities and their plan of service dates to the Transportation unit. They will use it as reference material but will not have time to refer to it in daily business.
- 3. Plan Developers will work with the Commercial Transportation providers to identify the type and amount authorized by the Transportation unit.
- 4. Transportation costs are being calculated as part of the overall cost of the plan in the implementation of Care Management for adult DD. They will be included in the Participant Profile as part of the past expenditures.
- 5. The Assessor must review the medical transportation request to assure the participant is being transported to the nearest DDA, is cost effective, and reflects the participant's assessed needs.
- 6. For participants with an adult DD ISP, the Medical Transportation unit will contact the appropriate Assessor with any questions.
- 7. The Assessor will contact the appropriate Medical Transportation specialist with any questions regarding medical transportation requests.

Region 1 & 3	Carla T	208-287-1171	turleyc@idhw.state.id.us
Region 2 & 4	Christine F	208-287-1172	fennerc@idhw.state.id.us
Region 5, 6 & 7	Sara H	208-287-1173	hunts@idhw.state.id.us

EDS P.O. Box 23 Boise, Idaho 83707

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U.S. POSTAGE PAID
BOISE, ID
PERMIT NO. 1





May Office Closure

The Department of Health and Welfare and EDS offices will be closed for the following State holiday:

Memorial Day, Monday, May 31, 2004

A reminder that MAVIS (the Medicaid Automated Voice Information Service) is available on State holidays at: (800) 685-3757 (toll-free) or (208) 383-4310 (Boise local) *MedicAide* is the monthly informational newsletter for Idaho Medicaid providers.

Co-Editors: Becca Ruhl, Division of Medicaid

Cynthia Brandt, Publications Coordinator, EDS

If you have any comments or suggestions, please send them to:

ruhlb@idhw.state.id.us

or

Becca Ruhl DHW MAS Unit PO Box 83720 Boise, ID 83720-0036

Fax: (208) 364-1911

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An informational newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid

June 2004

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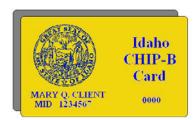
CHIP- B Coming Soon

In July, Idaho Medicaid will begin to accept applications for the new children's health insurance program: CHIP-B.

CHIP-B provides an affordable, basic health care insurance option for uninsured children who live in families with a gross annual income between 150% - 185% of Federal Poverty Guidelines.

Each eligible CHIP-B participant is issued a plastic identification card. The card looks similar to the Medicaid ID card, with the child's name and 7-digit medical identification number on the front of the card. The card is yellow and is identified as a CHIP-B card.

CHIP-B provides a limited benefit package. You may provide CHIP-B covered services under the terms of your existing provider enrollment agreement.





Two information releases published in this issue of *MedicAide* include important CHIP-B information. Information Release 2004-27 provides instructions for verifying CHIP-B eligibility. Information Release 2004-28 lists covered and non-covered CHIP-B services and provides detailed billing instructions.

You can find additional information about the CHIP-B program by selecting the CHIP link on the Idaho Department of Health and Welfare website at www.idahohealth.org.

A Gentle Reminder for Providers

Providers who bill for Medicaid services must accept payment from Medicaid as payment in full. Providers may not request additional payments from clients if the service was Medicaid approved.

"Most providers are very good about only submitting a bill at the Medicaid payment rate for the service, but now and then we find that additional "balance" bills are sent to clients," says Deputy Medicaid Administrator Randy May.

Federal and state regulations prohibit any additional billing beyond what the Medicaid rate is for a particular service. "Balance billing is usually just a mistake," says May. "Providers generally do a pretty good job of billing, but now and then things slip through the cracks."

The bottom line is this: providers must accept payment from Medicaid as payment in full if the bill is for Medicaid service.

If the provider is performing a service to a Medicaid client that is not covered by Medicaid, then the provider should (preferably in writing) let the client know prior to the delivery of the service that the service is not covered and that the client is responsible for payment. Also, if the participant has other insurance and the service is submitted to Medicaid for payment, the provider must bill the third party insurance first. Medicaid will pay the balance based on the Medicaid payment rate.

Medic/Aide June 2004

Coming Soon to a Regional Office Near You!

EDS Provider Relations Consultants conduct provider billing workshops every month in all seven regions of the state. In the coming months, workshops will be conducted on the second Tuesday of each month from 2:30-3:30 P.M.

Upcoming topics:

June 15 Submitting Transportation Claims

July 13 Installing and Using PES software

August 10 Accessing and Using Provider Resources

September 14 Reading and Using the Medicaid Remittance Advice

Pre-registration is appreciated but not required. Please contact your local Provider Relations Consultant for more information. You can find Consultant contact information in this newsletter on page 5.

Tips for Faster Processing of Claims

For the fastest possible processing of claims, send them electronically! With PES and other vendor software it is possible to send almost all claims electronically including crossovers and oxygen claims. Electronic claims can be approved to pay within hours of transmission.

If you want to get started in electronic claim submission, call MAVIS and ask for *TECHNICAL SUPPORT*. The number is (800) 685-3757. The EDI Technical Support team is available during normal business hours, 8:00 a.m. – 5:00 p.m. (Mountain Time).

If electronic billing is not an option for you, please follow these guidelines when submitting paper claims.

- Send all claims to P.O. Box 23, Boise, Idaho 83707
- Send all correspondence separately to the attention of a specific person and/or department. Do not include correspondence with claims. It will be scanned and included as claim documentation.

Everyday EDS receives approximately 5,000 pieces of mail. A machine opens all of the mail which is then sorted into correspondence and claims. All claims are fed into a scanner one page at a time to create an electronic image for processing. To speed the proper handling of your claims and correspondence and to avoid the loss of important information, please follow these guidelines:

- Do not fold claims; mail them flat in a large envelope.
- Do not staple or tape claims to the envelope. Do not tape or staple the claims and attachments together.
- Place any "attachments" behind the appropriate claim including EOBs. Make a copy of the EOB page for each claim to which it applies.
- Do not continue claims onto a second claim form. Each claim must have a total.
- Place all adjustment forms on top of any claims. It is not necessary to include a copy of the claim.
- Sort claims by type of claim form when sending several claim types in the same envelope.

DHW Phone Numbers
Addresses
Web Sites

DHW Websites

www.idahohealth.org

www2.state.id.us/dhw

www2.state.id.us/dhw/ medicaid/providers/ pharmacy.htm

Idaho Careline

211 (available in all areas) (800) 926-2588

Provider Fraud and Utilization Review

P. O. Box 83720 Boise, ID 83720-0036

(866) 635-7515 (toll free) (208) 334-0675

Email:

~medicaidfraud&sur@
idhw.state.id.us
(note: begins with ~)

Internet:

www2.state.id.us/dhw/ Medicaid/providers/fraud.htm

Healthy Connections

Region I - Coeur d'Alene (208) 666-6766 (800) 299-6766

Region II - Lewiston (208) 799-5088 (800) 799-5088

Region III - Caldwell (208) 455-7280 (800) 494-4133

Region IV - Boise (208) 334-4676 (800) 354-2574

Region V - Twin Falls (208) 736-4793 (800) 897-4929

Region VI - Pocatello (208) 239-6260 (800) 284-7857

Region VII - Idaho Falls (208) 528-5786 (800) 919-9945

Spanish Speaking (800) 862-2147

Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations

DME Specialist Bureau of Care Management PO Box 83720 Boise, ID 83720-0036 (866) 205-7403 (toll free) Fax (800) 352-6044 (att: DME Specialist)

PCG

P.O. Box 2894 Boise, ID 83701 (800) 873-5875 (208) 375-1132 Fax (208) 375-1134

Pharmacy

P.O. Box 83720 Boise, ID 83720-0036 (877) 200-5441 (toll free) (208) 364-1829 Fax (208) 364-1864

Web: www2.state.id.us/dhw/ medicaid/providers/ pharmacy.htm

Qualis Health (telephonic & retrospective reviews)
10700 Meridian Ave. N.
Suite 100
Seattle, WA 98133-9075
(800) 783-9207
Fax (800) 826-3836 or
(206) 368-2765

Qualis Health Website www.qualishealth.org/ idahomedicaid.htm

Transportation Prior Authorization Unit

(800) 296-0509 (208) 334-4990 Fax (800) 296-0513 (208) 334-4979

Ambulance Review

(800) 362-7648 (208) 287-1155

Fax (800) 359-2236 (208) 334-5242 June 1, 2004

MEDICAID INFORMATION RELEASE MA04-27

TO: All Medicaid Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: CHIP-B BENEFIT PACKAGE AND BILLING INSTRUCTIONS

Effective July 1, 2004, Idaho Medicaid will implement the new Idaho Title XXI Children's Health Insurance Program-Part B (CHIP-B).

CHIP-B is a basic health care program, administered by the State that pays for primary health care services for children. CHIP-B was created in response to legislation enacted by the 2003 Idaho Legislature. The intent of this legislation is to increase the availability of affordable, basic health care insurance to currently uninsured children who live in families with gross annual income between 150% - 185% of the Federal Poverty Guideline (FPG).

The CHIP-B program offers limited medical coverage to qualified applicants. The following is a list of **covered** services:

- Hospital services (inpatient and outpatient)
- Limited Clinical services (Mental Health Clinics, Regional Mental Health Clinics, and Diabetes Clinics)
- Physician, Osteopath, and Mid-Level Practitioner services
- Vision services
- Prescription drugs
- Laboratory services
- Emergent Ambulance/Air Ambulance services
- Rehabilitative Option for Rehab Mental Health services
- Essential Care services (District Health Departments, Indian Health Services Clinics, Rural Health Clinics)
- Federally Qualified Health Center services
- Birthing Center services
- Radiology Technical services (Mobile x-rays)
- Hearing services (Audiologist and Hearing Aid Vendors)

CHIP-B services will be reimbursed at the current Medicaid reimbursement rate and are subject to all current billing requirements, edits, and limitations for services under the regular Medicaid program. **Non-covered** services for CHIP-B clients include:

- All Inpatient Psychiatric services
- Transplant services
- Clinic services (Diagnostic, PWC, Speech and Hearing Clinic Services)
- Dental services
- Unit Dose Pharmacy services
- Home Health services
- Non-emergent transportation services (Commercial, Individual, Agency and Non-Medical Waiver Transportation)
- Long Term Care services
- Hospice services
- Rehabilitative Option for Developmental Disability Centers and School Based services
- Durable Medical Equipment and Supply services
- All Waiver services (Personal Care Services, Nursing Services, DD, TBI and ISSH)
- Case Management services
- Chiropractic services

Continued on page 4

- Dietician services
- Physical Therapy services
- Podiatry services
- Social Worker services
- Medicare Crossover Claims

SPECIAL BILLING INSTRUCTIONS

Coverage Changes and Claim Billing

If a participant changes their coverage from CHIP-B to Medicaid or from Medicaid to CHIP-B, charges must be billed on separate claims for payment. A claim which includes both CHIP-B and Medicaid services will be denied. For example, if the participant had CHIP-B coverage in July and then Medicaid coverage in August, the July CHIP-B services must be billed on one claim. The Medicaid services in August must be billed on a separate claim.

Previous Prior Authorizations

Previous prior authorizations are not a guarantee of payment if the client's eligibility changes from Medicaid to CHIP-B. Prior authorizations received under Medicaid will not be valid for CHIP-B if the service is not covered under CHIP-B. For example: a participant has a current prior authorization for non-medical transportation for the months of July and August. The participant has Medicaid coverage in July and CHIP-B in August. The non-medical transportation services rendered in July would be covered by the prior authorization, but the August services would not be covered because the client was no longer eligible for the same level of benefits under the CHIP-B program.

Healthy Connections

As with Medicaid, the Department requires most CHIP-B participants to enroll and participate in the Healthy Connections Case Management program. If you have questions about the Healthy Connections program in your area, contact your local Health Resources Coordinator. Health Resources Coordinators' contact numbers are published in the Provider Handbook and the MedicAide newsletter.

Claim Submission

Electronic CHIP-B claims should be sent to EDS using HIPAA compliant billing software the same way electronic Medicaid claims are sent today. Send CHIP-B paper claims to EDS, P.O. Box 23, Boise, ID 83707-0023. If you have questions about claims processing for CHIP-B participants, contact EDS at 1-800-685-3757 or in the local Boise area at 383-4310.

Additional Information

Additional information about the CHIP-B program can be found by selecting the CHIP link on the Idaho Department of Health and Welfare Website at http://www.idahohealth.org.

June 1, 2004

MEDICAID INFORMATION RELEASE MA04-28

TO: All Medicaid Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: ELIGIBILITY FOR CHILDREN'S HEALTH INSURANCE PROGRAM B

(CHIP-B)

Effective July 1, 2004, Idaho Medicaid will implement the new Idaho Title XXI Children's Health Insurance Program-Part B (CHIP-B).

CHIP-B is a basic health care program, administered by the State that pays for primary health care services for children. CHIP-B was created in response to legislation enacted by the 2003 Idaho Legislature. The intent of this legislation is to increase the

Continued on page 5

Information Release MA04-27 continued from page 3 EDS Phone Numbers

Addresses

MAVIS

(800) 685-3757 (208) 383-4310

EDS

Correspondence PO Box 23 Boise, ID 83707

Provider Enrollment P.O. Box 23 Boise, Idaho 83707

Medicaid Claims PO Box 23

PO Box 23 Boise, ID 83707

PCS & ResHab Claims PO Box 83755 Boise, ID 83707

Provider Enrollment (208) 395-2198

Provider Services (208) 395-2072

Client Assistance Line Toll free: (888) 239-8463

EDS Phone Numbers Addresses

Provider Relations Consultants

Region 1

Prudie Teal 1120 Ironwood Dr., # 102 Coeur d'Alene, ID 83814

prudie.teal@eds.com (208) 666-6859 (866) 899-2512 (toll free) Fax (208) 666-6856

Region 2

JoAnn Woodland 1118 F Street P.O. Drawer B Lewiston, ID 83501

joann.woodland@eds.com (208) 799-4350 Fax (208) 799-5167

Region 3

Mary Jeffries 3402 Franklin Caldwell, ID 83605

mary.jeffries@eds.com (208) 455-7162 Fax (208) 454-7625

Region 4

Jane Hoover 1720 Westgate Drive, # A Boise, ID 83704

jane.hoover@eds.com (208) 334-0842 Fax (208) 334-0953

Region 5

Penny Schell 2241 Overland Avenue Burley ID 83318

penny.schell@eds.com

Burley: Tuesday & Friday (208) 677-4002

Twin Falls: Mon, Wed, Thurs (208) 736-2143 Fax (208) 678-1263

Region 6

Sheila Lux 1070 Hiline Road Pocatello, ID 83201

sheila.lux@eds.com (208) 239-6268 Fax (208) 239-6269

Region 7

Bobbi Woodhouse 150 Shoup Avenue Idaho Falls, ID 83402

bobbi.woodhouse@eds.com (208) 528-5728 Fax (208) 528-5756 availability of affordable, basic health care insurance to currently uninsured children who live in families with gross annual income between 150% - 185% of the Federal Poverty Guideline (FPG).

CHIP-B Identification Card

A plastic identification card is issued when a participant is determined to be eligible for CHIP-B. The card looks similar to the current Medicaid ID card, with the participant's name and 7-digit medical identification number on the front of the card. The CHIP-B card is yellow and has "CHIP-B" rather than "Medicaid" printed on the front.

Requesting CHIP-B Eligibility Information

Possession of a CHIP-B identification card does not guarantee CHIP-B eligibility. You should verify eligibility each time services are rendered. You can request CHIP-B eligibility information using the same methods you currently use to request Medicaid eligibility information.

These methods include:

- EDS Provider Electronic Solution (PES) billing software or other HIPAA-compliant software
- HIPAA-compliant point-of-sale devices (POS)
- Medicaid Automated Voice Information Service (MAVIS)
- HIPAA-compliant vendor software (tested with EDS)

Understanding Eligibility Response Information

It is important to understand eligibility response information to ensure that your claims get paid. Participants may move between CHIP-B and Medicaid coverage as their financial situation changes. A participant may possess both a CHIP-B and a Medicaid identification card.

Because CHIP-B covers fewer services, it becomes more important to verify eligibility prior to rendering services to avoid claim denial.

If using:

- EDS PES, HIPAA-compliant vendor software, or a HIPAA-compliant point-of-sale device: The program description returned in the eligibility response is "CHIP-B."
- MAVIS: The voice dialogue indicates, "Benefits restricted to CHIP-B related services only." In the fax back option, MAVIS indicates "CHIP-B" in the program description section.

When you request eligibility information for a date range during which a participant was covered by CHIP-B for part of the range and by Medicaid for part of the range, the eligibility response will return the coverage description as well as the "From Date of Service" and "To Date of Service" for each coverage segment.

When you enter a procedure code in an eligibility request, the eligibility response indicates whether the procedure code is active in the claims payment system for the date requested. This information does **not** indicate that the service is covered under the CHIP-B program. For information on CHIP-B covered services see: **Information Release 2004-27**, **dated June 1**, **2004**.

Before providing services, check both participant eligibility and whether the services are covered under the CHIP-B program to help assure payment of your claim.

If you have questions regarding the information contained in this release, please contact EDS Provider Relations at 1-800-685-3757 or 383-4310 in the local Boise calling area.

You can find additional information about the CHIP-B program by selecting the CHIP link on the Idaho Department of Health and Welfare Website at http://www.idahohealth.org.

Thank you for your continued participation in the Idaho CHIP-B and Medicaid Programs.

MEDICAID INFORMATION RELEASE MA04-11

TO: School-Based Service Providers FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: REPLACEMENT OF INFORMATION RELEASE 2003-75

Idaho Medicaid recently implemented procedure code changes in order to comply with the federal regulations associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Information Release 2003-75 was previously sent to providers to inform them of the state-only code conversions to the appropriate CPT and HCPCS codes. The large number of system changes at one time resulted in some errors that need to be corrected. Additionally, a few system adjustments were implemented to ensure accurate payment processing. **Medicaid Information Release MA04-11 super-sedes Medicaid Information Release 2003-75.**

In most cases, the code changes were converted effective for dates of service on or after October 20, 2003. The exceptions to this effective date are indicated on the table below. Please be aware that some procedure codes require an attached modifier when the provider submits the claim. NOTE: *Modifiers must be used in the order listed to pay correctly*. Adjustments and revisions are in the Medicaid provider handbook and are available online at http://www2.state.id.us/dhw/medicaid/provhb/s3_toc.pdf

In most cases, the code changes were converted effective for dates of service on or after October 20, 2003. The exceptions to this effective date are indicated on the table below. Please be aware that some procedure codes require an attached modifier when the provider submits the claim. **NOTE:** *Modifiers must be used in the order listed to pay correctly.* Adjustments and revisions are in the Medicaid provider handbook and are available online at http://www2.state.id.us/dhw/medicaid/provhb/s3 toc.pdf

Obsolete Code	Valid Procedure Code	Description	Effective Date
8254A	G9002 *Requires TM	Coordinated Care Fee, Maintenance Rate This code was previously "Annual IEP Plan Development".	10/20/03
DEVELOP	MENTAL THERAPY		
8255S	H2000	Comprehensive Multidisciplinary Evaluation	10/20/03
8245S	H2014	Skills Training and Development, per 15 minutes	10/20/03
8250S	H2014 *Requires HQ modifier	Skills Training and Development , Group , per 15 minutes. This code was previously "Developmental Therapy/ Group".	10/20/03
INTENSIVE	BEHAVIORAL INT	ERVENTION	
8226A 8226S	H2019	Therapeutic Behavioral Services, per 15 minutes. This code was previously "IBI – Professional".	10/20/03
8228A 8228S	H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude), per 15 minute unit. This code was previously "IBI Consultation".	10/20/03
8227A 8227S	H2019 *Requires HM	Therapeutic Behavioral Services, per 15 minutes. This code was previously "IBI- Paraprofessional".	10/20/03
SPEECH &	HEARING		
8400S	92506	Evaluation of Speech, Language, Voice, Communication, and/or Auditory Processing and/or Aural Rehabilitation Status. This code was previously "Speech Evaluation by School District".	10/20/03
8410S	V5008	Hearing Screening.	10/20/03
8401S	92507 *Requires HO modifier*	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), professional; individual. This code was previously "Individual Speech/Hearing Therapy-Professional".	10/20/03
8402S	92508 *Requires HO modifier*	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), professional; two or more individuals. This code was previously "Group Speech/Hearing Therapy – Professional". NOTE: Effective for dates of service on or after 10/20/03, the rate is \$4.37 per unit.	10/20/03

Information Release MA04-11 continued from page 6

		inioimation Release MA04-11 C	orkinada irom pago d
Obsolete Code	Valid Procedure Code	Description	Effective Date
SPEECH &	HEARING—continu	ued	
8404S	92507 *Requires HM modifier*	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), technician; individual. This code was previously "Individual Speech/Hearing Therapy – Technician".	10/20/03
8403S	See 92508	[Group Speech/Hearing Therapy – Professional; by School with 3-4 students]	Code Terminated 10/20/03
8405S	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation), technician; group, two or more individuals. This code was previously "Group Speech/ Hearing Therapy – Technician". NOTE: Effective for dates of service on or after 10/20/03, the rate is \$1.99 per unit.	10/20/03
8406S	See 92508	[Group Speech/Hearing Therapy with 3-4 students, Technician; by School]	Code Terminated 10/20/03
PHYSICAL	THERAPY		
8500S	97001	Physical Therapy Evaluation	10/20/03
8501S	97110 *Requires HO modifier*	Therapeutic procedure , one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility. This code was previously "Individual Physical Therapy – Professional".	10/20/03
8502S	97150 *Requires HO modifier*	Therapeutic procedure(s), group (2 or more individuals). This code was previously "Group Physical Therapy - Professional". NOTE: Effective for dates of service on or after 10/20/03, the rate is \$3.59 per unit.	10/20/03
8503S	See 97150	[Group Physical Therapy; Professional, 3-4 students, by School District]	Code Terminated 10/20/03
8504S	97110	Therapeutic procedure , one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility. This code was previously "Individual Physical Therapy – Technician".	10/20/03
8505S	97150	Therapeutic procedure(s), group (2 or more individuals). This code was previously "Group Physical Therapy – Technician". NOTE: Effective for dates of service on or after 10/20/03, the rate is \$1.76 per unit.	10/20/03
8506S	See 97150	[Group Physical Therapy; Technician, by School District, 3-4 students]	Code Terminated 10/20/03
OCCUPATI	ONAL THERAPY		
8510S	97003	Occupational Therapy Evaluation, per 15 minute unit.	10/20/03
8511S	97530 *Requires HO modifier*	Therapeutic activities , direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes. This code was previously "Individual Occupational Therapy – Professional".	10/20/03
8512S	97530 *Requires HQ and HO modi- fier*	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes; 2 or more students. This code was previously "Group Occupational Therapy – Professional". NOTE: Effective for dates of service on or after 10/20/03, the rate is \$3.59 per unit.	10/20/03
8513S	See 97530	[Group Occupational Therapy – Professional; by School District; 3-4 students]	Code Terminated 10/20/03
8514S	97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes. This code was previously "Individual Occupational Therapy – Technician".	10/20/03

Obsolete Code	Valid Procedure Code	Description	Effective Date		
OCCUPATI	OCCUPATIONAL THERAPY—continued				
8515S	97530 *Requires HQ and HM modi- fier*	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes; 2 or more students. This code was previously "Group Occupational Therapy – Technician". NOTE: Effective for dates of service on or after 10/20/03, the rate is \$2.10 per unit.	10/20/03		
8516S	See 97530	[Group Occupational Therapy – Technician; by School District; 3-4 students]	Code Terminated 10/20/03		
РЅҮСНОТЬ	HERAPY				
8600S	T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter. This code was previously "Social History/ Evaluation". Note: this service is no longer reimbursed in 15 minute units. Use 1 unit per encounter.	10/20/03		
8700S	96100	Psychological testing (including psycho diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour. This code was previously "Psychiatric Testing Diagnostic Evaluation".	10/20/03		
8701S	90801	Psychiatric diagnostic interview examination i.e. SIB-R or CAFAS.	10/20/03		
8710S	90899	Unlisted psychiatric service – This code was previously "Individual Psychiatric Therapy". This code is reimbursed per 15 minute unit. NOTE: This is an interim code to be used by schools to be able to bill for psychotherapy services. This code replaces 90804, 90806, and 90808.	10/20/03		
8711S	90853	Group psychotherapy (other than of a multiple – family group); 2 or more students.	10/20/03		
8712S	See 90853	[Group Psychotherapy; by School District; 3-4 students]	Code Terminated 10/20/03		
8713S	90847	Family psychotherapy (conjoint psychotherapy) (with patient present).	10/20/03		
PSYCHOSO	PSYCHOSOCIAL REHABILITATION				
5003S	H2017	Psychosocial Rehabilitation Services, Individual, per 15 minutes	10/20/03		
5005S	H2017 *Requires HQ	Psychosocial Rehabilitation Services, Group, per 15 minutes	10/20/03		
5006S	H0031	Mental Health Assessment , by Non-Physician. This code was previously "Psychosocial Rehabilitation Evaluation".	10/20/03		
8225A	90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. This code was previously "Collateral Contact, per 15 minute unit".	10/20/03		
PERSONAL CARE SERVICES					
0501S	G9001	Coordinated Care Fee, Initial Rate. This code was previously "PCS Supervisory RN Assessment". NOTE: Effective for dates of service on or after 7/01/03, the rate is \$65.82 per assessment/plan.	10/20/03		
0503S	T1001	Nursing Assessment/Evaluation. This code was previously "Supervising RN Visit". NOTE: Effective for dates of service on or after 7/01/03, the rate is \$32.07 per visit.	10/20/03		

Obsolete	Valid Procedure	Information Release MAU4-11 (1 0
Code	Code	Description	Effective Date
PERSONAL	CARE SERVICES	- continued	
0527S	T1002 *Requires TD	RN Services, up to 15 minutes. This code was previously "Nursing Services – RN, Skilled".	10/20/03
0528S	T1003	LPN/LVN Services , up to 15 minutes. This code was previously "Nursing Services – LPN, Skilled".	10/20/03
0531S	T1002	RN Services , up to 15 minutes. This code was previously "Nursing Services RN Oversight of LPN".	10/20/03
0541S	T1004	Services of a Qualified Nursing Aide, up to 15 minutes. This code was previously "PCS by CNA". NOTE: Effective for dates of service on or after 7/01/03, the rate is \$3.35 per 15 minute unit.	10/20/03
TRANSPOR	RTATION		
0090S	A0080	Non-Emergency Transportation, per mile – vehicle provided by volunteer (Individual or Organization), with no vested interest.	10/20/03
0705S	T2001	Non-Emergency Transportation; Patient Attendant/Escort. This code was previously "Salary for Medically Necessary Attendant to Accompany Client".	10/20/03
0541S	T1004	Services of a Qualified Nursing Aide , up to 15 minutes. NOTE : Effective for dates of service on or after 7/01/03, the rate is \$3.35 per 15 minute unit.	10/20/03
DURABLE MEDICAL EQUIPMENT			
1399S	E1399	Durable Medical Equipment , Miscellaneous. This code was previously "Medical Equipment and Supplies".	10/20/03
INTERPRETIVE SERVICES			
8297A 8298A	8296A	Interpretive Services NOTE: Effective for dates of service on or after 8/01/03, the rate will be \$12.16 per one (1) hour unit, regardless of provider's certification. (See Information Release MA03-54 for additional information).	8/01/03

	Demoired Meditions and Definitions
	Required Modifiers and Definitions
НМ	Less than Bachelor degree level
НО	Masters degree level
HQ	Group setting
TD	RN
TM	Individualized Education Program (IEP)

If you have questions regarding the information contained in this release, please contact Carolyn Burt-Patterson (208) 364-1827. Thank you for your continued participation in the Idaho Medicaid Program.

Information Releases on Web

To obtain a copy of any current information release, please check the DHW website at **www2.state.id.us/dhw** and select **Medicaid**.

MEDICAID INFORMATION RELEASE MA04-12

TO: Aged & Disabled Waiver Providers

Certified Family Home Providers
Personal Care Service Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: REPLACEMENT OF INFORMATION RELEASE 2003-76

Idaho Medicaid recently implemented procedure code changes in order to comply with the federal regulations associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Information Release 2003-76 was previously sent to providers to inform them of the state-only code conversions to the appropriate CPT and HCPCS codes. The large number of system changes at one time resulted in some errors that need to be corrected. Additionally, a few system adjustments were implemented to ensure accurate payment processing. Medicaid Information Release MA04-12 supersedes Medicaid Information Release 2003-76.

In most cases, the code changes were converted effective for dates of service on or after October 20, 2003. The exceptions to this effective date are indicated on the table below. Please be aware that some procedure codes require an attached modifier when the provider submits the claim. NOTE: *Modifiers must be used in the order listed to pay correctly.* Adjustments and revisions are in the Medicaid provider handbook and are available online at http://www2.state.id.us/dhw/medicaid/provhb/s3_toc.pdf

	PERSONAL CARE SERVICES		
Obsolete Code	Valid Procedure Code	Description	Effective Date
0501P	G9002	Coordinated Care Fee, Maintenance Rate. This code was previously "PCS Assessment Client Evaluation Care Plan – Agency".	10/20/03
0503P	T1001	Nursing Assessment/Evaluation . This code was previously "RN Supervisor Visit – Agency".	10/20/03
0509P	NA	[Non-Technical Care Assistant – Unlisted Service]	Code Terminated 10/20/03
0513P	G9001	Coordinated Care Fee, Initial Rate. This code was previously "QMRP Client Evaluation and Plan Development – Agency".	10/20/03
0514P	H2020	Therapeutic Behavioral Services , per diem. This code was previously "QMRP Supervisory Visit – Agency".	10/20/03
0541P	T1019	Personal Care Services , per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse). This code was previously "Agency PCS".	10/20/03
0641P	S5145 *Requires U3 modifier*	Foster care, therapeutic child; per diem. This code was previously "Agency PCS – one client – daily care".	10/20/03
0643P	S 5145	Foster care, therapeutic, child; per diem. This code was previously "Independent PCS 8.25 – 24 hr. Client - Provider's Home".	10/20/03
0741P	S5145 *Requires U3 and HQ modifiers*	Foster care, therapeutic, child; per diem. This procedure was previously "Agency PCS – Two Clients – 24 Hour Care". Both listed modifiers are required.	10/20/03
0743P	S5145 *Requires HQ modifier*	Foster Care, therapeutic, child ; per diem. This code was previously "Independent PCS 8.25-24 hr, two clients in provider's home; no withholding".	10/20/03

AGED & DISABLED WAIVER SERVICES			
Obsolete Code	Valid Procedure Code	Description	Effective Date
0080P	A0080 *Requires U2 modifier*	Non-emergency transportation , per mile-vehicle provided by volunteer (individual or organization), with no vested interest. <i>This billing code is only valid for established transportation providers</i> .	10/20/03
0516P	G9001 *Requires U2 modifier*	Coordinated Care Fee, Initial Rate. Previously Case Management Assessment and ICSP. This is a one-time rate. 1 unit = ICSP development.	10/20/03
0515P	G9002	Coordinated Care Fee, Maintenance Rate. Previously Ongoing and Emergency Case Management. Maximum of 8 hours unless prior authorized by the RMS. 1 unit = 15 minutes.	10/20/03
0644P	\$5100 *Requires U2 modifier*	Day Care Services, Adult; per 15 minutes. This code was previously "Adult Day Care".	10/20/03
0646P	\$5125 *Requires U2 modifier*	Attendant Care Services; per 15 minutes. This code was previously "Attendant Care by CNA".	10/20/03
0648P	\$5120 *Requires U2 modifier*	Chore Services; per 15 minutes	10/20/03
0649P	\$5135 *Requires U2 modifier*	Companion care, adult (e.g. IADL/ADL); per 15 minutes. This code was previously "Companion Services".	10/20/03
0651P	90899 *Requires U2 modifier*	Unlisted psychiatric service or procedure This code was previously "Psychiatric Consultation".	10/20/03
0652P	S5130 *Requires U2 modifier*	Homemaker Service, NOS; per 15 minutes	10/20/03
0653P	S5170 *Requires U2 modifier*	Home Delivered Meals, including preparation; per meal.	10/20/03
0655P	T1005 *Requires U2 modifier*	Respite Care Services, up to 15 minutes. This code was previously "In-Home Respite".	10/20/03
0670P	T1001 *Requires U2 modifier*	Nursing Assessment/Evaluation This code was previously "Aged & Disabled Nursing Service".	10/20/03
0656P	T1002 *Requires U2 modifier*	RN Services , up to 15 minutes. This code was previously "Nursing Services by RN".	10/20/03
0657P	T1003	LPN/LVN Services , up to 15 minutes. This code was previously "Nursing Services by LPN".	10/20/03
0658P	S5115 *Requires U2 modifier*	Home Care Training , non-family; per 15 minutes. This code was previously "Consultation".	10/20/03
0659P	\$5160 *Requires U2 modifier*	Emergency Response System; installation and testing. This code was previously "Personal Emergency Response System, Installation".	10/20/03
0660P	S5161 *Requires U2 modifier*	Emergency Response System; service fee, per month (excludes installation and testing). This code was previously "Personal Emergency Response System, Monthly Rent".	10/20/03
0661P	\$5140 *Requires U2 modifier*	Foster Care, Adult; per diem. This code was previously "Adult Residential Care". Use U2 modifier if the resident is enrolled on the Aged & Disabled Waiver Program.	10/20/03

	AGED & DISABLED WAIVER SERVICES - continued		
Obsolete Code	Valid Procedure Code	Description	Effective Date
0601B	\$5140 *Requires U8 modifier*	Foster Care, Adult ; per diem. This code was previously "Specialized Family Home Care". Use U8 modifier if the resident is enrolled on the DD/ISSH Waiver Program.	10/20/03
0669P	S5165 *Requires U2	Home Modification; per service	10/20/03
1399P	E1399 *Requires U2	Durable Medical Equipment , Miscellaneous. This code was previously "Assistive Technology".	10/20/03

	Required Modifiers and Definitions
HQ	Group setting
U2	Aged & Disabled Waiver Program
U3	Traumatic Brain Injury Waiver Program
U8	Developmental Disability/ISSH Waiver Program

If you have questions regarding the information contained in this release, please contact Carolyn Burt-Patterson (208) 364-1827. Thank you for your continued participation in the Idaho Medicaid Program.

June 1, 2004

MEDICAID INFORMATION RELEASE MA04-15

TO: Rehabilitative Mental Health Service Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: REPLACEMENT OF INFORMATION RELEASE 2003-77

Idaho Medicaid recently implemented procedure code changes in order to comply with the federal regulations associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Information Release 2003-77 was previously sent to providers to inform them of the state-only code conversions to the appropriate CPT and HCPCS codes. The large number of system changes at one time resulted in some errors that need to be corrected. Additionally, a few system adjustments were implemented to ensure accurate payment processing. **Medicaid Information Release MA04-15 supersedes Medicaid Information Release 2003-77.**

In most cases, the code changes were converted effective for dates of service on or after October 20, 2003. The exceptions to this effective date are indicated on the table below. Please be aware that some procedure codes require an attached modifier when the provider submits the claim. NOTE: *Modifiers must be used in the order listed to pay correctly.* Adjustments and revisions are in the Medicaid provider handbook and are available online at http://www2.state.id.us/dhw/medicaid/provhb/s3 toc.pdf

Obsolete Code	Valid Procedure Code	Description	Effective Date		
ASSESSMEN	ASSESSMENT AND EVALUATION				
0100M	90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. This code was previously "Medical Report on Past Record Rather Than New Exam". 1 unit = 1 report	10/20/03		
0105M	NA	[Narrative Report on Past Record vs New Exam]	Code Terminated 10/20/03		
0110M	90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers. This code was previously "Medical Report Based on New Exam". 1 unit = 1 report	10/20/03		
5100H	See 90885	[Medical Report on Past Record Rather Than New Exam]	Code Terminated 10/20/03		
5110H	See 90889	[Medical Report Based on New Exam]	Code Terminated 10/20/03		
5001H	90801	Psychiatric Diagnostic Interview Examination Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
5820H	90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication. Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
5601H	96100	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour. This code was previously "Psychiatric Testing for Diagnosis and Evaluation" 1 unit =1 hour. Requires prior authorization.	10/20/03		
8193A	T1028	Assessment of home, physical, and family environment, to determine suitability to meet patient's medical needs. This code was previously "Social History and Evaluation". 1 unit = 15 mins.	10/20/03		
5006H	H0031	Mental Health Assessment, by non-physician. This code was previously "Rehabilitation Evaluation". 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
5007H	H0032	Mental Health Service Plan Development by non-physician. This code was previously "Task Plan Development". 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
PSYCHOSOC	IAL REHABILITATION	SERVICES			
5003H	H2017	Psychosocial Rehabilitation Services, per 15 minutes. This code was previously "Individual Psychosocial Rehabilitation". Requires prior authorization.	10/20/03		
5005H	H2014 *Requires HQ modi- fier*	Skills Training and Development, per 15 minutes. This code was previously "Group Psychosocial Rehabilitation". Requires prior authorization.	10/20/03		
5225H	90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. This code was previously "Collateral Contact – Face to Face". 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
5600H	90887 *Requires HE modifier*	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. This code was previously "Collateral Consultation – Telephone". 1 unit = 15 minutes. Requires prior authorization.	10/20/03		

Obsolete Code	Valid Procedure Code	Description	Effective Date		
PSYCHOSO	PSYCHOSOCIAL REHABILITATION SERVICES – continued				
5050H	90887 *Requires HQ modifier*	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. This code was previously "Collateral Consultation – Parent Group". 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
5000H	H2011	Crisis Intervention Service , per 15 minutes. This code was previously "Community Crisis Support". 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
5008H	See H2011	[Crisis Intervention – Emergency Room]	Code Terminated 10/20/03		
INDIVIDUAL	AND GROUP PSYCHO	OTHERAPY			
5010H	See 90804 , 90806 , & 90808	[Individual Psychotherapy]	Code Terminated 10/20/03		
H5010	Use 90804, 90806, 90808	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face-to-face with the patient. Codes are based on the length of service – use the code that is closest to the actual service time and bill as 1 unit. 90804 = 20-30 mins, 90806 = 45-50 mins, and 90808 = 75-80 mins. Physicians should use the UA modifier.	Code Terminated 10/20/03 Use new codes effective 10/20/03		
8110A	H0004 *Requires U4 modifier*	Behavioral Health Counseling and Therapy, per 15 minutes. This code was previously "Individual Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
	90810, 90812, 90814	Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, face-to-face with the patient. Codes are based on the length of service – use the code that is closest to the actual service time and bill as 1 unit. 90810 = 20-30 mins, 90812 = 45-50 mins, and 90814 = 75-80 mins. Physicians should use the UA modifier. Requires prior authorization.	10/20/03		
8115A	90899 *Requires U4 modifier*	Unlisted Psychiatric Service or procedure. This code was previously "Individual Interactive Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization	10/20/03		
H5020	90853	Group Psychotherapy (other than of a multiple-family group). Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
8111A	90853 *Requires U4 modifier*	Group Psychotherapy (other than of a multiple- family group). This code was previously "Group Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization	10/20/03		
8116A	90857 *Requires U4 modifier*	Interactive Group Psychotherapy. This code was previously "Group Interactive Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
5002H	90847	Family Psychotherapy (conjoint psychotherapy) (with patient present). Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization.	10/20/03		
8112A	90847 *Requires U4 modifier*	Family Psychotherapy (conjoint psychotherapy) (with patient present). This code was previously "Family Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes. Requires prior authorization.	10/20/03		

Obsolete	Valid Procedure	Description	Effective Date
Code	Code	Description	Lifective Date
OTHER PRO	GRAM SERVICES		
5062H	90862	Pharmacologic management , including prescription use, and review of medication with no more than minimal medical psychotherapy. 1 unit = 1 visit. Requires prior authorization.	10/20/03
8286A	G0001	Routine venipuncture for collection of specimen(s). This code was previously "Mental Health Blood Drawing Fee". 1 unit = 1 visit.	Code Terminated 10/20/03 Use new codes effective 10/20/03
8287A	90782	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular. This code was previously "Medication Injection – Mental Health Center". 1 unit = 1 injection.	Code Terminated 10/20/03 Use new codes effective 10/20/03
8288A	J3490	Unclassified Drugs. This code was previously "Medication supplied – Mental Health Center". The National Drug Code (NDC) is required on the claim in the comments field.	Code Terminated 10/20/03 Use new codes effective 10/20/03
H5200	T1001	Nursing assessment / evaluation. This code was previously "Nursing Service – Office Visit". 1 unit = 15 minutes.	10/20/03
5400H	97003	Occupational Therapy Evaluation 1 unit = 15 minutes. Requires prior authorization.	10/20/03
5300H	97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes This code was previously "Occupational Therapy – Individual". 1 unit = 15 minutes. Requires prior authorization.	10/20/03
8296A	8296A	Interpretive Services. This code was previously "Interpreter, Non-Certified". There is no longer a reimburse rate difference based on the provider's level of certification. Effective for dates of service on or after 8/01/03, the rate is \$12.16 per hour. 1 unit = 1 hour.	8/01/03
8297A	See 8296A	[Interpreter, Partially Certified]	Code Terminated 7/31/03
8298A	See 8296A	[Interpreter, Certified]	Code Terminated 7/31/03

Required Modifiers and Definitions		
HE	Nursing Home Fac/Mental Health Program	
HQ	Group setting	
UA	Professional Mental Health (by physician)	
U1	Performed by a Physician	
U4	Services provided to an individual living in a Nursing Facility	

If you have questions regarding the information contained in this release, please contact Carolyn Burt-Patterson (208) 364-1827. Thank you for your continued participation in the Idaho Medicaid Program.

EDS P.O. Box 23 Boise, Idaho 83707

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Check your mail!

In June all active providers will receive the new Idaho Medicaid Provider Resources CD. It contains the updated *Idaho Medicaid Provider Handbook*, the Provider Electronic Solutions (PES) software with upgrades, and the POS device user's quide.

Providers using the CD format of the handbook will be able to copy the handbook files to their desktop computer(s) for use, print paper copies of all the materials they want, and complete forms online to be printed and mailed.

Providers can use the PES software to check client eligibility and service limitations online as well as submit claims.

Providers who are unable to use the CD may request a paper copy of the provider handbook for their provider specialty.

MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

Co-Editors:
Becca Ruhl,
Division of Medicaid
Cynthia Brandt,
Publications Coordinator,
EDS

If you have any comments or suggestions, please send them to:

ruhlb@idhw.state.id.us

or

Becca Ruhl DHW MAS Unit PO Box 83720 Boise, ID 83720-0036

Fax: (208) 364-1911



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From the Idaho Department of Health and Welfare, Division of Medicaid

July 2004

CHIP-B Program Implemented This Month

On July 7th through July 16th, Idaho Medicaid will hold the first open enrollment period for the new Children's Health Insurance Program-Part B (CHIP-B). CHIP-B provides an affordable, basic health care insurance option for uninsured children who live in families with gross annual income between 150% - 185% of Federal Poverty Guidelines.

A plastic identification card is issued to each eligible CHIP-B participant. The card looks similar to the Idaho Medicaid ID card, with the child's name and 7-digit medical identification number on the front. The card is yellow and is identified as an Idaho CHIP-B Card. Information Release MA04-28, published in the June issue of *MedicAide*, provided instructions for verifying CHIP-B eligibility. See page 16 for a sample of the CHIP-B card.

CHIP-B provides a limited benefit package of basic health care services. Information Release MA04-27, published in the June issue of *MedicAide*, listed covered and non-covered CHIP-B services and provided detailed billing instructions. You may provide CHIP-B covered services under the terms of your existing provider enrollment agreement.

Two information releases published in this issue of *MedicAide* provide additional CHIP-B information. Information Release MA04-29 explains changes that Healthy Connections providers will see on their Remittance and Status Report and roster. Information Release MA04-30 explains how CHIP adjustments are processed.

You can find additional information about the CHIP-B program by selecting the CHIP link on the Idaho Department of Health and Welfare website at www.idahohealth.org.

Provider Liability Insurance

In the past some providers who are required to have general liability insurance have been approved based on professional liability insurance. This has been an oversight on the part of Medicaid and was perpetuated because there were multiple points for approving Medicaid provider applications. Approval of provider applications has now been centralized and proper liability insurance will be required.

EDS will be enforcing the following process:

- When providers reach their insurance expiration dates and send in their insurance documentation, EDS will review to assure the provider has the correct liability insurance.
- If a provider requires general liability insurance but only has professional liability insurance, they will be informed that they need to obtain general liability insurance.
- The provider will have three (3) months from the date of notification to obtain the proper insurance.
- If the provider does not provide Medicaid with proof of the proper insurance within three (3) months, their provider number will be inactivated.
- New applicants must provide proof of the proper liability insurance before they will be enrolled as a provider.

Medic/Aide July 2004

PES Software Patch

NOTICE: Providers using PES software to submit electronic claims: If you are using the PES software you recently received on the Idaho Medicaid Provider Reference CD (version 3.20), a defect was identified in the calculation of **certain** detail line dollar amounts. **This defect may cause the final calculation to be short by one penny.**

A correction has been made and an upgrade is available to download from the bulletin board. Please refer to the "Get Upgrades" section in your PES handbook. (Once upgraded your version should read 3.23.) If you have problems with this download or difficulties installing the upgrade, please contact MAVIS at (800) 685-3757 and ask for *"Technical Support"*.

Tips for Faster Processing of Claims

For the fastest possible processing of claims, send claims electronically! With PES and other vendor software, claims can be voided and then replaced with new claims.

"Re-submitting" Corrected Claims

When submitting a new claim to correct an old claim follow these steps:

- Wait for the old claim to appear on the Paid or Denied section of your weekly RA.
 Pended claims cannot be corrected.
- A paid claim can only be corrected through an adjustment. Submit an Adjustment Request Form to correct any errors on paid claims.
- A **denied** claim must be re-submitted as a new claim with corrected data.
 - Denied claims cannot be adjusted.
 - Use an electronic void and claim replacement if possible. This can be done regardless if the original claim was paper or electronic.
 - When submitting on a paper claim form, submit a new claim with the corrected information. If you are re-using an old claim with corrected information, use white correction tape to delete all detail lines that have already paid. If these details are not deleted, the claim will pend until an adjudicator can work it and deny the duplicate details. This can slow down the payment of your claim by up to a month.
- Do not write "Corrected Claim" on an old claim to re-submit it. This does not void or
 adjust the old claim and will cause the new claim to deny as a duplicate. Previously
 paid claims must be corrected through the adjustment process. Previously denied
 details must be re-submitted with the corrected information and any necessary

CPT 43659 Requires PA

CPT code 43659, "Laparoscopy, unlisted stomach procedure" requires prior authorization from the Department.

Coming Soon to a Regional Office Near You!

EDS Provider Relations Consultants conduct provider billing workshops every month in all seven regions of the state. In the coming months, workshops will be conducted on the second Tuesday of each month from 2:30-3:30 P.M.

Upcoming topics:

July 13 - Installing and Using PES software

August 10 - Accessing and Using Provider Resources

September 14 – Reading and Using the Medicaid Remittance Advice

Please pre-register with the Provider Relations Consultant in your region. You can find Consultant contact information in this newsletter.

DHW Phone Numbers Addresses

Web Sites

DHW Websites

www.idahohealth.org

www2.state.id.us/dhw

www2.state.id.us/dhw/ medicaid/providers/ pharmacy.htm

Idaho Careline

211 (available in all areas) (800) 926-2588

Provider Fraud and Utilization Review

P. O. Box 83720 Boise, ID 83720-0036

(866) 635-7515 (toll free) (208) 334-0675

Email:

~medicaidfraud&sur@
idhw.state.id.us
(note: begins with ~)

Internet:

www2.state.id.us/dhw/ Medicaid/providers/fraud.htm

Healthy Connections

Region I - Coeur d'Alene (208) 666-6766 (800) 299-6766

Region II - Lewiston (208) 799-5088 (800) 799-5088

Region III - Caldwell (208) 455-7280 (800) 494-4133

Region IV - Boise (208) 334-4676

Region V - Twin Falls (208) 736-4793 (800) 897-4929

(800) 354-2574

Region VI - Pocatello (208) 239-6260 (800) 284-7857

Region VII - Idaho Falls (208) 528-5786 (800) 919-9945

Spanish Speaking (800) 862-2147

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Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations

DME Specialist
Bureau of Care Management
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax
(800) 352-6044
(att: DME Specialist)

PCG

P.O. Box 2894 Boise, ID 83701 (800) 873-5875 (208) 375-1132 Fax (208) 375-1134

Pharmacy

P.O. Box 83720 Boise, ID 83720-0036 (877) 200-5441 (toll free) (208) 364-1829 Fax (208) 364-1864

Web: www2.state.id.us/dhw/ medicaid/providers/ pharmacy.htm

Qualis Health (telephonic & retrospective reviews)
10700 Meridian Ave. N.
Suite 100
Seattle, WA 98133-9075
(800) 783-9207
Fax (800) 826-3836 or
(206) 368-2765

Qualis Health Website www.qualishealth.org/ idahomedicaid.htm

Transportation Prior Authorization Unit

(800) 296-0509 (208) 334-4990 Fax (800) 296-0513 (208) 334-4979

Ambulance Review

(800) 362-7648 (208) 287-1155

Fax (800) 359-2236 (208) 334-5242 July 1, 2004

MEDICAID INFORMATION RELEASE MA04-29

TO: Healthy Connections Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: Healthy Connections Case Management Fees for CHIP-B Participants

On July 1, 2004, Idaho Medicaid implemented the new Children's Health Insurance Program-Part B (CHIP-B). Currently there are two types of CHIP programs:

- CHIP-A covers eligible children at the same level of coverage as traditional Medicaid
- CHIP-B provides limited medical coverage to qualified children

Effective August 1, 2004, your Remittance and Status Report and roster will change to accommodate CHIP-B.

Your **Remittance and Status Report** will have up to 3 different payouts associated with Healthy Connections Case Management (HCCM). These payouts will display in the *Financial Transactions* section of your weekly Remittance and Status Reports. Each type of payout is identified by a different financial reason code.

- Financial reason code 126 is the HCCM fee payment for all clients enrolled in a traditional Medicaid program.
- Financial reason code 127 is the HCCM fee payment for all clients enrolled in a CHIP-A program.
- Financial reason code **129** is the HCCM fee payment for all clients enrolled in the CHIP-B program.

Your **roster** will change to include CHIP-B participants. The new roster is separated into two categories, Medicaid and CHIP-B. Within each of these categories the report displays new enrollees, ongoing enrollees, and dis-enrollments.

The **Medicaid** category includes both traditional Medicaid and CHIP-A participants. The **CHIP-B** category includes only CHIP-B participants.

If you have questions about the changes to your Remittance and Status Report or roster, please contact your local Health Resources Coordinator. Health Resources Coordinators' contact numbers are published in the *Idaho Medicaid* Provider Handbook and the *MedicAide* newsletter.

You can find additional information about the CHIP-B program by selecting the CHIP quick link on the Idaho Department of Health and Welfare website at http://www.idahohealth.org.

DHW Website is Changing

Coming Soon - a new look for the DHW Internet Site.

More information and the new Internet address will be available in the August newsletter.

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July 1, 2004

MEDICAID INFORMATION RELEASE MA04-30

TO: All Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: Adjustments and Financial Transactions for CHIP Participants

In July 2004, Idaho Medicaid implemented the new Children's Health Insurance Program-Part B (CHIP-B). Currently there are two types of CHIP programs:

- CHIP-A covers eligible children at the same level of coverage as traditional Medicaid
- CHIP-B provides limited medical coverage to qualified children

Implementation of the new CHIP-B program will affect how claim adjustments and financial transactions appear on your weekly remittance and status reports.

Medicaid, CHIP-A, and CHIP-B services are reimbursed from separate state and federal funding sources. Medicaid services are paid from one funding source, CHIP-A from a different funding source, and CHIP-B from a third funding source. Because CHIP services are not reimbursed from Medicaid funds, any claim adjustment that results in an overpayment to the provider must be refunded by either:

- Providing additional services that are paid from the same funding source or
- Refunding the amount by sending a check from the provider to the State of Idaho, DHW Medicaid. There are two types of transactions that may occur in the adjustment process: claim voids and claim adjustments.

Claim Voids

When a provider requests an adjustment to **void** a claim for a participant enrolled in a particular program (Medicaid, CHIP-A, or CHIP-B), the claim is voided and an accounts receivable transaction is set up. This transaction will remain outstanding in the system until claims have been paid for other services from the **same** program funding source or until a refund from the provider of services has been received and processed for the amount owed.

- If claims have been paid from the same funding source as the voided claim: On the same remittance and status report, the system will withhold the accounts receivable balance from the claims payment. If the claims payment amount for the funding source of the accounts receivable is less than the receivable balance, the entire payment for the funding source will be withheld and the receivable balance will be reduced by that amount. The transaction is shown in the *Financial Transaction* section of the weekly remittance and status report with the original setup amount less the amount refunded.
- If no claims have been paid from the same funding source:

The transaction is displayed on the remittance and status report the week following the initial setup of the accounts receivable transaction in the *Financial Transaction* section. It is not shown again until new claims are processed and approved to pay from the same funding source.

• When claims are approved to pay from the same funding source in subsequent financial cycles:

The transaction is shown in the *Financial Transaction* section of the new remittance and status report.

For example, a provider requests an adjustment to void a claim for a CHIP-B participant with other primary insurance. The claim is voided and an accounts receivable is set up. When claims are approved to pay from the CHIP-B funding source, the system withholds the overpayment amount from those claims until the total amount is

IR MA04-30 continued on page 5

EDS Phone Numbers Addresses

MAVIS

(800) 685-3757 (208) 383-4310

EDS

Correspondence

PO Box 23 Boise, ID 83707

Provider Enrollment

P.O. Box 23 Boise, Idaho 83707

Medicaid Claims

PO Box 23 Boise, ID 83707

PCS & ResHab Claims

PO Box 83755 Boise, ID 83707

EDS Fax Numbers

Provider Enrollment (208) 395-2198

Provider Services (208) 395-2072

Client Assistance Line Toll free: (888) 239-8463

EDS Phone Numbers Addresses

Provider Relations Consultants

Region 1

Prudie Teal 1120 Ironwood Dr., # 102 Coeur d'Alene, ID 83814

prudie.teal@eds.com (208) 666-6859 (866) 899-2512 (toll free) Fax (208) 666-6856

Region 2

JoAnn Woodland 1118 F Street P.O. Drawer B Lewiston, ID 83501

joann.woodland@eds.com (208) 799-4350 Fax (208) 799-5167

Region 3

Mary Jeffries 3402 Franklin Caldwell, ID 83605

mary.jeffries@eds.com (208) 455-7162 Fax (208) 454-7625

Region 4

Jane Hoover 1720 Westgate Drive, # A Boise, ID 83704

jane.hoover@eds.com (208) 334-0842 Fax (208) 334-0953

Region 5

Penny Schell 2241 Overland Avenue Burley ID 83318

penny.schell@eds.com

Burley: Tuesday & Friday (208) 677-4002

Twin Falls: Mon, Wed, Thurs (208) 736-2143 Fax (208) 678-1263

Region 6

Sheila Lux 1070 Hiline Road Pocatello, ID 83201

sheila.lux@eds.com (208) 239-6268 Fax (208) 239-6269

Region 7

Bobbi Woodhouse 150 Shoup Avenue Idaho Falls, ID 83402

bobbi.woodhouse@eds.com (208) 528-5728 Fax (208) 528-5756 IR MA04-30 continued from page 4

recouped. The CHIP-B transaction and the paid amount from claims with the same funding source are shown in the *Financial Transaction* section of the weekly remittance and status report.

Claim Adjustments

When a provider requests an adjustment to **change** a claim for a participant enrolled in a particular program (Medicaid, CHIP-A, or CHIP-B) resulting in an overpayment to the provider, EDS makes the change, recycles it as a new claim, and sets up an accounts receivable for the transaction. Adjustments are shown as a net adjusted amount with a negative dollar amount and the balance owed against the original claim.

- If claims are approved to pay with the same funding source:
 Their payment is applied to the amount owed from the adjustment. It is shown on the Adjusted Claims section of the weekly remittance and status reports.
- If no claims are approved to pay from the same funding source:
 The financial transaction is displayed the week following the initial setup of the accounts receivable transaction on the Adjusted Claims section of the weekly remittance and status report. It is not shown again until new claims are processed and approved to pay from the same funding source.
- When claims are approved to pay from the same funding source in subsequent financial cycles:

The remaining adjustment is shown in the **Remaining Balance on Previous Ad- justments** section of the new remittance and status report.

For example, a provider requests an adjustment to reduce the units of service for a participant enrolled in the CHIP-A program. An EDS financial clerk reduces the units of service on the claim and sets up an account receivable for the overpayment. When claims are approved to pay from the CHIP-A funding source, the system withholds the overpayment amount from those claims until the total amount is recouped. The CHIP-A transaction and the paid amount from claims with the same funding source are shown in the Adjusted Claims (first week) or the **Remaining Balance on Previous Adjustments** (future) section of the weekly remittance and status report.

For both voids and adjustments, if no claims have been processed within 30 days of the initial accounts receivable setup, the provider is notified by letter of the outstanding accounts receivable. At that time, the provider is required to refund the overpayment by sending a copy of the letter and a check, made payable to **State of Idaho, DHW Medicaid**, to:

EDS Attn: Financial Department PO Box 23 Boise, ID 83707

For additional information regarding this process, call (800) 685-3757 or 383-4310 in the local Boise calling area. Ask for *AGENT* to speak with an EDS Provider Services Representative.

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June 4, 2004

MEDICAID INFORMATION RELEASE MA04-16

TO: Developmental Disability Agency Service Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: REPLACEMENT OF INFORMATION RELEASE 2003-78

Idaho Medicaid recently implemented procedure code changes in order to comply with the federal regulations associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Information Release 2003-78 was previously sent to providers to inform them of the state-only code conversions to the appropriate CPT and HCPCS codes. The large number of system changes at one time resulted in some errors that need to be corrected. Additionally, a few system adjustments were implemented to ensure accurate payment processing.

Medicaid Information Release MA04-16 supersedes Medicaid Information Release 2003-78.

In most cases, the code changes were converted effective for dates of service on or after October 20, 2003. The exceptions to this effective date are indicated on the table below. Please be aware that some procedure codes require an attached modifier when the provider submits the claim. **NOTE:** *Modifiers must be used in the order listed to pay correctly.* Adjustments and revisions are in the Medicaid provider handbook and are available online at http://www2.state.id.us/dhw/medicaid/provhb/s3_toc.pdf

Obsolete Code	Valid Procedure Code	Description	Effective Date
ASSESSMEN	T AND EVALUATIO	N	
0100M	99080	Providers should use this code for the completion of the Medical Care Evaluation form from a record review. This code was previously "Medical Report on Past Record Rather Than New Exam". Use diagnosis code V70.3 . This code is typically billed by the participant's Healthy Connections Physician. 1 unit = 1 completed form	10/20/03
0105M	See 99080	[Narrative Report on Past Record vs New Exam]	Code Terminated 10/20/03
0110M	99450	Providers should use this code for program required History and Physical Evaluations . This code was previously "Medical Report Based on New Exam". Use diagnosis code V70.3 . 1 unit = 1 completed evaluation	10/20/03
0601M M0601	96100	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g. WAIS-R, Rorschach, MMPI) with interpretation and report, per hour. This code was previously "Psychological Testing for Diagnosis and Evaluation". This code no longer allows for a physician modifier. 1 unit = 1 hour	10/20/03
8193A	T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs. This code was previously "Social History and Evaluation". 1 unit = 15 minutes	10/20/03
8225A	90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. This code was previously "Collateral Contact". 1 unit = 15 minutes	10/20/03
9089A	90801	Psychiatric diagnostic interview examination. Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03
9082A	See 90801	[Interactive Medical Psychiatric Diagnostic Interview Exam]	Code Terminated 10/20/03

Obsolete Code	Valid Procedure Code	Description	Effective Date	
PSYCHOTHE	PSYCHOTHERAPY SERVICES			
8110A	H0004 *Requires U4 modifier*	Behavioral Health Counseling and Therapy, per 15 minutes. This code was previously "Individual Psychotherapy for Nursing Facility Recipient". Physicians should use the U1 modifier. 1 unit = 15 minutes.	10/20/03	
8111A	90853 *Requires U4 modifier*	Group Psychotherapy (other than of a multiple-family group). This code was previously "Group Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03	
8112A	90847 *Requires U4 modifier*	Family Psychotherapy (conjoint psychotherapy) (with patient present). This code was previously "Family Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03	
8115A	90899 *Requires U4 modifier*	Unlisted Psychiatric Service or procedure. This code was previously "Individual Interactive Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03	
8116A	90857 *Requires U4 modifier*	Interactive Group Psychotherapy. This code was previously "Group Interactive Psychotherapy for Nursing Facility Recipient". Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03	
9083A	90853	Group psychotherapy (other than of a multiple-family group). This code was previously "Group Medical Psychotherapy". Physicians should use U1 modifier. 1 unit = 15 minutes	10/20/03	
9084A	H0004	Behavioral Health Counseling and Therapy , per 15 minutes. This code was previously "Individual Medical Psychotherapy". Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03	
9085A	See H0004	[Interactive Individual Medical Psychotherapy]	Code Terminated 10/20/03	
9086A	See 90853	[Interactive Group Medical Psychotherapy]	Code Terminated 10/20/03	
9087A	90847	Family psychotherapy (conjoint psychotherapy) (with patient present). This code was previously "Family Medical Psychotherapy". Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03	
OCCUPATIO	NAL THERAPY			
8275A	97003	Occupational Therapy Evaluation 1 unit = 15 minutes	10/20/03	
H5300	97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes. This code was previously "Occupational Therapy – Individual". 1 unit = 15 minutes	10/20/03	
8270A	97535 *Requires HQ modifier*	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes. This code was previously "Occupational Therapy, Group". 1 unit = 15 minutes.	10/20/03	

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Obsolete Code	Valid Procedure Code	Description	Effective Date
SPEECH & H	EARING SERVICES		
8130A	92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status. This code was previously "Speech Evaluation – CDC". Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03
8140A	See 92506	[Hearing Evaluation – CDC]	Code Terminated 10/20/03
8230A	92507	Treatment of speech language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual. This code was previously "Individual Speech Therapy". 1 unit = 15 minutes.	10/20/03
8235A	92508	Treatment of speech language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals. This code was previously "Group Speech Therapy-CDC". 1 unit = 15 minutes	10/20/03
PHYSICAL T	HERAPY		
8268A	97001	Physical Therapy Evaluation 1 unit = 15 minutes	10/20/03
8260A	97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility. This code was previously "Individual Physical Therapy-CDC". 1 unit = 15 minutes	10/20/03
8265A	97150 *Requires HQ modifier*	Therapeutic procedure(s), group (2 or more individuals). This code was previously "Group Physical Therapy – CDC". 1 unit = 15 minutes	10/20/03
INTENSIVE E	BEHAVIORAL INTER	RVENTION	
8226A	H2019	Therapeutic Behavioral Services. This code was previously "IBI – Professional". 1 unit = 15 minutes	10/20/03
8227A	H2019 *Requires HM modifier*	H2019 Therapeutic Behavioral Services . This code was previously "IBI – Paraprofessional". 1 unit = 15 minutes	10/20/03
8228A	H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude). This code was previously "IBI Consultation". 1 unit = 15 minutes.	10/20/03
DEVELOPME	ENTALTHERAPY SE	RVICES	
8245A	H2014	Skills Training and Development, per 15 minutes. This code was previously "Developmental Therapy – Individual; CDC". 1 unit = 15 minutes	10/20/03
8246A	H2014 *Requires U4 modifier*	Skills Training and Development, per 15 minutes. This code was previously "Developmental Therapy, Individual for Nursing Facility Recipient". 1 unit = 15 minutes	10/20/03
8247A	H2021	Community-Based Wrap-Around Services, per 15 minutes. This code was previously "Developmental Therapy, Individual in Home or Community". 1 unit = 15 minutes	10/20/03

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Obsolete Code	Valid Procedure Code	Description	Effective Date
DEVELOPMENTALTHERAPY SERVICES - continued			
8248A	H2021 *Requires HQ modifier*	Community-Based Wrap-Around Services, per 15 minutes. This code was previously "Developmental Therapy, Group of 2 in Home or Community". 1 unit = 15 minutes NOTE: Since 8248A & 8249A were combined, effective for dates of service on or after 10/20/03, the new rate will be \$2.10 per 15 minute unit	10/20/03
8249A	See H2021 w/ HQ modifier	[Developmental Therapy Group of 3 or More in Home or Community, 15 minute units]	Code Terminated 10/20/03
8250A	H2014 *Requires HQ modifier*	Skills Training and Development , per 15 minutes. This code was previously "Developmental Therapy; Group – 15 minutes". 1 unit = 15 minutes.	10/20/03
8251A	H2014 *Requires HQ & U4 modifier*	Skills Training and Development , per 15 minutes. This code was previously "Developmental Therapy; Group for Nursing Facility Recipient". 1 unit = 15 minutes.	10/20/03
8255A	H2000	Comprehensive Multidisciplinary Evaluation. This code was previously "Developmental Therapy Evaluation – CDC". 1 unit = 15 minutes.	10/20/03
8256A	T1023 *Requires U4 modifier*	Screen for individual in a specific program, project or treatment protocol. This code was previously "Developmental Evaluation; Nursing Facility Recipients". 1 unit = 15 minutes.	10/20/03
INTERPRETIVE SERVICES			
8296A	8296A	Interpretive Services. This code was previously "Interpreter, Non-Certified". 1 unit = 1 hour NOTE: Since 8297A & 8298A were combined, effective for dates of service on or after 8/01/03, the new rate will be \$12.16 per one (1) hour unit. Contact "Idaho CareLine" at 1-800-926-2588 for interpreters in your region.	10/20/03
8297A	See 8296A	[Interpreter, Partially Certified]	Code Terminated 7/31/03
8298A	See 8296A	[Interpreter, Certified]	Code Terminated 7/31/03

Required Modifiers and Definitions

НМ	Less than Bachelor degree level	
HQ	HQ Group setting	
U1	Performed by a Physician	
U4 Services provided to an Individual Living in a No Facility		

If you have questions regarding the information contained in this release, please contact Carolyn Burt-Patterson (208) 364-1827. Thank you for your continued participation in the Idaho Medicaid Program.

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June 4, 2004

MEDICAID INFORMATION RELEASE MA04-17

TO: Mental Health Clinic Service Providers FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: REPLACEMENT OF INFORMATION RELEASE 2003-79

Idaho Medicaid recently implemented procedure code changes in order to comply with the federal regulations associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Information Release 2003-79 was previously sent to providers to inform them of the state-only code conversions to the appropriate CPT and HCPCS codes. The large number of system changes at one time resulted in some errors that need to be corrected. Additionally, a few system adjustments were implemented to ensure accurate payment processing.

Medicaid Information Release MA04-17 supersedes Medicaid Information Release 2003-79.

In most cases, the code changes were converted effective for dates of service on or after October 20, 2003. The exceptions to this effective date are indicated on the table below. Please be aware that some procedure codes require an attached modifier when the provider submits the claim. **NOTE:** *Modifiers must be used in the order listed to pay correctly.* Adjustments and revisions are in the Medicaid provider handbook and are available online at http://www2.state.id.us/dhw/medicaid/provhb/s3_toc.pdf.

Obsolete Code	Valid Procedure Code	Description	Effective Date	
ASSESSMEN	ASSESSMENT AND EVALUATION			
0100M	90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. This code was previously "Medical Report on Past Record Rather Than New Exam". 1 unit = 1 report	10/20/03	
0105M	See 90885	[Narrative Report on Past Record vs. New Exam]	Code Terminated 10/20/03	
0110M	90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers. This code was previously "Medical Report Based on New Exam". 1 unit = 1 report	10/20/03	
0601M	96100	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour. This code was previously "Psychological testing for diagnosis and evaluation". This code no longer allows for a modifier. NOTE: 1 unit = 1 hour (no longer 15 minute unit)	10/20/03	
8193A	T1028	Assessment of home, physical, and family environment, to determine suitability to meet patient's medical needs. This code was previously "Social History and Evaluation". 1 unit = 15 mins.	10/20/03	
8225A	90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. This code was previously "Collateral Contact". 1 unit = 15 minutes.	10/20/03	
9089M	90801	Psychiatric Diagnostic Interview Examination Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03	
9082M	90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication. Physicians should use U1 modifier. 1 unit = 15 minutes.	10/20/03	

Obsolete Code	Valid Procedure Code	Description	Effective Date
PSYCHOTHERAPY SERVICES			
9084M	90804, 90806, or 90808	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face-to-face with the patient. Codes are based on the length of service – use the code that is closest to the actual service time and bill as 1 unit. 90804 = 20-30 mins, 90806 = 45-50 mins, and 90808 = 75-80 mins. Physicians should use the UA modifier.	10/20/03
9085M	90810, 90812, or 90814	Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, face-to-face with the patient. Codes are based on the length of service – use the code that is closest to the actual service time and bill as 1 unit. 90810 = 20-30 mins, 90812 = 45-50 mins, and 90814 = 75-80 mins. Physicians should use the UA modifier.	10/20/03
9083M	90853	Group Psychotherapy (other than of a multiple-family group). This code was previously "Group Medical Psychotherapy". Physicians should use the U1 modifier. 1 unit = 15 minutes	10/20/03
9086M	90857	Interactive group psychotherapy. This code was previously "Interactive Group Medical Psychotherapy". Physicians should use U1 modifier. 1 unit = 15 minutes	10/20/03
9087M	Family psychotherapy (conjoint psychotherapy)(with patient present). Physicians should use U1 modifier. 1 unit = 15 minutes		10/20/03
8105A	H0004 *Requires U4 modifier* Behavioral Health Counseling and Therapy, per 15 minutes. This code was previously "Individual Psychotherapy for Nursing Facility Recipient". Physicians should also use U1 modifier. 1 unit = 15 minutes		10/20/03
8106A	90853 *Requires U4 modifier*	Group Psychotherapy (other than of a multiple-family group). This code was previously "Group Psychotherapy for Nursing Facility Recipient". Physicians should also use U1 modifier. 1 unit = 15 minutes	10/20/03
8107A	90847 *Requires U4 modifier*	equires U4 Nursing Facility Recipient". Physicians should also use U1 modifier	
8117A	90899 *Requires U4 modifier*	Unlisted Psychiatric Service or procedure. This code was previously "Individual Interactive Psychotherapy for Nursing Facility Recipient". Physicians should also use U1 modifier. 1 unit = 15 minutes.	10/20/03
8118A	90857 *Requires U4 modifier*	Interactive Group Psychotherapy. This code was previously "Group Interactive Psychotherapy for Nursing Facility Recipient". Physicians should also use U1 modifier. 1 unit = 15 minutes.	10/20/03

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Obsolete Code	Valid Procedure Code	Description	Effective Date	
MEDICATION	MEDICATION SERVICES			
9081M	90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy – per encounter. 1 unit = 1 visit	10/20/03	
8286A	G0001	Routine venipuncture for collection of specimen(s) – per procedure. This code was previously "Mental Health Drawing Fee". 1 unit = 1 procedure.	10/20/03	
8287A	90782	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular – per procedure. This code was previously "Medication Injection Mental Health Center". 1 unit = 1 procedure	10/20/03	
		Unclassified Drugs. This code was previously "Medication supplied – Mental Health Center".		
8288A	J3490	NOTE: See Medicaid Information Release MA04-06 for specific billing instructions at www2.state.id.us/dhw/medicaid/MedicAide/1003.pdf	10/20/03	
H5200	T1001	Nursing assessment/evaluation. This code was previously "Nursing Service – Office Visit". 1 unit = 15 minutes	10/20/03	
MISCELLANE	OUS CLINIC SERVIC	ES		
8290A	H2014	Skills Training and Development. This code was previously "Partial Care – Mental Health Only". 1 unit = 15 minutes.	10/20/03	
H5300	97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/ adaptive equipment) direct one-on-one contact by provider, each 15 minutes. This code was previously "Occupational Therapy-Individual". 1 unit = 15 minutes	10/20/03	
8299A	NA	[Unlisted Service Mental Health Clinics and A/CDC]	Code Terminated 10/20/03	
8300A	NA	[Psychological Services Performed by PhD Psychologist]	Code Terminated 10/20/03	
9088M	90880	Hypnotherapy, 25-30 minutes. 1 unit = 25-30 minute session	10/20/03	
INTERPRETI	INTERPRETIVE SERVICES			
8296A	8296A	Interpretive Services. This code was previously "Interpreter, Non-Certified". 1 unit = 1 hour NOTE: Since 8297A & 8298A were combined, effective for dates of service on or after 8/01/03, the new rate will be \$12.16 per one (1) hour unit. Contact "Idaho CareLine" at 1-800-926- 2588 for interpreters in your region.		
8297A	See 8296A	[Interpreter, Partially Certified]	Code Terminated 7/31/03	
8298A	See 8296A	[Interpreter, Certified]	Code Terminated 7/31/03	

Required Modifiers and Definitions

UA	Professional Mental Health (by physician)	
U1	U1 Performed by a Physician	
U4	Services provided to an individual living in a Nursing Facility	

If you have questions regarding the information contained in this release, please contact Carolyn Burt-Patterson (208) 364-1827. Thank you for your continued participation in the Idaho Medicaid Program.

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July 1, 2004

MEDICAID INFORMATION RELEASE MA04-32

TO: Pharmacies, Nursing Facilities, and Residential or Assisted Living Facilities

FROM: Kathleen Allyn, Deputy Administrator SUBJECT: RETURNED DRUG FEE PROCESS

Effective 7/1/04, pharmacies will be able to receive a returned drug fee of \$6.00 each time they accept the return of unused medication from an Idaho Medicaid prescription (IDAPA 16.03.09. 817.07). This fee only applies to unused medications returned by either a Nursing Facility or a Residential or Assisted Living Facility. **To qualify for the fee, the value of the unused medication returned from** *each* **prescription must equal \$15.00 or more and must be for dates of service on or after 7/1/04.** Continue to process claims adjustments for these returns using existing procedures.

To request the returned drug fee from the Department, the pharmacy must complete a Returned Drug Fee Request Form.

To access an electronic (Excel spreadsheet) version of this form go to: www2.state.id.us/dhw/Medicaid and click on Information for Providers. Then click on Medicaid Information Releases and click on 2004 Information Releases. Look for MA04-32 in the *Number column*. In the *Subject* column click on the Returned Drug Fee Request Form and it will take you to the Excel version of the form.

To receive a paper copy by fax or mail, please call (208) 364-1994.

The following information must be on the form in order to process your request:

All Provider Information

Participant MID #

NDC #

Quantity Information

- RX # (from the original claim remittance advice)
- Dispensing Date
- Billing Date

Send the completed form to the Department in either the electronic or paper format. Each form submitted must contain claims for only one calendar month, by bill date. The Department will process each form submitted to calculate the returned drug fees due to the pharmacy. The Department will pay the pharmacy a lump sum payment that will show up on the pharmacy's remittance advice report. The Department will mail a copy of the Returned Drug Fee Request Form, with tracking number, to the pharmacy. The tracking number will be the date of the remittance advice that contains the returned drug fee payment.

If you have any questions concerning the information contained in this release, please contact Angela Simon, Senior Financial Specialist for the Bureau of Medicaid Policy, at (208) 364-1994.

Thank you for your continued participation in the Idaho Medicaid Program.

May 18, 2004

MEDICAID INFORMATION RELEASE MA04-33

TO: All Personal Care Services (PCS) Providers and School Districts Providing Medicaid Services

FROM: Kathleen Allyn, Deputy Administrator

SUBJECT: NEW PAYMENT RATES EFFECTIVE JULY 1, 2004

Effective July 1, 2004, Medicaid will make some changes to its reimbursement for Personal Assistance Services (personal care and attendant services). As required by Idaho Code and IDAPA 16.03.09.148, the Department conducted a salary survey to calculate the new rates. The maximum allowable amounts are based on wages and salaries paid for comparable positions within nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs). NOTE: Service provided on or before June 30, 2004, must be billed separately from services provided on or after July 1, 2004. There may be an error in your payment if you do not use separate claim forms.

The new rates are listed below by procedure code.

SUPERVISORY RN CODES:

G9002	Coordinated Care Fee – Maintenance Rate (Agency)	\$ 67.76/visit
G9001	Coordinated Care Fee – Initial (School)	\$ 67.76/visit
T1001	Nursing Assessment/Evaluation (Agency)	\$ 33.02/visit
T1001	Nursing Assessment/Evaluation (School)	\$ 33.02/visit

SUPERVISORY QMRP CODES:

G9001	Coordinated Care Fee – Initial (Agency)	\$ 89.53/visit
H2020	Therapeutic Behavioral Services (Agency)	\$ 29.84/day

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PERSONAL ASSISTANCE SERVICE PROVIDER CODES:

AGENCY PROVIDERS

T1019	Personal Care	\$ 3.43/15 min unit
T1004	Services of a Qualified Nursing Aide	\$ 3.43/15 min unit
S5145	Foster Care, Therapeutic – Child	\$ 71.45/day
S5145 HQ ¹	Foster Care, Therapeutic – Group	\$ 61.39/day per client

INDEPENDENT PROVIDER'S HOME (NO WITHHOLDING)

S5145	Foster Care, Therapeutic – Child	\$ 68.30/day
(Children	under Early and Periodic Screening, Diagnosis, and Treatment P	rogram (EPSDT) only)

S5145 HQ¹ Foster Care, Therapeutic – Group \$50.17/day per client (Children under EPSDT Program only)

HOME AND COMMUNITY BASED SERVICES:

S5125 U2 ¹	Attendant Care Services	\$ 3.43/15 min unit
$T1001 U2^{1}$	Nursing Assessment/Evaluation (Agency)	\$ 33.02

¹ Procedure code modifier

If you have questions about this process, please contact your Regional Medicaid Services office. Thank you for your participation in the Idaho Medicaid Program.

July 1, 2004

MEDICAID INFORMATION RELEASE MA04-34

TO: Providers of Obstetric Services
FROM: Kathleen Allyn, Deputy Administrator

SUBJECT: BILLING FOR ULTRASOUND AND STRESS/NON-STRESS TESTS FOR MULTIPLE PREGNANCIES

Effective for dates of service on or after 7/1/2004, use these guidelines to bill ultrasound and fetal stress/non-stress test procedures for a multiple pregnancy:

76802, 76810, and 76812 - Obstetrical Ultrasound "Add-On" Codes

- ✓ These codes may only be used in conjunction with the primary procedures 76801, 76805 and 76811.
- ✓ Don't use modifier -51 or -59 with these codes.
- ✓ Bill these add-on codes on **one line**, and indicate the total number of additional fetuses in the quantity field.
- ✓ You must document the multiple pregnancy by using an appropriate diagnosis code **or** adding a note in the comments field of the electronic or paper claim to indicate a multiple pregnancy. *Failure to provide this documentation will cause the additional procedures to be denied.*

76816, **76818**, and **76819** – Obstetrical Ultrasounds, and **59020**, **59025** – Fetal Stress and Non-Stress Tests

- ✓ Bill the first fetus on one detail line without modifiers -51 or -59.
- ✓ Bill the same code on **separate** lines for each additional fetus with modifiers -51 and -59 on each line, and enter quantity of "1" for each line.
- ✓ You must document the multiple pregnancy by using an appropriate diagnosis code **or** adding a note in the comments field of the electronic or paper claim to indicate a multiple pregnancy. *Failure to provide this documentation will cause the additional procedures to be denied.*
- ✓ Medicaid will reimburse each additional procedure at 50% of the first procedure.

76815 and 76817

- ✓ Use only once per exam regardless of the number of fetuses.
- ✓ Don't use modifiers -51 or -59.

For questions regarding billing requirements, please contact EDS at 1-800-685-3757. Thank you for your continued participation in the Idaho Medicaid Program.

MEDICAID INFORMATION RELEASE 2004-35

TO: Prescribing Providers, Pharmacists, Pharmacies, Hospitals, and Long-Term Care Facilities

FROM: Randy May, Deputy Administrator

SUBJECT: New Prior Authorization Criteria For Ace Inhibitors and Calcium Channel Blockers Drug Class

Drug/Drug Class: Ace Inhibitors and Calcium Channel Blockers

Implementation Date Effective for dates of service on or after JULY 1, 2004

Idaho Medicaid is implementing an Enhanced Prior Authorization Program for select therapeutic classes including the identification of preferred agents. The Enhanced Prior Authorization Program (EPAP) is designed to provide Medicaid participants the most effective drug at the right price. Beginning July 1, 2004, ACE Inhibitors and Calcium Channel Blockers will be the next drug classes to have new prior authorization requirements. The Pharmacy & Therapeutics Committee recommends allowing prescriber choice of product in these two classes while optimizing utilization of multi-source generics.

Enhanced Prior Authorization drug class	Preferred Agent(s)	Non-preferred Agents^
ACE INHIBITORS	Benazepril (generic only) Benazepril/HCTZ (generic only) Captopril (generic only) Captopril/HCTZ (generic only) Enalapril maleate (generic only) Enalapril maleate/HCTZ (generic only) Fosinopril (generic only) Fosinopril/HCTZ (Monopril HCT®) Lisinopril (generic only) Lisinopril/HCTZ (generic only) Moexipril (generic only) Moexipril (generic only) Moexipril/HCT (Uniretic®) Perindopril (Accon®) Quinapril (Accupril®) Quinapril/HCTZ (Accuretic®) Ramipril (Altace®) Trandolapril (Mavik®)	Capoten® Capozide® Lotensin® Lotensin/HCT® Monopril® Prinivil® Prinzide® Univasc® Vaseretic® Vasotec® Zestoretic® Zestril®
CALCIUM CHANNEL BLOCKERS	Amlodipine (Norvasc®) Bepridil (Vascor®) Diltiazem HCL (generic only) Diltiazem ER capsule (generic only) Diltiazem ER tablet (Cardizem LA®) Felodipine (Plendil®) Isradipine (DynaCirc®) Isradipine CR (DynaCirc CR®) Nicardipine HCL (generic only) NicardipineSR (Cardene SR®) Nifedipine (generic only) Nifedipine ER (generic only) Nimodipine (Nimotop®) Nisoldipine (Sular®) Verapamil HCL (generic only) Verapamil ER tablet (Covera HS® and generic) Verapamil SR (generic only) Verapamil SR (generic only) Verapamil ER capsule (Verelan PM®)	Adalat CC® Calan® Calan SR® Cardene® Cardizem® Cardizem CD® (where multi-source available) Cardizem SR® Dilacor XR® Isoptin SR® Procardia® Procardia XL® Tiazac® (where multi-source available) Verelan®

[^]Use of non-preferred agents must meet prior authorization requirements for brand name products. For prior approval, contact the Medicaid Drug Prior Authorization help desk at (208) 364-1829 or fax a PA request form to (208) 364-1864 to initiate a review and potentially authorize claims. ¹

The Enhanced PA Program and drug class specific PA criteria are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. The determination of medications considered preferred within a drug class is based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes in comparison with other therapeutically interchangeable alternative drugs. A secondary consideration is cost.

In the coming months additional therapeutic drug classes will be added to the Enhanced Prior Authorization (EPAP) program. Please watch future information releases and the Medicaid Pharmacy website at www.idahohealth.org for details.

As always, your support is critical to the success of this Medicaid Pharmacy initiative. Our goal is to partner with you to provide quality, cost-effective health care to your patients. Questions regarding the Prior Authorization program may be referred to Medicaid Pharmacy at (208) 364-1829.

Specific Prior Authorization criteria and fax forms for all drug classes may be obtained from the Department of Health and Welfare Pharmacy Program website at: http://www.idahohealth.org

EDS P.O. Box 23 Boise, Idaho 83707

PRSRT STD
U.S. POSTAGE PAID
BOISE, ID
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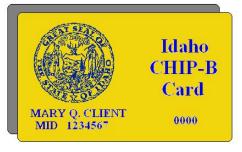
Sample of Idaho CHIP-B Card

CHIP-B provides an affordable, basic health care insurance option for uninsured children who live in families with a gross annual income between 150% - 185% of Federal Poverty Guidelines.

Each eligible CHIP-B participant is issued a plastic identification card. The card looks similar to the Idaho Medicaid ID card, with the child's name and 7-digit medical identification number on the front. The card is yellow and says "Idaho CHIP-B Card" on its face.

Always check eligibility for CHIP-B and Medicaid participants.

See page 1 for more information on the CHIP-B program. Detailed information is included in Information Releases MA04-27, 28, 29, and 30.



MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

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From the Idaho Department of Health and Welfare, Division of Medicaid

August 2004

Clarification on National Drug Codes

For providers who are experiencing difficulties with billing National Drug Codes (NDCs), the following information may be helpful. NDCs are divided into three segments that are generally separated by a hyphen. Like an ICN (internal control number), each segment has a specific meaning:

First segment: 5-digit Labeler Code (code may be 1 to 5 numeric digits in length)

Second segment: 4-digit Product Code (code may be 1 to 4 numeric digits in length)

Third segment: 2-digit Package Size (code may to 1 or 2 numeric digits in length)

A complete NDC consists of 11 digits in a 5–4–2 configuration. If you are looking at your NDC on the box, bottle, vial, etc., check to make sure that it follows the 5–4–2 guidelines.



Even though a manufacturer's NDC may only contain 10 digits, if the NDC is not reported in the 5–4–2 format, the claim processing system cannot determine to which segment the digits apply and does not recognize the number for processing. If one of the segments is not the required length, add a zero to the **beginning** of that segment to create an 11-digit number.

If the first segment only has 4 digits, add a zero to the **beginning** of the first segment.

Example: 0089-0815-21 becomes **0**0089-0815-21

If the second segment only has 3 digits, add a zero to the **beginning** of the second segment.

Example: 49502-685-03 becomes 49502-0685-03

If the third segment only has 1 digit, add a zero to the **beginning** of the third segment.

Example: 50906-0380-6 becomes 50906-0380-06

NDCs should be obtained from the original carton or container. While individual components may have an identification number, it is not the valid manufacturer NDC.

Example: a box of injectables contains 10 syringes. The NDC on the box is the valid NDC, while each syringe will have an identification number relating to the NDC.

Providers also have several excellent information resources available to them regarding NDCs. These include, but are not limited to: drug company representatives, Physician Desk Reference (PDR), their local pharmacy, or the Red Book.

The Look of the Department Web Site Is Changing

The Department's Web site gets a new look and feel. Beginning August 1, you will see a more navigable and user-friendly web site at the new web address of www.healthandwelfare.idaho.gov.

"We are developing our new site to meet customer demands, providing them with information on our services quickly and easily. The new site will improve our ability to speak with a clear and consistent voice across our web pages," says Bill Walker, chief of the Bureau of Public Information and Communications

Helping Consumers Obtain Services

The new structure concentrates on helping consumers obtain services. On the left hand side will be a navigation bar featuring tabs for Children, Families, Health, Medical, Food/Cash/Assistance, and About Us. A customer does not need to know the structure of the Department to find services, but can click on one of the tabs in their area of interest to find help.

As an example, if provider needs to find a change in a Children's Health Insurance Program they can click on the "Medical" tab and access everything pertaining to CHIP including poverty guidelines, benefits under the new CHIP-B program and more. They do not need to know that CHIP is in Medicaid.

An added bonus to the change is that the new Web site is searchable. If you want to find information on a change in Medicaid services enter the key words and you will have a list of all the Information Releases, publications and more about the subject. Each page will have multiple points or 'doors' to services, with the most requested information at the top of each page.

The rest of the page will have a center column for program information and services, with a right hand column for helpful links. One of the key entries in this helpful links column will be a heading that says "I want help with..." with links underneath for most requested services. The links could include such things as getting help with information release, policy, or how to access mental health services.

S, J, and Q Codes

The Idaho Department of Health and Welfare Medicaid Division instituted a new policy for dates of service February 1, 2004 forward concerning S, J, and Q codes. In preparation for capturing NDC information for increased drug rebate monies, the NDC, quantity, units of measure, and billed charge are required on all claims for S, J, and Q codes.

If you are billing **electronically** for S, J, or Q codes for dates of service February 1, 2004 forward, you must enter the 11-digit NDC, quantity, units of measure, and billed charge. Depending on the software used, you can enter the data on a specific NDC tab or in the comments field (header or detail). Without the required information, the claims will be denied. (PES, the Idaho Medicaid software, uses a NDC tab on its claim forms.)

RALF Rule Changes

On March 17, 2004 changes to the Residential or Assisted Living Rules, IDAPA 16.03.22.428.04., went into effect. The changes allow the return of unused or discontinued medication to the dispensing pharmacy for credit when specific conditions are met. Contact your dispensing pharmacy for the conditions under which this is allowed. When medications are returned, the facility must document the return in the log of disposal of medications.

For more information, see Information Release MA04-32 (published in the July 2004 *MedicAide*).

DHW Phone Numbers Addresses Web Sites

DHW Websites www.healthandwelfare.idaho.

Idaho Careline

211 (available in all areas) (800) 926-2588

Provider Fraud and Utilization Review P. O. Box 83720 Boise, ID 83720-0036

(866) 635-7515 (toll free) (208) 334-0675

Email:

~medicaidfraud&sur@idhw.state.id.us (note: begins with ~)

Healthy Connections

Region I - Coeur d'Alene (208) 666-6766 (800) 299-6766

Region II - Lewiston (208) 799-5088 (800) 799-5088

Region III - Caldwell (208) 455-7280 (800) 494-4133

Region IV - Boise (208) 334-4676 (800) 354-2574

Region V - Twin Falls (208) 736-4793 (800) 897-4929

Region VI - Pocatello (208) 239-6260 (800) 284-7857

Region VII - Idaho Falls (208) 528-5786 (800) 919-9945

Spanish Speaking (800) 862-2147

Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations

DME Specialist
Bureau of Care Management
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax
(800) 352-6044
(att: DME Specialist)

PCG

P.O. Box 2894 Boise, ID 83701 (800) 873-5875 (208) 375-1132 Fax (208) 375-1134

Pharmacy

P.O. Box 83720 Boise, ID 83720-0036 (877) 200-5441 (toll free) (208) 364-1829 Fax (208) 364-1864

Qualis Health (telephonic & retrospective reviews)
10700 Meridian Ave. N.
Suite 100
Seattle, WA 98133-9075
(800) 783-9207
Fax (800) 826-3836 or
(206) 368-2765

Qualis Health Website www.qualishealth.org/ idahomedicaid.htm

Transportation Prior Authorization Unit

(800) 296-0509 (208) 334-4990 Fax (800) 296-0513 (208) 334-4979

Ambulance Review

(800) 362-7648 (208) 287-1155 Fax

(800) 359-2236 (208) 334-5242

New CHIP-B Program Up and Running

You may soon see participants of the new Children's Health Insurance Program (Part-B), known as CHIP-B. You will know immediately the participant is enrolled in CHIP-B because their ID card is bright yellow.

CHIP-B is a limited, direct services benefit plan, administered by the State of Idaho that pays for children's primary care services. This program's benefits are limited, so always check eligibility before providing services.

The Department of Health and Welfare launched the new CHIP-B program in July. The first open enrollment period was July 7-16, 2004.

Want to know more? There are several ways to get more information about CHIP-B:

- CHIP-B articles in the June and July issues of the MedicAide newsletter
- Information Releases that provide details about the benefit plan, checking eligibility and billing for CHIP-B services are also found in the June and July issues of the MedicAide Newsletter
- Visit the CHIP website by selecting the "CHIP" link at www.healthandwelfare.idaho.gov

If you need more details after reviewing the information above, the following resources are also available:

For questions about CHIP-B program policies, contact the CHIP Unit at:

1-866-326-2485 (toll-free)

1-208-528-5980 (fax)

For questions about billing for CHIP-B services, contact EDS at:

1-800-685-3757 or in the local Boise area at 383-4310

Surgery for the Correction of Obesity

Surgery for the correction of obesity, including CPT code 43659 (unlisted laparoscopy procedure, stomach) is covered only with prior authorization from the Bureau of Care Management.

Please refer to Section 3 of your *Idaho Medicaid Provider Handbook*, Physician/ Osteopath Program Guidelines, Section 3.2.5.1, for Department requirements concerning surgical procedures to correct obesity. This handbook may be accessed online at: www.healthandwelfare.idaho.gov.

Services that Require Prior Authorization

If you bill for services that require prior authorization, and you need to **void** a claim, here is an important tip to ensure the units are returned to the prior authorization.

On the Adjustment Request Form, include the following information: "Zero out the units" in the "Correct Information for Adjustment" field. If you do not zero out the units, they may not be added back into the prior authorization. If the units are not added back in, you will not be able to receive reimbursement for future services unless the authorizing agency creates another authorization or adds more units to the current authorization.

If you have questions on this issue, please contact EDS at (800) 685-3757 or (208) 383-4310 in the Boise calling area or your local Provider Relations Consultant (names and phone numbers are listed in this *MedicAide Newsletter*) .

MEDICAID INFORMATION RELEASE #MA04-41

TO: CERTIFIED FAMILY HOMES AND RESIDENTIAL AND ASSISTED LIVING

FACILITIES

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: NEW BILLING PROCEDURE FOR ADULT RESIDENTIAL CARE

Effective July 1, 2004, there was a rate increase for code S5140-U2 (Adult Residential Care) for Certified Family Homes and Residential and Assisted Living Facilities that bill this code. All Residential Care providers will receive a letter notifying them of the new rate for each of their clients. If you do not receive a letter for a participant living in your facility, please notify your local Regional Medicaid Services unit. Billing system changes for claims with dates of service on or after July 1, 2004 will be complete by 7/12/04, so providers may submit claims to EDS for this code after that date.

Approval of service by the Regional Medicaid Services unit is still required prior to delivery of service

A prior authorization number is not needed for dates of service on or after July 1, 2004

A prior authorization *number is* needed for dates of service *prior* to July 1, 2004

If you have any questions about the information in this release, please contact Christine Baylis at 208-364-1891. Thank you for your continued participation in the Idaho Medicaid program.

August 1, 2004

MEDICAID INFORMATION RELEASE MA04-43

TO: Mental Health Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: HIGHLIGHTS OF THE RULE CHANGES IN MEDICAID MENTAL

HEALTH SERVICES

This Information Release will summarize the negotiation process used to update rules, highlight key changes, and provide clarification regarding requirements in Medicaid mental health service benefits.

Over the last six months, a group of mental health providers, consumers, advocates and Department staff worked together to negotiate amendments to the temporary rule docket that was presented during the 2004 legislative session. There were a number of changes made to clarify definitions and requirement expectations. The reasons driving this work included the need to address safety issues, respond to consumers' treatment issues, ensure professional standards, and promote consistent business practices. Amendments were made in the rules governing Psychosocial Rehabilitation (PSR) and Mental Health Clinic services. The rules are posted on the web at: http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

While this article does not attempt to itemize all of the amendments, it will address those issues that require clarification regarding requirements.

Medicaid has received a number of phone calls regarding the requirements for physician supervision. This requirement has been a federal requirement since the inception of the Medicaid program but was not specifically described in these rules prior to changes made in December 2003. The reference for this requirement can be found in the State Medicaid Manual at http://cms.hhs.gov/manuals and in the Code of Federal Regulations at 42 CFR 440.90.

(Continued on page 5)

EDS Phone Numbers Addresses

MAVIS

(800) 685-3757 (208) 383-4310

EDS

Correspondence PO Box 23 Boise, ID 83707

Provider Enrollment P.O. Box 23 Boise, Idaho 83707

Medicaid Claims PO Box 23 Boise, ID 83707

PCS & ResHab Claims PO Box 83755 Boise, ID 83707

EDS Fax Numbers
Provider Enrollment
(208) 395-2198

Provider Services (208) 395-2072

Client Assistance Line Toll free: (888) 239-8463

EDS Phone Numbers Addresses

Provider Relations Consultants

Region 1

Prudie Teal 1120 Ironwood Dr., # 102 Coeur d'Alene, ID 83814

prudie.teal@eds.com (208) 666-6859 (866) 899-2512 (toll free) Fax (208) 666-6856

Region 2

JoAnn Woodland 1118 F Street P.O. Drawer B Lewiston, ID 83501

joann.woodland@eds.com (208) 799-4350 Fax (208) 799-5167

Region 3

Mary Jeffries 3402 Franklin Caldwell, ID 83605

mary.jeffries@eds.com (208) 455-7162 Fax (208) 454-7625

Region 4

Jane Hoover 1720 Westgate Drive, # A Boise, ID 83704

jane.hoover@eds.com (208) 334-0842 Fax (208) 334-0953

Region 5

Penny Schell 2241 Overland Avenue Burley ID 83318

penny.schell@eds.com

Burley: Tuesday & Friday (208) 677-4002

Twin Falls: Mon, Wed, Thurs (208) 736-2143 Fax (208) 678-1263

Region 6

Sheila Lux 1070 Hiline Road Pocatello, ID 83201

sheila.lux@eds.com (208) 239-6268 Fax (208) 239-6269

Region 7

Bobbi Woodhouse 150 Shoup Avenue Idaho Falls, ID 83402

bobbi.woodhouse@eds.com (208) 528-5728 Fax (208) 528-5756 (Continued from page 4)

It is important to clarify the requirements for physician involvement in mental health clinics. Based on consultations with the Centers for Medicaid and Medicare and the Idaho Attorney General's office, we have clarified that the role of the physician is chiefly to provide clinical direction and care to the patients.

- The physician must enter into an affiliation with the clinic and the related documentation of the affiliation (contract) must be kept on-site at the clinic.
- The physician must see the patient at least once, prescribe the care (sign the treatment plan), and sign the updates to the plan if they represent any changes.
- The physician must ensure that services provided are safe and efficient and in accordance with accepted medical practice.

The requirement for physician involvement in clinics is not supervision of the individual clinicians who work at the clinic nor does it entail any administrative function.

Patients who receive PSR and/or clinic services must obtain a referral from their Healthy Connections physician when they are part of the Healthy Connections program.

When a potential patient selects a clinic, the clinic must first conduct an Intake Evaluation and then refer the patient to the affiliated medical physician who will establish the medical necessity of mental health clinic services. The medical physician is able to bill a "Psychiatric Diagnostic Interview", code 90801, for this service.

The clinic has thirty days from the time a patient first enters the mental health clinic to develop an individualized treatment plan. The information from the physician's Psychiatric Diagnostic Interview should be helpful in this formulation. The physician, the patient and the clinic staff member must sign the treatment plan. The plan must be updated at least every 120 days after that. The physician should sign the plan anytime the plan changes in type or amount of services or for any other reason the physician specifies.

The work group spent significant effort amending partial care services in order to clarify the intent of this service. Partial care services in the clinic now include specific requirements for eligibility of participants and for provider programming. Effective August 1^{st,} partial care will be available up to thirty-six hours weekly instead of fifty-six hours.

The work group continues to meet together to address various unresolved issues and ongoing challenges affecting Medicaid mental health services.

Other rule changes include the rules governing case management services, now referred to as "service coordination". All service coordination rules are now grouped in one chapter located in IDAPA 16.03.17. These rules are posted on the web at:

http://www2.state.id.us/adm/adminrules/rules/idapa16/0317.pdf

It is highly recommended that all providers read the entire text of the rule section that applies to the services they provide in order to be adequately informed of requirements.

Please direct any questions or concerns regarding this information to Pat Guidry at:

guidryp@idhw.state.id.us

or

3232 Elder Street, Boise, ID 83705-4711

Thank you for your continued participation in the Idaho Medicaid program.

July 1, 2004

MEDICAID INFORMATION RELEASE 2004-23

TO: Prescribing Providers, Pharmacists, Pharmacies, Hospitals, and Long-Term Care Facilities

FROM: Randy May, Deputy Administrator

SUBJECT: NEW PRIOR AUTHORIZATION CRITERIA FOR STATIN DRUG CLASS.

Drug/Drug Class: STATIN

Implementation Date: Effective for dates of service on or after August 1, 2004

Idaho Medicaid is implementing an Enhanced Prior Authorization Program for select therapeutic classes including the identification of preferred agents. The Enhanced Prior Authorization Program (EPAP) is designed to provide Medicaid participants the most effective drug at the right price. Beginning August 1, 2004, statins will be the next drug class to have new prior authorization requirements:

Enhanced Prior Authorization drug class	Preferred Agent(s)	Non-preferred Agents^
• STATIN	Advicor®	• Mevacor®
	• Altocor®	
	• Crestor®	
	• Lescol®	
	Lescol XL [®]	
	• Lipitor [®]	
	Lovastatin-various generic	
	Pravachol®	
	• Zocor [®]	

[^]Use of non-preferred agents must meet prior authorization requirements

Point-of-service pharmacy claims will be routed through an automated computer system to apply PA criteria specifically designed to assure effective drug utilization. Through this process, therapy will automatically and transparently be approved for those patients who meet the system approval criteria. Quantity limits and age criteria will be applicable to all drug products covered by Medicaid (preferred and non-preferred). If your client does not meet age and prescription quantity restrictions you may receive a prior authorization requirement. For those patients who do not meet the system approval criteria, it will be necessary for you to contact the Medicaid Drug Prior Authorization help desk at (208) 364-1829 or fax a PA request form to (208) 364-1864 to initiate a review and potentially authorize claims.

The Enhanced PA Program and drug class specific PA criteria are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. The determination of medications to be considered preferred within a drug class is based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes in comparison with other therapeutically interchangeable alternative drugs and secondarily on cost.

To assist our providers with providing the right care at the right time with the right price the department is presenting the relative cost ranking of the preferred agents net of all rebates in this class. The Department requests that all Medicaid providers consider this ranking as a **secondary** factor when determining the most appropriate drug therapy for their patients.

Lowest to Highest Relative Cost (Cost to Medicaid after rebates)			
LOVASTATIN - generic	100%	(Lowest Cost)	
LESCOL®	140%		
LESCOL XL®	160%		
ALTOCOR®	200%		
ADVICOR®	280%		
LIPITOR®	400%		
CRESTOR®, PRAVACHOL®	410%		
ZOCOR®	450%	(Highest Cost)	

IR MA04-23 continued on page 7

IR MA04-23 continued from page 6

Additional therapeutic drug classes will be added in the coming months to the Enhanced Prior Authorization (EPAP) program. Please watch for further information releases and the Medicaid Pharmacy website at www.idahohealth.org for details.

Brand Name Drug Prior Authorization – Update

To encourage the cost effective utilization of medications covered by Idaho Medicaid, rules governing the Idaho Medicaid pharmacy program include the requirement of prior authorization for brand name drugs when acceptable generic forms exist. (IDAPA 16.03.09.810.01.d).

Additional brand name medications with available generic equivalents will require prior authorization effective **August 1**, **2004**. The list of brand name drugs requiring prior authorization has been updated and reformatted on the Medicaid Pharmacy website (**www.idahohealth.org**).

Brand name PA forms and criteria are also available on the Medicaid Pharmacy website. Prescribers and pharmacy providers are reminded that clients must have failed or be intolerant of a minimum of two equivalent generic medications, documented on a FDA MedWatch form, for consideration of brand name PA approval and payment.

As always, your support is critical to the success of this Medicaid Pharmacy initiative. It is our goal to partner with you in the provision of quality, cost-effective health care to your patients. Questions regarding the Prior Authorization program may be referred to Medicaid Pharmacy at (208) 364-1829.

Attention Service Coordination Providers:

The form to request additional crisis service coordination hours was recently updated. The most current form is dated 6/22/04. You can access the new form online at:

www.healthandwelfare.idaho.gov

Regional Training

EDS Provider Relations Consultants conduct provider billing workshops every month in all seven regions of the state. In the coming months, workshops will be conducted on the second Tuesday of each month from 2:30-3:30 P.M.

Upcoming topics:

August 10 – Accessing and Using Provider Resources

September 14 - Reading and Using the Medicaid Remittance Advice

Please pre-register with the Provider Relations Consultant in your region. You can find EDS consultant contact information in this newsletter.

¹ Specific Prior Authorization criteria and fax forms for all drug classes may be obtained from the Department of Health and Welfare Pharmacy Program website at: http://www.idahohealth.org

EDS P.O. Box 23 Boise, Idaho 83707

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September Office Closure

The Department of Health and Welfare and EDS offices will be closed for the following State holiday:

Labor Day, Monday, September 6, 2004

A reminder that MAVIS (the Medicaid Automated Voice Information Service) is available on State holidays at: (800) 685-3757 (toll-free) or (208) 383-4310 (Boise local)

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