MedicAide
An informational newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **September 2004**

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

New CHIP-B Program Off To A Good Start

Idaho families have a second chance to apply for the new CHIP-B health insurance program from September 1 to September 14. The new open enrollment period coincides with the beginning of school.

The first open enrollment ended July 16, with applications for more than 2,800 children – well below the 5,600 who could enroll in the program. Many of those who applied are not eligible because their families have existing basic health coverage.

CHIP-B is low cost health coverage for Idaho children who don't have basic health coverage and don't qualify for Idaho Medicaid or CHIP-A. Income can be up to 185% of the federal poverty level. CHIP-B costs $15 per child each month. Children up to age 19 within income guidelines may be eligible.

Children who are enrolled in CHIP-B are starting to access health care services. Providers have asked several questions about how the new program works:

Q: Do I need a new provider number for CHIP-B?

A: No, a new provider number is not needed. Idaho Medicaid providers can provide care for children enrolled in CHIP-B under the terms of existing provider agreements.

Q: What services does the CHIP-B plan cover?

A: Fewer services are covered under CHIP-B than under the Medicaid plan. For a complete list of covered services, refer to Information Release 2004-28, which was published in the June 2004 issue of *MedicAide.*

Q: Is there a different fee schedule?

A: No, the reimbursement rate for CHIP-B covered services is the same as the Medicaid rate.

Q: Where do I send CHIP-B claims?

A: Send claims in either electronic or paper format to the same address you use for Medicaid claims.

Q: Are there changes to the billing practices?

A: Yes, there are a few changes. Information Release 2004-28 provides detailed billing instructions. It was published in the June issue of *MedicAide. Two information releases published in the* July issue of *MedicAide provide additional billing 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.

For CHIP billing questions, call EDS toll free at 800-685-3757 or in the local Boise calling area 383-4310.

To find out more about the CHIP-B program, call the CHIP Unit at 866-326-2485.

Quit: U can do it! Cessation Program

Research shows that having health care providers ask about smoking status and urging them to quit doubles a patient's success. Feedback from Blue Cross of Idaho Foundation for Health (BCIFH) first smoking cessation efforts showed that 40 percent of participants want their providers to ask them about smoking more or at every visit. That is why we are asking you to join Blue Cross of Idaho's Foundation for Health smoking cessation efforts.

The program will start August 16, 2004 and is open to all Idaho residents regardless of insurance status.

What Do Health Care Providers Need to Do?
The intervention consists of a combination of three steps:

1. Health care provider guidance;
2. Telephone cessation counseling;
3. Medication that can help patients quit smoking.

Health care providers only need to ask their patients if they smoke and if they are ready to quit. Then they refer the patient to the Quitline via fax or patient instruction. Finally, the physician writes a prescription or non-prescribing providers can help arrange for a prescription or direct the patient to contact their physician. Blue Cross of Idaho Foundation for Health will provide a total of 150 payment vouchers with $10 co-pay for a 30-day supply of medication if the patient has a physician prescription (prescription required for over-the-counter medications).

How the Program Works
Health care providers and their office staff need to ask patient's about smoking and urge them to quit. Providers can then refer patients to Quitline counseling at **1-888-280-2265** in two ways:

1. Send in a fax to the Quit Line on the BCIFH provided referral form. The patient will need to sign a privacy release/referral and then it can then be faxed to the Quitline. In this case, the Quitline makes the first call to the patient.
2. Provide the patient the Quitline number and encourage him/her to call the Quitline. In this case, the patient is responsible for making the first call to the Quitline.

What is Available from "Quit: U can do it!"

- Free **1-888-280-2265** Quitline cessation counseling and information to Idaho residents regardless of insurance status;
- 30-day pharmacological cessation assistance voucher with a patient co-pay of only $10;
- Materials providers can utilize with their patients such as:
  - Patient prompt cards to use in waiting and exam rooms that encourage patients to talk to their provider if they want to quit smoking;
  - Quitline fax referral sheets;
  - Prescription pads.

Contact
For more information or materials for "Quit: U can do it!" contact Marnie Basom at (208) 331-8841 or MBasom@BCIdaho.com. The materials mentioned above will be posted on the Blue Cross of Idaho Foundation for Health website at www.BCIdahofoundation.org closer to the implementation date.

DHW Phone Numbers
Addresses
Web Sites

DHW Websites
www.healthandwelfare.idaho.gov

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

Changing Your Provider Address

The Idaho Medicaid program uses five different address types including one for a contact person.

How can I change my address?
The following information is needed in order to begin a change of address:

- Provider name
- Idaho Medicaid provider number
- Address type to be changed (pay to, mail to, service location, billing service or contact person)
- Effective date of address and/or telephone number change
- Old address (if available)
- New address
- New telephone phone number (if any)
- New contact person (if any)
- Authorized signature and date

A *Change of Address Form* is available in the Forms Appendix of the Idaho Medicaid Provider Handbook or can be requested from EDS (call MAVIS, ask for PROVIDER ENROLLMENT). The form can be either mailed or faxed back to EDS.

What is the difference between the address types?
EDS maintains several types of address on file for enrolled providers:

Pay To: address used for mailing remittance advice and warrant (or warrant stub).

Mail To: address used for mailing the *MedicAide* newsletter, provider resources CD, and other correspondence.

Service Location: address used for mailing prior authorizations. The DHW requires a physical address even if all correspondence is sent to a P.O. box. To change this address, include both the physical address and the P.O. box.

Billing Service: the address of your billing service, if any.

Contact Person: name, address and phone number of specific contact person for provider, if any.

How long should I expect a change to take?
No more than two business days from the date the request is **received** by EDS. If you call to verify that the change was made, wait three business days if the request was faxed and at least 5 business days if the request was mailed.

How do I add another physical service location?
Specify on your request that you want to **add** a service location. Some providers are required to complete additional steps to having a location added. Contact Provider Enrollment for more information.

How soon should I request a change?
All address changes are processed within 2 business days after the request is received regardless of any future date you may request. If you anticipate a change in the future, wait until a week before you want the change to be in effect before mailing or faxing the request.

Requests that include a specific future date are returned and the sender is asked to re-submit the request by mail or fax about a week before the desired change date.

What if I have more than one provider number that requires the same changes?
You may list more than one provider number if the addresses to be changed are the same for each provider.

Attention: All Professional Providers Billing Botox with HCPCS Codes
Re: Reminder of Medicaid Botox Policy

Botox7 Cosmetic, NDC 00023923201, is not covered by Medicaid. Medicaid covers Botox type A and Botox type B *when medically necessary. Use the following* HCPCS (Healthcare Common Procedure Coding System) codes to bill Botox:

- Type A - J0585
- Type B - J0587

The NDC code is *always* required when billing these J codes.

Additional instructions for billing HCPCS codes for drugs and biologicals are available online at: http://www.healthandwelfare.idaho.gov/

Click on Medical, then Medicaid Providers, and MedicAide Newsletter. Scroll down to the June 2004 and October 2003 issues.

Reminder to All Providers

Participants are limited to 12 hours per calendar year for behavioral health and rehabilitative therapy evaluations. This limit includes:

- Occupational Therapy Evaluation
- Physical Therapy Evaluation
- Psychological Evaluation
- Psychiatric Diagnostic Interview
- Developmental Therapy Evaluation
- Speech and Hearing Evaluations

Dentist License Renewal

If you are an Idaho dentist and renew your license on or before 9/30/04, you do **not** need to send or fax a copy of your license renewal to EDS. However, if you renew **after** 9/30/04, you must send or fax a copy of your license renewal to EDS in order to have your provider number reactivated.

The Idaho Board of Dentistry (IBD) will provide an electronic file to EDS on a weekly basis until 10/1/04 of Idaho dentists who have renewed their licenses. EDS will use information in the IBD electronic file to update license information for dentists participating in the Idaho Medicaid program.

If you have any questions, please call EDS Provider Enrollment at 1-800-685-3757.

Prescribing Provider Numbers Billed on Paper Pharmacy Claims

Field 13 on the paper Pharmacy claim is for the prescribing provider number. For paper claims this field should have no more than seven characters. It is a field that reads both alpha and numeric characters.

Since paper pharmacy claims are usually hand written, the scanner has difficulty determining which characters are alpha Os and which are numeric 0s (zeroes). To distinguish between the two characters, numeric 0s (zeroes) must have a slash mark through them.

If the prescribing provider number is more than seven characters, enter it instead in Field 21, Compound Drug Information, and enter the date in field 13 using the MMDDYY format (putting a slash through the 0s).

Prescriber Code (7 characters)
13. Prescriber Code
ABØØ567 - 2 zeros

Prescriber Code (more than 7 characters)
13. Prescriber Code
Ø915Ø4 - date with slashes
21. Compound Drug Information field
ABØØ5678 - prescriber ID

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
601 Poleline, Suite 3
Twin Falls, ID 83303

penny.schell@eds.com
(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

Determining Other Insurance Coverage

The following is adapted from the Idaho Medicaid Provider Handbook, Section 2.4.3.

Before billing Idaho Medicaid, determine if a participant has other insurance coverage. Use MAVIS, a point of service device, an inquiry through EDS billing software (PES) or other vendor software to check other insurance. The system lists the name of the insurance company if it is one of the top 100 companies identified by Idaho Medicaid and the type of coverage. Use the following codes to determine the type of other insurance coverage. If there is other insurance coverage for the services rendered, bill the other insurance carrier first.

TPR coverage codes:

0001	Full Coverage
0002	Full Coverage No Dental
0003	Full Coverage No Dental No Drugs
0004	Full Coverage No Vision
0005	Full Coverage No Dental No Vision
0006	Accident Only Policy
0007	Hospital Only Policy
0008	Surgical Policy
0009	Accident & Hospital Only
0010	Cancer Only Policy
0011	Dental Only
0012	Drug Only
0013	Vision
0014	Medicare Part A
0015	Medicare Part B
0016	Medicare Supplement - No Drug
0017	Full Coverage with Dental, without Drug
0018	Medicare Supplement with Drug
0019	Full Coverage - No LTC
0020	Full Coverage - No Dental - No LTC
0021	Full Coverage - No Drug - No LTC
0022	Full Coverage - No Vision - No LTC
0023	Full Coverage - No Dental - No Drug - No LTC
0024	Full Coverage - No Dental - No Vision - No LTC
0025	Full Coverage - No Dental - No Vision - No Drug
0026	Full Coverage - No Dental - No Vision - No Drug -No LTC
0027	Medicare HMO
0029	Unknown
0038	Air Ambulance Coverage
0039	LTC/Nursing Home Coverage
0040	Full Coverage No Vision No Drug and LTC

Developmental Disability Agency Providers

Effective on or after service date 7/22/04, prior authorization for Developmental Therapy Evaluation, H2000, is no longer required.

Hospital Providers

When billing revenue codes that require a corresponding HCPCS or CPT code, the only valid modifiers are TC, RT and LT. Using other modifiers will cause the claim to be denied. Revenue codes, which are broken into professional and technical components, require the TC modifier.

July 23, 2004

MEDICAID INFORMATION RELEASE 2004-38

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

FROM: Randy May, Deputy Administrator

SUBJECT: STATE MAXIMUM ALLOWABLE COST (SMAC) PROGRAM

Effective August 8, 2004, the Idaho Department of Health and Welfare (DHW) will update the State Maximum Allowable Cost (SMAC) program. The Idaho Department of Health and Welfare has contracted with Myers and Stauffer to provide assistance in establishing and maintaining the State Maximum Allowable Cost (SMAC) program for generic pharmaceuticals.

The update included additions and changes to drugs subject to the SMAC program and the SMAC reimbursement rates for those products. A link to the complete list of the drugs included in the SMAC program can be accessed through the Idaho Medicaid pharmacy website at www.idahohealth.org or link directly at www.mslcidaho.com.

Additional brand name products will require prior authorization beginning **August 1, 2004** for products that have multiple generic equivalents available. A complete list of drugs that require Brand Name prior authorization is available at www.idahohealth.org.

The SMAC Program Will be Updated Quarterly
Idaho Medicaid recognizes that changes in pharmaceutical prices and product availability occur on a regular basis. In order to reflect current market conditions, Idaho Medicaid will obtain and review industry data frequently. In addition, Idaho Medicaid recognizes that the most current and reliable information regarding changes in acquisition cost and product availability will be provided by the pharmacies. Providers are encouraged to inform Myers and Stauffer, Idaho Medicaid's SMAC program contractor, of specific changes in the pharmacy marketplace affecting the SMAC program.

Review of Providers' Inquiries Regarding SMAC Rates
Providers who wish Idaho Medicaid to consider adjustments to SMAC rates or other concerns about the SMAC program may make such a request by contacting Myers and Stauffer. Providers will be asked to provide as much information as possible to assist Idaho Medicaid and Myers and Stauffer in understanding the specific issue being raised and the provider's desired outcome. Helpful information should include but not be limited to drug purchase summaries, invoices, remittance advices, and other such documentation. In the absence of sufficient information to assess concerns about SMAC rates or other aspects of the SMAC program, provider requests cannot be fully considered. Providers initiating requests for review of SMAC rates or other issues may be contacted to request supporting documentation or other information.

Providers are encouraged to contact the Myers and Stauffer Pharmacy Unit to discuss:

- Changes in ability to purchase drugs at or below the applicable SMAC rate
- Changes in product availability
- Questions regarding SMAC rates
- Questions concerning drugs on the SMAC rate list
- How to obtain a copy of the SMAC rate list
- Other questions, comments, or concerns

Contacting Myers and Stauffer
Pharmacies can reach the pharmacy unit of Myers and Stauffer by several methods, including toll free telephone, facsimile, e-mail, Internet or regular mail.

Regular Mail:	Myers and Stauffer LC Pharmacy Unit 8555 N. River Road, Suite 360 Indianapolis, Indiana 46240
Telephone:	800-877-6927 weekdays between 8:00 AM and 5:00 PM (Eastern Standard Time)
Fax:	317-571-8481
E-mail:	pharmacy@mslc.com
Internet:	www.mslcidaho.com

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To receive the appropriate assistance with your question or concern, please indicate (regardless of the method of communication chosen) that you are an Idaho Medicaid pharmacy with a question or concern regarding the SMAC program. If you call and a pharmacy reimbursement analyst is not available, you will be asked to leave a message. You will receive a return telephone call within 24 hours, during the week (Monday-Friday). At this point additional information may be requested to properly evaluate your concern.

Online Contact Information
Comments or questions may also be forwarded to Myers and Stauffer via the Internet at any time by visiting www.mslcidaho.com. This Internet site has been developed exclusively to support the Idaho Medicaid SMAC program. On the site providers will find the SMAC rate schedule and updates, ability to view the current federal upper limits (FUL), frequently asked questions, and online forms to send questions and comments to Myers and Stauffer. Within 24 hours, staff from Myers and Stauffer will respond. Myers and Stauffer can also be reached by electronic mail. To reach Myers and Stauffer by electronic mail, providers may forward inquiries to pharmacy@mslc.com.

September 1, 2004

MEDICAID INFORMATION RELEASE # MA04-39

TO: **All Providers of Adult Developmental Disabilities Services**

FROM: Randy May, Deputy Administrator

SUBJECT:
1. **REVISED ISP FORMAT (Plan of Service):** Information Replaces IR# 2003-05 dated January 17, 2003
2. **PROVIDER STATUS REVIEW process begins September 1, 2004** for plans dated March 2004 as defined in IDAPA 16.03.13.06-07 available online at: http://www2.state.id.us/adm/adminrules/rules/idapa16/0313.pdf
3. **PLAN MONITOR SUMMARIES are required for all Plans of Service developed on or after March 1, 2004**

NOTE: (The information contained in this Information Release reflects training provided by the Regional Medicaid Services Units (RMS) in July and August. All of the new forms and directions that are referenced below are available online at: http://www.healthandwelfare.idaho.gov or you can contact your local RMS office for electronic copies of the forms and for answers to any questions.)

1. Revised ISP format

The Long Term Goal Page of the ISP has been replaced by a Personal Summary Page - effective for all ISP's, (Plans of Service) **developed on or after September 1, 2004**.

- ✓ This page must be updated annually. It includes a narrative report that gives the current status of the participant in a strengths-based description.
- ✓ Topics that must be addressed during the Person-Centered Planning Meeting are identified on the form.
- ✓ The Personal Summary Page should also identify long term goals or needs that fall into one (1) of three (3) outcome areas: independence and. Maintain or enhance quality of life and/or increase or maintain self-determination.

These long term goals should be the basis for the goals identified on the Supports and Services page(s) and objectives on implementation plans. Goal statements describe the outcome of the service or support to assist the person reach a level of greater independence, less support, or maintenance.

Services and Supports are defined in IDAPA 16.03.13. and are available online at: http://www2.state.id.us/adm/adminrules/rules/idapa16/0313.pdf

Clarifications of these definitions are:

Services: Activities **paid** for by the Department that allows the individual to reside safely and effectively in the community.

- ° **Formal Services** are reimbursable and **have objective-based data**, i.e. residential habilitation, developmental therapy, or community-supported employment.

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- **Informal Services** are reimbursable but **do not have objective-based data**, i.e. transportation, service coordination, or durable medical equipment.

Supports: Activities **not paid** for by the Department that allows the individual to reside safely and effectively in the setting of their choice.

- **Formal/Informal Supports: Do not have objective-based data.**

2. Provider Status Reviews

Provider status reviews must be submitted to the plan monitor no later than ten (10) days following the 6 month due date. Residential Habilitation Program coordinators, Developmental Disabilities Agencies, Community Supported Employment, Nursing Services, OT, PT, Speech Therapy when provided through the DDA, and Behavioral Consultation Service providers are required to submit a Status Review to the Plan monitor 2 times per year. The first review is due 6 months after the plan start date and the second is due at the annual person-centered planning meeting. There is no standardized form for the Provider Status Review, but a sample form is available containing the minimum elements of the status review. Providers may continue to use agency forms used to report data monthly, quarterly, semiannually, or annually. The Status Review must include short-term goals identified by the domain. Short term goals should be further identified by:

Formal service – Paid services that have program objectives and data collection is required

Informal services – Paid services/no data collection required

Informal supports – Non-paid activities

Quantifiable measures for behavioral objectives must be reported using the Department's Key identified on the Status Review.

3. Plan Monitor Summary

The Plan monitor summary must be completed 2 times per year, six months after the plan start date and at the annual person-centered planning process. The plan monitor will use the provider status review information to evaluate outcomes of services identified on the plan and initiate action to resolve any concerns. Plan monitors must evaluate the compliance of outcomes for the goals that were projected to be accomplished within the plan year.

Plan monitors must file the Provider Status Reviews and Plan Monitor Summary in the participant file in the agency office 14 calendar days after the signed completion date. The second (annual) provider status reports and plan monitor summary information will be presented during the annual person-centered planning process. Copies of the provider status reviews and the Plan Monitor Summary must be submitted to the Assessor (IAP) with the new Plan of Service for prior authorization of services on the new plan. Services that do have status review information at the time of the annual person-centered planning process will not be included on the new plan until the status review is submitted to the plan monitor.

EX	Plan Date	1st Status Review Due	Plan Monitor Summary Filed
	March 1	*September 11*	*September 25*
	April 30	*November 9*	*November 23*
	May 31	*December 10*	*December 24*
	June 15	*December 25*	*January 8*

All of the new forms and directions that are referenced above are available online at:

http://www.healthandwelfare.idaho.gov; go to "Medical"; then "Medicaid Providers"; then "Information Releases"; scroll to the bottom of the page to *"Attachments".*

You can also contact your local RMS office for electronic copies of the forms and for answers to any questions.

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

September 1, 2004

MEDICAID INFORMATION RELEASE 2004-40

TO: All Hospital-Based Ambulance Service Providers

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: HOSPITAL-BASED AMBULANCE SERVICES PROVIDER BILLING CLARIFICATION

All claims for hospital-based ambulance services **billed on or after September 1, 2004,** may only be billed using out-patient bill type 131. Ambulance services billed using an in-patient bill type will be denied.

Ambulance services must not be billed in conjunction with emergency room charges. They must be billed separately.

If you have questions regarding this information, please contact Angela Simon at 208-364-1994. We appreciate your continued participation in the Idaho Medicaid program.

August 1, 2004

MEDICAID INFORMATION RELEASE 2004-45

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

FROM: Randy May, Deputy Administrator

SUBJECT: NEW PRIOR AUTHORIZATION CRITERIA FOR LONG ACTING OPIOID DRUG CLASS

Drug/Drug Class: LONG ACTING OPIOID

Implementation Date: Effective for dates of service on or after October 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 October 1, 2004, long acting opioids will be the next drug class to have new prior authorization requirements:

Enhanced Prior Authorization drug class	Preferred Agent(s)	Non-preferred Agent(s)^
LONG ACTING OPIOIDS	Avinza®	Duragesic patches®
	Kadian®	Morphine sulfate long-acting
	Methadone	MS Contin ®
		Oxycodone HCl long-acting
		OxyContin®

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

^ Use of any covered product may be subject to prior authorization for quantities or uses outside Food and Drug Administration (FDA) guidelines or indications

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. Specific Prior Authorization criteria and fax forms for all drug classes, including the long acting opioids, are available on the Department of Health and Welfare Pharmacy Program website at: http://www.idahohealth.org

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. **To assist in managing patients affected by these changes, Medicaid will be sending in a separate mailing to prescribing providers whose patients will be affected.**

The Enhanced PA Program and drug class specific PA criteria are based on evidence-based clinical criteria and

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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 Long Acting Opioids 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)	
Methadone	100%
Kadian	260%
Avinza	370%
MS Contin	650%
Morphine Sulfate	740%
Oramorph SR	770%
Duragesic	820%
Oxycontin	1110%

Use of any covered product may be subject to prior authorization for quantities or uses outside Food and Drug Administration (FDA) guidelines or indications. Idaho Medicaid prescription monthly quantity limits for the long acting opioid drug class is included with this mailing.

Educational material regarding the use of long acting opioids in chronic non-malignant pain and methadone dose titration will be provided to all Medicaid pharmacists and prescribers in the August 2004 DUR Discovery newsletter.

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.

A current listing of all the preferred agents by drug class is available online at www.idahohealth.org.

Idaho Medicaid Quantity Limits on Long-Acting Opioids

Drug	Maximum Quantity per Month
Avinza® 30 mg	204
Avinza® 60 mg	136
Avinza ® 90 mg	68
Avinza ® 120 mg	136
Duragesic® 25 mcg/hr	15
Duragesic ® 50 mcg/hr	15
Duragesic ® 75 mcg/hr	20
Duragesic® 100 mcg/hr	40
Kadian ® 20 mg	68
Kadian ® 30 mg	204
Kadian ® 50 mg	68
Kadian® 60 mg	136
Kadian® 100 mg	68
Methadone 5 mg	204
Methadone 10 mg	340
Methadone 40 mg	170
Morphine Sulfate Long Acting 15 mg	102
Morphine Sulfate Long Acting 30 mg	204
Morphine Sulfate Long Acting 60 mg	136
Morphine Sulfate Long Acting 100 mg	68
Morphine Sulfate Long Acting 200 mg	102
MS Contin® 15 mg	102
MS Contin ® 30 mg	204
MS Contin® 60 mg	136
MS Contin® 100 mg	68
MS Contin® 200 mg	102
Oramorph SR® 15 mg	102
Oramorph SR® 30 mg	204
Oramorph SR® 60 mg	136
Oramorph SR ® 100 mg	68
Oxycodone 80 mg long acting	136
Oxycontin® 10 mg	102
Oxycontin ® 20 mg	102
Oxycontin® 40 mg	102
Oxycontin ® 80 mg	136
Oxycontin ® 160 mg	68

EDS
P.O. Box 23
Boise, Idaho 83707

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BOISE, ID
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IDAHO DEPARTMENT OF HEALTH & WELFARE

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)

Scheduled System Outage

EDS is installing a backup generator the last Sunday in September. System outages are planned during the early morning and evening. While no other interruptions are expected, they are possible.

MAVIS, POS, and Pharmacy claims processing will be unavailable during an outage. Please check your weekly RAs for further information. EDS regrets any inconvenience this might cause providers.

Scheduled system outage hours:
Sunday, September 26, 2004
4:00 - 5:00 AM and 6:00 - 7:00 PM

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

MedicAide
An informational newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **October 2004**

In this issue:

1 POS Device Frequently Asked Questions
2 Interactive Claim and Eligibility System Upgrade
3 Claim Appeals
3 Change in Mental Health Services
4 PWC Covered Services
4 Reminder To All Healthy Connections Providers

Information Releases

5 2004-46 New PA Criteria for Pharmacy

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

POS Device Frequently Asked Questions

To help providers use the POS device distributed by the Department of Health and Welfare, the following frequently asked questions are answered.

Q. At my office, we need to dial '9' before making an outside call. Do we also need to dial '9' with our POS device? How do we set that up?

A. If you need to dial a number before making an outside call from your office telephone, you will need to set up the POS device to also dial that number. This is called the Private Automatic Branch Exchange (PABX) code. Most phone systems use the number 9. To set up your POS device, you will change the PABX code to read: **9,** (That is, the number nine followed by a comma.)

Step 1. Begin at the WELCOME screen and press any button. Select **F3** (SYSTEM), **F2** (DEVICE SETUP), and enter the password **000000** (six zeros). Press the green arrow key.

Step 2. Select **F4** (TERMINAL) and verify that the screen displays: **#1/1:**

Step 3. Select **F3** (SLCT), **F2** (NEXT), **F2** (NEXT). The screen should say EDIT TERMINAL. On the next line it should say PABX Code. There should be no number entered for the code at this time.

Step 4. Select **F3** (EDIT) and enter **9 *** (or the number you must dial for outside calls followed by an asterisk.) Press the ALPHA key. This will change the asterisk into a comma. You will now see this displayed: **NEW: 9,**

Step 5. Press the green arrow key to accept the change and select **F4** (EXIT). You will be prompted to cancel or save changes. Select **F2** (OK) and **F4** (EXIT).

Q. I received the error message: NO CARRIER AVAILABLE

A. There are two common causes of this error message. The first is a bad phone line. Check the line by disconnecting the POS device and connecting a telephone. If there is a dial tone, you have a good line. If there is no dial tone, you will need to fix the line.

The second cause is that a '**9**' (or other number) is entered as a PABX code when it is not necessary to dial a **'9'** to get an outside phone line. This error is the opposite of the first question about dialing '**9**' to get an outside line. Follow the above instructions for adding the PABX code. At Step 3, the screen should show **PABX Code** followed by a number. If there is a number, select **F3** (EDIT) and press the green arrow key to delete the PABX number. Select **F4** (EXIT). You will be prompted to cancel or save changes. Select **F2** (OK) and **F4** (EXIT).

Q. After entering the client information and sending the transaction, I received the error message *997 HOST ERROR*. What's the problem?

A. Check to see that the POS device is set to the current date. If it doesn't have the current date, follow these instructions.

Step 1. Begin at the WELCOME screen and press any button. Select **F3** (SYSTEM), **F2**

(Continued on page 2)

POS Device Frequently Asked Questions

(Continued from page 1)

(DEVICE SETUP), and enter the password **000000** (six zeros). Press the green arrow key. The SETUP menu appears.

Step 2. Press the purple NEXT key twice to move through the menu until DATE/TIME appears. Select **F2** (DATE/TIME).

Step 3. Enter the correct **date** using the MMDDYYYY format. As an example, November 5, 2003 would be entered as 11052003. Press the green arrow key to complete the date change.

Step 4. Enter the correct **time** using the HHMMSS format where HH refers to the hour in military time, MM is minutes, and SS is seconds. For example, a time of 8:30 a.m. at zero seconds must be entered as 083000; 3:30 p.m. at 45 seconds must be entered as 153045. Press the green arrow key to complete the change.

Step 5. Press the red **X** key (CANCEL) until you are back to the screen with the date and time. Verify that they are correct.

Q. I swipe the card through the slot but nothing happens. What do I need to do?

A. The card can only be read from the 'Welcome to IDAIM' screen. Make sure that this is the screen that is displaying. If it isn't there, press the red cancel button until the Welcome screen displays. Also, please remember that the slot on the front of the POS device is not activated and does not read the card.

Q. When I try to send an inquiry, there is an error message that says: No Line Available.

A. The common causes of this problem are usually related to the telephone cord such as no cord connected to the POS device, a defective telephone cord between the POS device and the wall jack, a defective telephone line inside the building, or the telephone cord is plugged into a network connection.

Make sure that the telephone cord is connected at both ends and try again. If it still says 'no line', disconnect the POS device and connect a telephone to the line. Listen for a dial tone. If there is no dial tone, the cord is probably defective and needs to be replaced. Replace the cord between the telephone and wall jack with a cord you know is good and re-test with a telephone. If there is a dial tone, disconnect the phone and reconnect the POS device. If there is no dial tone, then you will have to check the phone jack and the telephone line itself.

Interactive Claim and Eligibility System Upgrade

There will be a 8-hour interruption of service for system upgrade and maintenance on November 13-14, 2004.

This will affect all **interactive** transactions:

- eligibility requests
- pharmacies submitting claims

The date and time of the service interruption is:

Saturday – Sunday, November 13–14, 2004

10:00 P.M. – 6:00 A.M. Mountain Standard Time

During the interactive service interruption, batch claims can still be submitted. They will be held for processing until the system is back up.

MAVIS will also be available for client eligibility information.

DHW Phone Numbers
Addresses
Web Sites

DHW Websites
www.healthandwelfare.idaho.gov

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) 455-7163
(208) 455-7244
(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

Claim Appeals

To request a review of a claim denial for reasons other than billing errors or the reimbursement amount for a billed service, submit a written request to the EDS Correspondence Team. Please include the following:

- The provider number
- The reason you feel the claim should have been paid or why you were not properly reimbursed
- Supporting documentation

Please send this information to:

EDS Correspondence Team
PO Box 23
Boise ID 83707

EDS will review the claim, send a written explanation if the claim was processed correctly and will direct you as to your next steps.

If you do not agree with the EDS decision, you can request a review of the denial and/or reimbursement amount of a billed service. Simply send a written request for review to DHW and include the following information with the appeal:

- Copy of EDS' review notice
- Copy of adjustment request form if applicable
- Original claim form and all attachments and supporting documentation
- Copy of RA

Please send review requests to:

Medicaid Claim Appeals
Attn: MAS Unit
P.O. Box 83720
Boise, Idaho 83720-0036

Medicaid staff will review the claim and respond in writing with the final determination.

If you do not agree with Medicaid's decision, you can contact Medicaid at the address listed above with a written request for additional review if you can provide NEW information. Please include the following:

- Copy of Medicaid's review notice
- New information
- Original claim form and all attachments

Any appeals that do not follow these procedures will be returned to the provider.

Submitted by DHW

Change in Mental Health Services

The following is a correction to information published as Information Release MA04-43:

The August 2004 MedicAide Bulletin contained Information Release MA04-43 that addressed highlights of the rule changes in Medicaid mental health services. The article contained a statement that the partial care benefit has been reduced from fifty-six (56) hours to thirty-six (36) hours per week. It is true that the mental health work group recommended the reduction of the partial care benefit limit; however, **the change in the limit for partial care will not be effective (enforced) until Sine Die, 2005 legislative session.** Since we are changing the amount of a Medicaid benefit, we felt that it was best for us not to enforce this change before it was approved by the legislature.

PWC Covered Services

Medicaid developed the Pregnant Women and Children's (PWC) program to help ensure that all women have access to prenatal and postpartum care. The ultimate goal is to ensure the health of mothers and infants.

According to Idaho Medicaid policy, covered services for a female client with PWC coverage are limited to those that are clearly **documented as** meeting one of two criteria:

- Is the condition being treated a **direct result** of the current (or recently completed) pregnancy?
- If the condition is not treated, will it **endanger** the mother and/or fetus?

If either one of these criteria is met, you must use a paper claim form to bill for the services and include justification (e.g., lab reports, chart notes, etc).

Reminder To All Healthy Connections Providers

When submitting a change to or a new Enrollment Form, please send it to the Regional Healthy Connections Office near you. Sending it to a different location could delay the processing of the change. Please contact your local Health Resource Coordinator at the numbers below if you have any questions.

Region 1
1120 Ironwood, Suite 102
Coeur d'Alene, ID 83814-2659
(208) 666-6766
(800) 299-6766
Fax (208) 666-6856

Region 2
1118 F Street
P.O. Drawer B
Lewiston, ID 83501
(208) 799-5088
(800) 799-5088
Fax (208) 799-5167

Region 3
3402 Franklin Rd.
Caldwell, ID 83605-6932
(208) 455-7163
(208) 455-7244
(800) 494-4133
Fax (208) 454-7625

Region 4
1720 Westgate, Suite A
Boise, ID 83704
or: P.O. Box 83720
Boise, ID 83720-0026
(208) 334-4676, opt. 2, 3, or 4
(800) 354-2574
Fax (208) 334-0953

Region 5
601 Poleline Rd., Suite 3
Twin Falls, ID 83301
(208) 736-4793
(800) 897-4929
Fax (208) 736-2116

Region 6
1070 Hiline, Suite 260
P.O. Box 4166
Pocatello, ID 83205
(208) 239-6260
(800) 284-7857
Fax (208) 239-6269

Region 7
150 N. Shoup Street, Suite 20
Idaho Falls, ID 83402
(208) 528-5786 or (208) 528-5766
(800) 919-9945
Fax (208) 528-5756

Spanish Interpretive Service: For the Healthy Connections Program statewide
(800) 862-2147

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
601 Poleline, Suite 3
Twin Falls, ID 83303

penny.schell@eds.com
(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

September 1, 2004

MEDICAID INFORMATION RELEASE 2004-46

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

FROM: Randy May, Deputy Administrator

SUBJECT: **NEW PRIOR AUTHORIZATION CRITERIA FOR ESTROGEN, ORAL HYPOGLYCEMIC, AND URINARY INCONTINENCE DRUG CLASSES**

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 October 1, 2004, Estrogen, Oral Hypoglycemic, and Urinary Incontinence agents will be the next drug classes to have new prior authorization requirements:

Drug/Drug Class: URINARY INCONTINENCE
Implementation Date: Effective for dates of service on or after October 1, 2004

Drug Class	Preferred Agent(s)	Non-preferred Agent(s)^
URINARY INCONTINENCE	Detrol® Ditropan XL® Oxybutynin Oxytrol®	Detrol LA® Ditropan® Flavoxate Urispas®

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

^Use of any covered product may be subject to prior authorization for quantities or uses outside Food and Drug Administration (FDA) guidelines or indications

A current listing of all the preferred agents by drug class and prior authorization criteria is available online at www.healthandwelfare.idaho.gov.

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)	
Oxybutynin	100%
Oxytrol®	430%
Detrol®	470%
Ditropan XL®	620%

Drug/Drug Class: ESTROGENS and ORAL HYPOGLYCEMICS

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

As recommended by the Idaho Medicaid Pharmacy and Therapeutics Committee, the Estrogen and Oral Hypoglycemic drug classes will fall under the Brand Name Prior Authorization criteria. The drugs in these two classes were found to be equally efficacious with moderate side effects; therefore, Idaho Medicaid will designate a wide range of preferred agents in these two classes. Brand Name Prior Authorization requirements are applied to brand name products for which there are at least two FDA "A" rated generic equivalents. The listings below are accurate as of 8/1/04:

Drug Class	Preferred Agent(s)	Non-preferred Agent(s)^
ESTROGENS	Alora® Cenestin® Climara® Esclim® Estraderm® Estradiol Estring® Estrogel® Estropipate Femring® Gynodiol® 1.5mg Menest® Ogen® vaginal Premarin® oral Premarin® vaginal Vagifem® Vivelle® Vivelle-Dot®	Estrace® Gynodiol® (strengths with generics available) Ogen®
ORAL HYPOGLYCEMICS	Acetohexamide Amaryl® Chlorpropamide Glipizide Glipizide ER Glyburide Glyburide micro Prandin® Starlix® Tolazamide Tolbutamide	DiaBeta® Diabinese® Dymelor® Glucotrol® Glucotrol XL® Glynase® Micronase® Orinase® Tolinase®

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. 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. **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 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.

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.healthandwelfare.idaho.gov for details.

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.

EDS
P.O. Box 23
Boise, Idaho 83707

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October Office Closure

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

Columbus Day, Monday, October 11, 2004

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Cynthia Brandt,
Publications Coordinator,
EDS

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or

Becca Ruhl
DHW MAS Unit
PO Box 83720
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Fax: (208) 364-1911

MedicAide

An informational newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **November 2004**

In this issue:

1 Gipson Named Medical Director for Medicaid

1 Interactive Claim and Eligibility System Upgrade

2 SPBU Seeking Recruits

2 New Region 7 PRC

2 Coming Soon to a Regional Office Near You

3 MAVIS, Client Eligibility, and 9-1-1

4 1099 Federal Misc. Information Form

4 Change of Provider Information Form

5 Dental Providers

5 DME Providers

Information Releases

5 2004-51 Hospice Rates

6 MA04-50 Residential Habilitation Supported Living Reimbursement/ Service Level Clarification

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

Gipson Named Medical Director for Medicaid

Dr. Terry Gipson, a long-time Boise internist, family practice physician and psychiatrist, assumed the role of medical director of Idaho's Medicaid program Oct. 4.

Dr. Terry Gipson

"Dr. Gipson brings a wealth of knowledge and experience to Medicaid," says David Rogers, Medicaid Division administrator. "He is a highly qualified physician and respected psychiatrist who brings expertise on mental health issues as well as a depth of experience in day-to-day medicine, hospital care, health insurance and pharmaceuticals. His background as an internist and family practice physician uniquely qualifies him to help deal with the wide range of challenges facing Idaho Medicaid."

"This is a wonderful opportunity to help shape health care in Idaho," says Dr. Gipson. "Medicaid is a very important part of the health care delivery system, so our decisions have a lot of impact not only on individuals, but on everyone in the state — even if they're not Medicaid participants."

Dr. Gipson was associate medical director at Blue Cross of Idaho. He has held the post since 1998. Prior to that he was a psychiatrist in private practice and medical director for the Psychiatric Center at St. Alphonsus Regional Medical Center in Boise.

Story by Ross Mason

Interactive Claim and Eligibility System Upgrade

There will be an 8-hour interruption of service for system upgrade and maintenance on November 13-14, 2004.

This will affect all **interactive** transactions:

- eligibility requests
- pharmacy claims

The date and time of the service interruption is:

Saturday – Sunday, November 13–14, 2004

10:00 P.M. – 6:00 A.M. Mountain Standard Time

During the interactive service interruption, batch claims can still be submitted. They will be held for processing until the system is back up.

MAVIS will also be available for client eligibility information.

Contributed by EDS Systems Support

Small Provider Billing Unit Seeking Recruits

"This program saved us!

Most of our claims were getting denied...

Our representative guided us and taught us what Medicaid needed on its claims."

an SPBU graduate

The Small Provider Billing Unit (SPBU) is looking for providers who bill fewer than 100 Medicaid claims a month, don't use a billing service, and **want to save time and money by billing more efficiently**. The SPBU is recruiting now for their training program. Some of the benefits of joining the SPBU are:

- Comprehensive training in Idaho Medicaid billing procedures
- One-on-one training with an SPBU representative
- Three-phase program lasting up to one year
- Participation in the program is free

As a member of the SPBU program, you will learn how to take advantage of all of the resources on the *Idaho Medicaid Provider Resources CD*. In addition, you will learn how to read an RA, request prior authorization, complete an electronic or paper claim form, verify client eligibility and Healthy Connections, and use the *Idaho Medicaid Provider Handbook* to answer other questions.

If you are interested in joining the SPBU program or would like to learn more, call the Medicaid Automated Voice Information Service (MAVIS) at 1-800-685-3757, ask for *AGENT*. You will be connected with a Provider Services Representative who will take your name, provider number, and phone number. A member of the SPBU will then contact you and get you started in the program.

Submitted by *EDS* SPBU

New Region 7 Provider Relations Consultant

Beginning October 4, Debra Babicz joined the EDS team as the Provider Relations Consultant for Region 7 (Idaho Falls). Debra brings many years of medical practice office management and customer service experience with her. Debra replaces Bobbi Woodhouse, who recently returned to the medical practice environment as a CMA. Please join us in wishing good luck to Bobbi, and welcoming Debra!

Coming Soon to a Regional Office Near You!

EDS Provider Relations Consultants will begin a new series of provider billing workshops starting in November. Workshops will be every-other month, and will cover general Medicaid billing, provider resources, PES software, and more.

The first workshop will be from 2:00-4:00 P.M. on Tuesday, November 9, in all regions except Region 7, which will be from 2:00-4:00 P.M. on Wednesday November 10. Please pre-register with your local Provider Relations Consultant. You can find Consultant contact information in this newsletter on page 5.

Submitted by *EDS* Provider Relations Consultants

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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

MAVIS, Client Eligibility, and 9-1-1

One of the top reasons that claims are denied is that providers have not checked client eligibility for the date of service. Whenever you need help with client eligibility, MAVIS is available to take your call. Providers can rely on the information they receive from MAVIS (the Idaho Medicaid Automated Voice Information Service) to be accurate and up-to-date. In addition, MAVIS is fast, can send a fax with all the requested eligibility information, **and** gives a verification number.

When calling MAVIS to check on client eligibility, you can move quickly through the menu by using the keypad.

Press **9** as soon as you hear MAVIS say *"Good…"* You will by-pass the greeting and introduction as MAVIS jumps to the Main Menu.

Press **1** as soon as you hear MAVIS say *"Main Menu…"* You will by-pass the Main Menu as MAVIS jumps to the Client Information Menu.

You can then either speak or use the keypad to enter the client's identifying information. Whether speaking to a provider service representative or using MAVIS, you always need two forms of client information. Have any two of the following ready:

- client's 7-digit Medicaid Identification Number
- client's date of birth
- client's Social Security number
- client's name (first and last)

Press **1** as soon as you hear MAVIS say *"What kind of…"* You will by-pass the Client Information menu as MAVIS jumps to Eligibility and Healthy Connections Information. Other client information shortcuts are:

2 Other Insurance

3 Lock-in

4 Long Term Care Eligibility

5 Service Limits

6 Prior Authorization Number

After MAVIS has found information on a client, she asks if the caller wants the information faxed. If the answer is YES, MAVIS asks for the fax number and then returns to Eligibility to collect any other requests. At the end of the call, MAVIS creates one fax that includes eligibility dates, Healthy Connections participation, special programs (such as Medicare or CHIP-B), and sends this within seconds to the caller's fax number. MAVIS makes three attempts to fax the requested information to the provider.

Call MAVIS at 1-800-685-3757, 24 hours a day, 7 days a week.

Submitted by *EDS* Provider Relations Team

1099 Federal Miscellaneous Information Form

Providers are reminded that the 2004 tax year is coming to a close. Please verify that the provider name and mailing address on your most recent RA is correct. After the first of the year, the federal 1099 form will be sent to the current name and address on file with *EDS*.

Avoid delays in receiving the 1099 form by ensuring that *EDS* has current information on file. Please use the attached Change of Provider Information Authorization Form. It is also available in your Idaho Medicaid Provider Handbook Forms Appendix. The provider must sign the form to authorize a change in the pay-to name or address, or the tax ID number.

Make it a routine practice to notify *EDS* Provider Enrollment whenever changes are made to phone numbers, mailing and billing addresses, names of group members, W-9 changes, and banking information for electronic funds transfer (EFT).

Change of Provider Information Authorization Form

Provider Number:	**Provider Name:**
Date requested information is effective:	
Please change the information for the following name(s) or address(es): _____ Pay-to Includes RA & check _____ Mail-to Includes correspondence _____ Service Location(s) Physical address change or add	
Old Name	New Name (attach a signed W-9 with effective date if Pay-To name is changing)
Old Address:	New Address:
Old Telephone Number:	New Telephone Number:
Old Tax ID Number:	New Tax ID Number: (attach a signed W-9 with effective date)
Additional Comments	
Provider Signature: **Date Signed:**	

Mail to: EDS
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: EDS
att. Provider Enrollment
(208) 395-2198

Submitted by *EDS* Financial Team

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
601 Poleline, Suite 3
Twin Falls, ID 83303

penny.schell@eds.com
(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
Debra Babicz
150 Shoup Avenue
Idaho Falls, ID 83402

debra.babicz@eds.com
(208) 528-5728
Fax (208) 528-5756

September 22, 2004

MEDICAID INFORMATION RELEASE #2004-51

TO: ALL HOSPICE PROVIDERS

FROM: Leslie M. Clement, Acting Deputy Administrator

SUBJECT: HOSPICE RATES

Effective for dates of service on or after 10/01/04, Medicaid has revised its hospice rates as follows:

Revenue Code/Description	Rural	Urban Ada/Canyon County
651 – Routine Care	$118.49	$120.59
652 – Continuous Care	$690.91	$703.15
655 – Respite Care	$129.69	$131.49
656 – General Inpatient Care	$524.50	$533.18

If you have already been paid at the previous rate for dates of service on or after 10/1/2004, you can submit claim adjustments to correct your reimbursement to the new rate.

The Hospice cap will be $19,635.67.

If you have any questions, please contact Sheila Pugatch at (208) 364-1817.

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

ATTENTION: Dental Providers

RE: Billing Current Dental Terminology (CDT) codes D1110 and D4910

The following guidelines will clarify the correct billing of CDT codes D1110 and D4910.

The Current Dental Terminology (CDT) code D1110, is defined by the American Dental Association as "A dental prophylaxis performed on transitional or permanent dentition that includes scaling and/or polishing procedures to remove coronal plaque, calculus and stains." D1110 is allowed every 6 months.

If your client needs this procedure more frequently, request a dental Prior Authorization using the guidelines found in Information Release (IR) 2003-87, issued 10/15/2003. This IR is available online. Go to www.healthandwelfare.idaho.gov. In the *'I want help with...'* column, select Medicaid Provider Information. In the *Other Resources* column, select Information Releases. Scroll down to MEDICAID INFORMATION RELEASE 2003-87 and select.

CDT code D4910 is limited to every 3 months. **This code should only be used for clients who have completed active (surgical or nonsurgical) periodontal therapy.** Please refer to the CDT 4 manual for further clarification.

ATTENTION: DME Providers

RE: Car Seats

To bill car seats for persons over the age of 4, use the code T5001 (positioning seat for persons with special orthopedic needs, for use in vehicles).

November 1, 2004

MEDICAID INFORMATION RELEASE MA04-50

TO: **Residential Habilitation Agencies, Targeted Service Coordinators, and Developmental Disability Agencies**

FROM: Leslie Clement, Acting Deputy Administrator

SUBJECT: RESIDENTIAL HABILITATION SUPPORTED LIVING REIMBURSEMENT/SERVICE LEVEL CLARIFICATION

Medicaid Information Release MA04-50 supercedes Medicaid Information Release 2003-82 and Informational Letter 2004-44 (including attachment #2 Policy Clarification)

SUPPORTED LIVING ACUITY-BASED LEVELS OF SUPPORT

New applications for supported living received on or after October 1, 2004, and annual plans due on or after January 12, 2005, will be authorized using the following criteria. Plan implementation will follow the existing timeframes under the Adult DD Care Management business model:

- Plan Development for January plans will occur during the month of November, and
- Review and Authorization of services for January plans will occur during the month of December.

High Support
H2022 Daily Rate - Blended Staff - $221.12/day – 24 hours/day supported living service

Participants must meet one of the SIB-R Support Levels of Pervasive or Extensive described below:

> **SIB-R Support Score 1-24, SIB-R Support Level Pervasive** – "Individuals require pervasive or highly intense levels of support and supervision. This level of support is provided in all circumstances and requires highly intense personal supervision and related levels of support at all times."
>
> **SIB-R Support Score 25-39, SIB-R Support Level Extensive** – "Individuals require extensive or continuous support and supervision."

Additionally:

- Providers receiving reimbursement under High Supports are required to provide both group and one-on-one supported living services. Plans must identify hours per day/week of group and one-on-one supported living services.
- The blended staff rate includes a combination of one-on-one and group supported living.
- No home and community-based developmental therapy services, center-based developmental therapy services, or adult day care services will be authorized for a participant receiving this service.
- Non-medical transportation is included in this daily rate and will not be authorized separately.

Intense Support
H2016 Daily Rate - 1:1 Staff - $263.36/day – 24 hours/day supported living service

The intense support level is for those exceptional individuals who require intense one-on-one support. These individuals will be evaluated on a case-by-case basis using the following support criteria. At the time of the participant's annual review, functional/behavioral assessment, and status review, their records documenting habilitation interventions and progress made during the preceding year will be reviewed to determine the continuing need for this level of intense behavioral support.

Participants must meet one or more of the criteria described below to qualify for Intense Support.

1. **Criminal/Aggressive Behaviors**

   A. Participants with recent felony convictions and/or charges for offenses related to the serious injury/harm of another person or participants charged with such a felony. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration.

   B. Participants with a history of predatory sexual offenses and that are at high risk to re-offend based on a

(Continued on page 7)

(Continued from page 6)

sexual offender risk assessment completed by an appropriate professional.

C. Participants with a documented history of serious aggressive behavior showing a pattern of causing harm to themselves or others. (Note: this level of service is not available for participants exhibiting episodic aggressive behavior; in these cases, crisis intervention services should be utilized.) The participant's serious aggressive behavior must be such that their threat or use of force on another reasonably makes that person fear bodily harm; in addition, the participant must have the capability to carry out such threats. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others, as identified in the Extenuating Circumstances form.

2. Complex Medical Conditions
Participants with chronic or acute medical conditions that are so complex or unstable that one-on-one staffing is required to provide frequent interventions and constant (24 hours/day) monitoring. Without these interventions and monitoring the participant would require placement in a nursing facility, hospital, or ICF/MR with 24 hour on-site nursing. This requires medical documentation verifying the existence of the complex medical condition(s) and indicating the need for this level of service.

Additionally:

- Participants authorized for Intense Supports must receive one-on-one staffing at all times.
- No home and community based developmental therapy services, center-based developmental therapy services, or adult day care services will be authorized for a participant receiving this service.
- Non-medical transportation is included in this daily rate and will not be authorized separately.

Hourly Support
H2015- U8 $12.72/hour for individual supported living services, and
H2015-U8 HQ $7.48/hour for group supported living services

Participants who do not meet either the High or Intense Support criteria may receive hourly supported living services according to their assessed needs. Hourly supported living services will only be authorized when a participant is actually receiving these services. Plans must identify the hours per day/week that a participant is engaged in other paid services, unpaid/informal supports, and time alone. Hourly services are billed with the following procedure codes:

Home and community based developmental therapy services and center-based developmental therapy services will be authorized only ***for individuals who require hourly supported living.*** For these individuals, all developmental therapy services, in combination with OT, Adult Day Care, and IBI, is limited to 30 hours per week.

Conditions for All Supported Living Levels

- Community integration goals must be addressed in all supported living plans. Services are expected to provide for the following outcomes: maintained or enhanced independence, quality of life, and self-determination. When possible, participants will be expected to transition to lesser supports as these outcomes are attained.
- The 21-day advance PA for higher reimbursement during the temporary absences of roommates is only available to participant's receiving hourly supported living.
- Staffing ratios must meet the individualized needs of each participant.
- The Independent Assessment Provider (IAP) may approve plans that fall outside of their level of support budget range without pending them to the Care Manager for participants meeting the criteria for High or Intense Support. The IAP will pend plans that do not contain sufficient documentation to support the need for Intense Support. If a participant doesn't qualify for either High or Intense Support and the IAP cannot negotiate an hourly plan, the plan pends to the Care Manager.

We will issue another Information Release in the December MedicAide that will address reimbursement for those participants who are in school and for those participants who are receiving supported employment services.

If you have any questions concerning the information contained in this release, please contact Jean Christensen, Manager, Behavioral Health, Bureau of Care Management at (208) 364-1828.

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

EDS
P.O. Box 23
Boise, Idaho 83707

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

November Office Closures

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

Veterans Day, Thursday, November 11, 2004

Thanksgiving Day, November 25, 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

MedicAide
An informational newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **December 2004**

In this issue:

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2 Healthy Connections Referrals for Certain Dental Services

2 Attention Vision Providers

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3 2004-52 Disenrollment Of Healthy Connections Enrollees From Your Practice

4 MA04-54 Billing Dialysis Claims

5 MA04-55 Clarification Of Medicaid Reimbursement Policy for Billing the Components of the Global Surgical Procedure Codes

6 MA04-56 Residential Habilitation Agencies, Targeted Service Coordinators, and Developmental Disability Agencies

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

Hospital, Outpatient, and Professional Providers Billing Medications With HCPCS

The Idaho Medicaid program recovers millions of dollars every year through the drug rebate program. In the last year, over $30 million was rebated by drug manufacturers whose drugs were used by Medicaid clients. Using drug claim information from paid claim history, each manufacturer is contacted and a rebate is requested. To do this, it is important to have accurate drug claim information or the manufacturers can dispute the rebate.

To improve the recovery rate and save money for Idaho taxpayers, providers billing HCPC codes (J Codes/Q Codes) must include all required NDC information either on the appropriate electronic screen or on the NDC Detail Attachment for paper claims. If an invalid NDC is used, the claim will be voided or adjusted.

Before completing your claim, confirm how the NDC is set up for units and measurements in the Idaho Medicaid system. This can be done through:

- MAVIS
- State website at: www.healthandwelfare.idaho.gov
- Calling your local PRC
- Calling the MAVIS and asking for *AGENT*

When completing the claim:

- Use the NDC number as it appears on the product administered
- Complete all required fields for NDC information when billing electronically or on paper including: NDC (11-digit number), units, basis of measurement (gram, milliliter, or unit)
- Verify that the correct unit or basis of measurement is being billed for that NDC (gram, milliliter, or unit)
- Verify that the number of units billed for that NDC has the correct conversion for the units billed on the HCPC code. It is highly unlikely that the units on the HCPC code will be the same as on the NDC.

Example

The provider has dispensed Gemzar. The HCPC is J9201 (each unit is equal to 200mg) The equivalent NDC is 00002 7502 01 (which is set up for a vial; strength is 1 gram or 1000mg; and unit is each).

The provider bills with HCPC J9201 for 2000mg. To complete the NDC Detail Attachment, the provider needs to convert the J Code unit to NDC units and enters:

- NDC is **00002 7502 01**
- Number of units is **2**
- Basis of measurement is **unit**

In this example, 10 units of the J code equals two units of the NDC code (10 x 200 = 2000mg; each vial is 1 gram).

Submitted by *EDS* Drug Rebate Team

Healthy Connections (HC) Referrals for Certain Dental Services

Basic dental care, performed in the dentist's office does not require a Healthy Connections referral. However, should an Idaho Medicaid client on Healthy Connections seek services for oral surgery or dental care to be performed in a hospital (in-patient or out-patient setting) or in a free standing ambulatory surgical center, a Healthy Connections referral must be obtained in advance from the client's Healthy Connections (HC) provider. **Only the client's HC provider can issue the Healthy Connections referral.**

When you verify a client's eligibility using MAVIS, PES software or a POS device, the HC provider's information will be available, if the client is on Healthy Connections. If the HC provider does not have hospital privileges at the facility where the procedure is to be performed, he/she will need to send a referral to a provider with privileges to cover the pre-operative physical exam. Once the HC referral is secured please forward a copy on to the appropriate providers (hospital, anesthesiologist, physician performing the pre-operative examination if other that the HC provider) to bill for their services.

If you have any questions regarding this information please contact your Regional Health Resources Coordinator. For the phone number of your regional Healthy Connections office, see the contact information on this page.

Attention Vision Providers

Problems with the Medicaid Automated Voice Information Service (MAVIS) giving in-correct limitation information for vision services were corrected on October 14, 2004. Please use MAVIS to determine whether Medicaid clients have exhausted their vision benefit.

You can get service limits by requesting 'Client Information' from the main menu and then 'Service Limits'. You can also press 9 to get the main menu as soon as you hear MAVIS say "Good..." then press 1 for client information and then 5 for service limits. It is no longer necessary to speak to an agent to obtain service limitation information.

Submitted by *EDS* Provider Services

Billing Unlisted HCPC/CPT Codes

To shorten the time it takes for your claim to process through the system, be sure to use the HCPC or CPT that best describes the service provided. Using unlisted or dump procedure codes results in slower claims processing since there is no specific price on file for these codes and they must be manually reviewed and priced by either EDS or DHW.

If you are not able to find a specific code for the service provided, then an unlisted or dump code can be used. It is important to include a descriptive and legible report for all unlisted/dump CPT codes and an invoice for all unlisted/dump HCPC codes listed on the claim. Invoices should contain a description matching what is listed on the claim form **and** a clearly identifiable price for the item billed. Invoices that list a "case", "box", or "package" quantity and price should provide pricing information for a single component to allow the pricing of an individual item billed on the claim form.

DHW Phone Numbers
Addresses
Web Sites

DHW Websites
www.healthandwelfare.idaho.gov

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
Regional Health Resources Coordinators

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

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

Region III - Caldwell
(208) 455-7163
(208) 455-7244 (Spanish)
(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) 528-5766
(208) 528-5786
(800) 919-9945

Spanish Speaking (statewide)
(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

November 1, 2004

MEDICAID INFORMATION RELEASE 2004-52

TO: **All Healthy Connections (HC) Providers**

FROM: Leslie M. Clement, Acting Deputy Administrator

SUBJECT: DISENROLLMENT OF HEALTHY CONNECTIONS ENROLLEES FROM YOUR PRACTICE

Effective December 1, 2004, Medicaid policy will change regarding when a Healthy Connections provider may disenroll a participant from their practice. Our current policy allows providers to notify an enrollee when they wanted to disenroll him/her with or without cause. Providers are also required to copy us so that we may process the disenrollment request.

Changes in the Code of Federal Regulations related to Medicaid Managed Care Programs (42 CFR 438.56 (b)(1)(2)(3)) requires that the State contract with the Primary Care Provider (PCP) must:

1. Specify the reasons for which the Primary Care Case Manager (PCCM) may request disenrollment of an enrollee; and
2. Provide that the PCCM may not request disenrollment because of:
   a. a change in the enrollees health status; or
   b. the enrollee's utilization of medical services; or
   c. diminished mental capacity; or
   d. uncooperative or disruptive behavior resulting from his/her special needs, except where his/her continued enrollment with the PCP seriously impairs the PCP's ability to furnish services either to the enrollee or other enrollees (patients); and
3. Specify the methods by which the PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

To meet these requirements, our policy effective December 1, 2004 regarding provider disenrollment of a Medicaid HC enrollee will be the following:

1. The enrollee and the Regional Health Resources Coordinator must receive written notification if the PCCM requests disenrollment for any of the following reasons:
   a. The enrollee fails to follow treatment plan
   b. The enrollee misses appointments without notifying provider (missed appointment policies for Medicaid participants must be the same as for all other patients)
   c. The enrollee/PCP relationship is not mutually acceptable (for instance disruptive or uncooperative behavior not due to the enrollees special needs)
   d. The enrollee's condition would be better treated by another provider (except for 2.d. above)
   e. The PCP has moved and/or is no longer in practice
2. The written notice from the provider must give the enrollee the reason for the request for disenrollment.
3. Disenrollment requests for other than the reasons listed above must be approved by the Regional Health Resources Coordinator prior to notifying the enrollee.
4. Requests for disenrollment must be sent to the Regional Health Resources Coordinator at least thirty (30) days prior to the requested disenrollment date. All disenrollment will be dated the first of the next month after the thirty days have elapsed.

If you have any questions regarding these changes in policy please contact your Regional Health Resources Coordinator.

IDAHO MEDICAID PROVIDER HANDBOOK:

This information release does **not** replace information in your Idaho Medicaid Provider Handbook.

December 1, 2004

MEDICAID INFORMATION RELEASE MA04-54

TO: Free-Standing Dialysis Facilities

FROM: Leslie Clement, Acting Deputy Administrator

SUBJECT: BILLING DIALYSIS CLAIMS

Idaho Medicaid is pleased to announce that we are now able to accept Type of Bill 721, 722, 723, and 724 for dialysis claims. This will facilitate the crossover billing from Medicare. The following revenue codes and procedure codes to bill for dialysis services are acceptable:

Revenue Code	Corresponding HCPCS Code (if applicable)
270 Supplies	
272 Sterile Supplies	
634 EPO < 10,000 Units	Q4055 (Other Q codes for EPO prior to 04/01/2004)
635 EPO >= 10,000 Units	Q4055 (Other Q codes for EPO prior to 04/01/2004)
636 Drugs requiring detailed coding	Correct HCPCS injection code
821 Hemodialysis/Composite Rate	90999
831 Peritoneal/Composite Rate	90945 or 90947
841 CAPD/Composite Rate	90945 or 90947 and 90993
851 CCPD/Composite Rate	90945 or 90947 and 90993
881 Ultrafiltration	
882 Home Dialysis Aid Visit	

The G codes G0308–G0327 effective January 1, 2004 and implemented by Medicare on October 18, 2004 for managing patients on dialysis with variable payments based on the number of visits provided within each month should be used for services performed in an outpatient setting. Only one G code should be billed per month for the services performed in that month. Another billing requirement is to put the service date on each detail line (form locator 45 of the UB92). The FROM and THROUGH dates of service at the header (form locator 6 on the UB 92), must match the total days billed at the detail level.

EXAMPLE: If the detail dates of service are:

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	46 SERV. DATE
821	Hemodialysis/Composite	$200.00	01/03/2004
821	Hemodialysis/Composite	$200.00	01/10/2004
821	Hemodialysis/Composite	$200.00	01/20/2004

The header dates of service must be:

6. STATEMENT COVERS PERIOD	
FROM	THROUGH
01/03/2004	01/20/2004

Thank you for your patience while system changes were being made to accommodate this billing method. We appreciate your continued participation in the Medicaid program. If you have questions concerning billing for these services, please call EDS at 1-800-685-3757 or locally at 383-4310.

IDAHO MEDICAID PROVIDER HANDBOOK:

This Information Release replaces information in the following section of your Idaho Medicaid Provider Handbook: Section 3.6.5 Freestanding Dialysis Units of the Hospital Service Guidelines dated 6-1-2004.

EDS Phone Numbers

Addresses

MAVIS

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

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November 1, 2004

MEDICAID INFORMATION RELEASE MA04-55

TO: Physicians and Hospitals

FROM: Leslie Clement, Acting Deputy Administrator

SUBJECT: CLARIFICATION OF MEDICAID REIMBURSEMENT POLICY FOR BILLING THE COMPONENTS OF THE GLOBAL SURGICAL PROCEDURE CODES: PRE-OPERATIVE, INTRA-OPERATIVE AND POST-OPERATIVE

Definition of a Global Surgical Package

The CIGNA Medicare Part B Provider Manual describes a **Global Surgical Package** as "a single fee paid for pre-operative, intra-operative and post-operative services." This means payment of the global fee for the procedure includes all services necessary to prepare for, provide for, and recover from the procedure.

Modifiers Used to Bill the Components of the Global Surgical Package

The American Medical Association's (AMA) CPT Manual specifies three modifiers to use when billing the components of a global surgical package:

- modifier 54 intra-operative care (surgical care only),
- modifier 55 post-operative care, and
- modifier 56 pre-operative care.

In preparation for this information release, the Department reviewed its current pricing methodology and claims processing of the Global Surgical Package and verified that Medicare and the American Medical Association's guidelines are followed.

Claim Denials and Findings:

1. The majority of the denied claims are due to improper billing for the global surgical package when the physician does not provide the post-operative care. Modifier 56 and/or modifier 54 are not being used appropriately.
2. Hospital Emergency Room providers routinely bill the global surgical code when there is no intent to furnish the post-operative care.

NOTE: The Department recommends that all hospital emergency room providers bill the procedure code with modifier 54 (surgical care only). If the client returns to the emergency room for follow-up care, then the hospital provider may bill with the original surgical procedure code with modifier 55 (post-operative care).

3. Services performed during the post-operative period which are directly related to the surgery (i.e. suture removal) were billed with an Evaluation and Management (E & M) code, instead of the original surgical code and modifier 55. Supporting documentation was not included with the claim. Claims are denied when supporting documentation is not included with the claim and the E&M codes are used incorrectly.

In an effort to assure both the surgeon and local practitioner are paid when splitting the surgical care rendered, the Department will adhere to the following requirements:

Modifiers for physicians to use

1. Use **modifier 54** when billing for pre-operative and intra-operative care.
2. Use **modifier 55 when billing for post-operative** care (i.e. returns to Emergency Room for suture removal). This modifier pays at 20% of the global fee to be allowed once per surgical procedure.
3. Use **modifier 56** for pre-operative management only. This is an informational modifier and will not affect provider's reimbursement.

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Please refer to the Surgery Guidelines and Appendix A of the most current CPT Manual.

NOTE: If a physician bills a surgical procedure with a modifier 55 (post-operative care), and the surgeon has already been paid the global surgical fee, the claim for the global surgical package will be recouped by the Department. The surgeon can then re-bill the global surgical package with a modifier 54.

Local practitioner assuming post-operative care for an out-of-area provider

Use modifier 55 when billing for postoperative care with the same surgical CPT code billed on the original surgical claim.

Billing E&M codes

Use a ***modifier 24*** with the appropriate E&M code when billing for services during a post-operative period when the service is:

- unrelated to the surgical diagnosis
- a treatment of an underlying condition
- a complication(s) resulting from the surgery
- an added course of treatment which is not part of the normal recovery from surgery

NOTE: E & M codes cannot be billed with a modifier 55.

The primary diagnosis for the provider billing for unrelated postoperative care must reflect the client's current problem and support the attached explanation. Providers are required to keep supporting documentation on file for audit purposes.

If you have any questions regarding these billing requirements, please contact EDS at 383-4310 (in Boise) or 1-800-685-3757. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK:

This information release does **not** replace information in your Idaho Medicaid Provider Handbook.

December 1, 2004

MEDICAID INFORMATION RELEASE MA04-56

TO: **Residential Habilitation Agencies, Targeted Service Coordinators, and Developmental Disability Agencies**

FROM: Leslie Clement, Acting Deputy Administrator

SUBJECT: **1. RESIDENTIAL HABILITATION SUPPORTED LIVING BILLING INSTRUCTIONS FOR DD AND ISSH WAIVER PARTICIPANTS ATTENDING PUBLIC SCHOOL**

2. BILLING AND ADDENDUM PROCESS CLARIFICATIONS FOR MEDICAID INFORMATION RELEASE MA04-50

1. Supported Living Daily Rate for DD and ISSH Waiver Participants Attending Public School

As a result of some provider concerns about hourly billing for participants who meet the High or Intense Support criteria and attend public school, Medicaid has developed an adjusted daily rate for these participants. Providers can submit

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plan addendums for these participants to request a change to daily rate reimbursement for dates of service on or after 1/1/05. Two billing codes have been designated for use in billing the daily supported living rates. Procedure code H2016 can accommodate multiple reimbursement rates. For this procedure code, the prior authorization will contain a narrative description in the comment field that reflects the prior authorized service, number of approved days, and reimbursement rate. Procedure code H2022 is reserved for billing the daily rate for participants who require High Support.

For participants receiving High Support and attending public school, bill the following:

School Days	Procedure Code - H2016	$175/day
Non-School Days	Procedure Code - H2022	$221.12/day

For participants receiving Intense Support and attending public school, bill the following:

School Days	Procedure Code - H2016	$208.50/day
Non-school Days	Procedure Code - H2016	$263.36/day

These rates are based on an annualized prior authorization amount for the number of school days at the reduced rate and the number of non-school days at the full rate. The school rate must be billed for all days the participant is in school for 3 hours or more. Additional non-school days will be prior authorized to accommodate minor fluctuations in attendance based on historical absenteeism and related data for each participant. Significant changes in school attendance that impacts the hours needed for supported living will be addressed through the addendum process.

It is the responsibility of the school district to provide the services necessary to allow a participant to access educational opportunities. However, if a provider receives communication from the school that a participant cannot attend without being accompanied by supported living personnel, please notify Mary Wells, Bureau of Medicaid Policy, by email at: wellsm@idhw.state.id.us , or by phone at: (208) 364-1955.

2. Clarifications to Medicaid Information Release MA04-50 Supported Living Acuity Based Levels of Support

There has been some confusion regarding plans for 24 hours of supported living services. Plans for 24 hours of supported living services are only available for those participants who meet the High or Intense Support criteria. The process for billing 24 hour supported living is established through daily rates. All other supported living may be billed using the hourly billing process. Plans developed for these participants will identify natural supports, alone time, and other Medicaid services. Supported living providers may bill for a portion of the plan but not for the entire 24 hour period.

Some supported living providers have asked for clarification about when they could addend plans to reflect Intense Support needs. If a participant's plan contained "community wrap around services" prior to 10/1/04, the plan can be addended to add Intense Support if the participant meets the Intense Support criteria. Addendums for Intense Support may only be requested between 10/1/04 and 12/31/04. Approved addendums received within this time frame can be authorized retroactively back to 10/1/04 as long as there is documentation that the participant has been receiving 1:1 support since that time. In order to receive the higher reimbursement rate for this service during the retroactive period, claims billed using procedure code H2022 at $221.12/day must be voided and new claims must be submitted using procedure code H2016 at $263.36. After 12/31/04, participants must wait until their annual plan date in 2005 to add Intense Support. If you are uncertain what type of documentation is necessary to validate the need for Intense Support, please contact your regional Independent Assessment Provider.

We are continuing to review our billing procedures related to community supported employment for providers that bill supported living daily rates. There are no changes at this time to the current practice.

If you have any questions concerning the information contained in this release, please contact Jean Christensen, Manager, Behavioral Health, Bureau of Care Management at (208) 364-1828.

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

IDAHO MEDICAID PROVIDER HANDBOOK:

This information release does **not** replace information in your Idaho Medicaid Provider Handbook.

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December Office Closures

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

Friday, December 24, 2004

Friday, December 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.

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