MedicAide
An informational newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **July 2006**

In this issue:

Information Releases:

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

June 2, 2006

MEDICAID INFORMATION RELEASE MA06-18

TO: All Medicaid Providers

FROM: Leslie Clement, Deputy Administrator

SUBJECT: **ELIGIBILITY AND BENEFIT PLAN COVERAGE UNDER MEDICAID MODERNIZATION**

In July 2006, Idaho Medicaid is implementing new benefit plans to support the Medicaid Modernization initiative.

NEW benefit plans, effective July 2006 include:

- **Medicaid Basic Plan Benefits** – for low-income children and adults with eligible dependent children. This plan provides complete health, prevention and wellness services for children and adults who don't have disabilities or other special health needs.
- **Medicaid Enhanced Plan Benefits** – includes all services of Medicaid Basic Plan Benefits, plus additional services to cover the needs of participants with disabilities or special health concerns. The services in this plan include the full range of services covered by the Idaho Medicaid program.

A third plan, the **Medicare/Medicaid Coordinated Plan** is under development. This plan is for individuals who are also covered under Medicare. A separate information release will be issued in the future to provide details about this new plan.

Beginning July 2006, participants who meet eligibility requirements for Medicaid will be enrolled in either Medicaid Basic Plan Benefits or Medicaid Enhanced Plan Benefits. Plan assignment is based on health needs.

Children currently covered under the CHIP-B program will be transitioned to one of the new benefit plans effective July 1, 2006. The CHIP-B benefit plan will no longer exist after this date. The new Medicaid Basic Plan and Enhanced Plan Benefits include different services than the CHIP-B Plan. These services are summarized in this information release.

EXISTING Medicaid programs will continue to remain in place after July, 2006:

- **Pregnant Women Plan** – limited to pregnancy related services only.
- **Presumptive Eligibility Plan** – limited to outpatient pregnancy related services only.
- **Qualified Medicare Beneficiary Plan** - limited to Medicare paid services only.

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Requesting and Understanding Eligibility and Benefit Plan Information

Possession of a Medicaid identification card does not guarantee eligibility. To ensure claims are not denied due to eligibility or benefit plan issues, verify participants' eligibility and benefit plan on the actual date of service. Confirmation of eligibility and coverage is not available for dates in the future.

When an eligibility inquiry is submitted, participants who are eligible for the full range of Medicaid services will have their benefit plan reported as "Medicaid" in the eligibility response. Participants who are not eligible for the full range of Medicaid services will have their restrictions reported according to their benefit plan. For example: if the participant is eligible for Medicaid Basic Plan Benefits, eligibility will be reported as "benefits restricted to Medicaid Basic Plan services". The benefit plans for Presumptive Eligibility, Pregnant Women, and Qualified Medicare Beneficiary programs remain unchanged and the restrictions for participants on these plans will be reported accordingly.

You can request eligibility and benefit plan information using the same methods that are currently available. These methods include:

- Medicaid Automated Voice Information System (MAVIS)
- EDS Provider Electronic solution (PES) billing software
- HIPAA-compliant point of service devices (POS)
- HIPAA-compliant EDS tested vendor software

Medicaid Identification Cards

All participants, with the exception of Otherwise Ineligible Aliens and Presumptive Eligibility participants, will receive a white plastic identification card. The yellow Idaho CHIP-B identification card will no longer be issued. However, if a participant presents with the yellow Idaho CHIP-B identification card, it may still be used to verify eligibility and benefit plan information.

Medicaid Services Covered under the New Benefit Plans

Coverage under **Medicaid Enhanced Plan Benefits** includes the full range of Medicaid services covered by the Idaho Medicaid program with exclusions and limitations described in the provider handbook. Coverage and limitations under **Medicaid Basic Plan Benefits** is summarized in Table 1 below:

Table 1. Types of Services and Medicaid Basic Plan Benefits Limitations/Exclusions

Type of Service	Covered in Medicaid Basic Plan	Basic Plan Limitatins/Exclusions (in addition to established Medicaid exclusions and limitations)
Inpatient Hospital Services	X	10 day limit for inpatient mental health services, based on a rolling year.
Outpatient Hospital Services (including Emergency Services)	X	
Ambulatory Surgical Center Services	X	
Physician Services	X	
Other Practitioner Services, including Podiatrist, Optometrist, Chiropractor, Physician Assistant	X	

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DHW Phone Numbers
Addresses
Web Sites

DHW Websites
www.healthandwelfare.idaho.gov

Idaho Careline
211 (available throughout Idaho)
(800) 926-2588 (toll free)

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) 528-5786
(800) 919-9945

In Spanish (en Español)
(800) 378-3385 (toll free)
(800) 494-4133 (toll free)

Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations

DME Specialist
Bureau of Medical Care
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax (800) 352-6044
(Attn: 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
(866) 827-9967 (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:

Developmental Disability and Mental Health
(800) 296-0509, #1172
(208) 287-1172

Other Non-emergent and Out-of-State
(800) 296-0509, #1173
(208) 287-1173

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

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

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

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Table 1. Types of Services and Medicaid Basic Plan Benefits Limitations/Exclusions

Type of Service	Covered in Medicaid Basic Plan	Basic Plan Limitatins/Exclusions (in addition to established Medicaid exclusions and limitations)
Nurse Midwife Services	X	
Certified Pediatric Nurse Practitioner or Certified Family Nurse Practitioner Services	X	
Primary Care Case Management (Healthy Connections)	X	
Prevention Services (includes well-baby, well-child and well-adult preventative medicine exams)	X	Adult (over age 21) preventative medicine exams are limited to one per rolling year. The year starts on the date of the initial examination. The year ends 360 days later. Prior Authorization is required for additional assessments within the same year.[1]
Nutrition Services, including diabetic education and training	X	
Laboratory and Radiological (X-Ray) Services	X	
Prescribed Drugs	X	
Family Planning Services	X	
Inpatient **Psychiatric Hospital** Services for individuals under age 21	X	10-day limit for inpatient mental health services, based on a rolling year.
Partial Care treatment		Covered only in the Enhanced Plan.
Psychosocial Rehabilitation	X	Limited to services provided by School Districts.
Outpatient Mental Health	X	Mental Health Clinic providers are limited to 26 combined outpatient mental health services per participant per calendar year. The existing psychiatric service limitations also apply. Additionally, select providers are able to perform diagnostic and evaluation services.[2]
Home Health Care	X	
Physical Therapy	X	
Respiratory Care Services	X	
Medical Equipment and Supplies	X	
Prosthetic Devices	X	
Vision Services/Eyeglasses	X	
Speech, Hearing and Language Services	X	
Medical and Surgical Services furnished by a dentist	X	

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Table 1. Types of Services and Medicaid Basic Plan Benefits Limitations/Exclusions

Type of Service	Covered in Medicaid Basic Plan	Basic Plan Limitatins/Exclusions (in addition to established Medicaid exclusions and limitations)
Dental Services (includes dentures)	X	
Rural Health Clinic Services	X	
Federally Qualified Health Center Services	X	
Indian Health Services Facility	X	
Independent School District Services	X	
Medical Transportation	X	
EPSDT/Special Services for Children	X	Medicaid Basic Plan Benefits do not cover Intensive Behavioral Intervention and Private Duty Nursing, unless provided by School Districts. A child who requires services not available under the Basic Plan may receive those services under the Enhanced Plan.
Pregnancy-Related Services	X	
Intermediate care facility services		Covered only in the Enhanced Plan.
Nursing Facility Services		Covered only in the Enhanced Plan.
Personal Care Services		Limited to services provided by School Districts.
Home and Community-Based Waiver Services		Covered only in the Enhanced Plan.
Hospice Care		Covered only in the Enhanced Plan.
Developmental Therapy Services	X	Developmental Disability and Rehab Mental Health providers are limited to diagnostic and evaluation services. [2]

[1] Information Release MA06-17, published in this issue of MedicAide, provides additional information about preventative medicine services.

[2] Information Release 2006-15, published in this issue of MedicAide, provides additional information about mental health exclusions and limitations.

If you have questions about this information, please contact EDS at 800-685-3757 or (208) 383-4310 in the local Boise calling area. Thank you for your continued participation in the Idaho Medicaid program.

LMC/cl/sw

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
Janice Curtis
1070 Hiline Road
Pocatello, ID 83201
janice.curtis@eds.com
(208) 239-6268
Fax (208) 239-6269

Region 7
Ellen Kiester
150 Shoup Avenue
Idaho Falls, ID 83402
ellen.kiester@eds.com
(208) 528-5728
Fax (208) 528-5756

July 1, 2006

MEDICAID INFORMATION RELEASE 2006-15

TO: Psychosocial Rehabilitation Agencies, Mental Health Clinics, Developmental Disability Agencies, School-Based Providers, Speech and Hearing Clinic (ISSH), Developmental Disability Centers, Waiver Vendors, Independent Supervising Registered Nurse (PCS)

FROM: Leslie M. Clement, Deputy Administrator

SUBJECT: **EXCLUSIONS AND LIMITATIONS OF MEDICAID BASIC PLAN BENEFITS**

As a part of Medicaid Modernization, Medicaid benefits are changed according to participants' needs effective for dates of service beginning July 1, 2006. There are three new benefits plans: Medicaid Basic Plan Benefits, Medicaid Enhanced Plan Benefits and Medicare/Medicaid Coordinated Plan Benefits. This Information Release describes the exclusions and limitations in Medicaid Basic Plan Benefits.

Schools

The following services are excluded from Medicaid Basic Plan Benefits except when provided by a school district:

- Psychosocial Rehabilitation
- Intensive Behavioral Intervention
- Personal Care Services
- Developmental Therapy

All services that are presently school-based will continue to be offered under Medicaid Basic Plan Benefits with the same limitations that presently exist.

Other Medicaid Providers

The following services are excluded from Medicaid Basic Plan Benefits:

- Partial Care
- Service Coordination
- Intermediate care facility services (ICF-MR)
- Nursing Facility Services
- Home and Community-Based Waiver Services (A&D, TBI, DD, ISSH)
- Hospice Care

All above listed services continue to be covered in Medicaid **Enhanced** Plan Benefits. Evaluation to determine eligibility for these services is available under Medicaid **Basic** Plan Benefits. The services in Medicaid Enhanced Plan Benefits include the full range of services covered by the Idaho Medicaid program.

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For certain provider specialties, services under Medicaid Basic Plan are restricted to diagnostic and evaluation procedures. This restriction applies to the following provider specialties:

015 Speech and Hearing Clinic (ISSH)

130 Developmental Disability Centers (DDAs)

131 Rehab Mental Health Services

141 Waiver Vendors

163 Independent Supervising Registered Nurse (PCS)

164 Licensed Practical Nurse Independent (PDN)

165 Nursing Agency (PDN)

168 Registered Nurse Services Independent DD Waiver

169 Registered Nurse Services Agency DD Waiver

176 Mental Health Case Management

177 Personal Care Services Case Management

Please see Table 1 below for the list of the procedure codes and descriptions of the limited procedures allowed for the above identified provider types in Medicaid Basic Plan Benefits.

Table 1. Procedure Codes, Select Provider Specialties, and Procedure Descriptions Allowed in Medicaid Basic Plan Benefits for the Purposes of Diagnosis and Evaluation Only

Procedure Code	Provider Specialty	Procedure Description
H2000	130	Comprehensive multidisciplinary evaluation; Developmental therapy evaluation.
T1023	015 130 131 163 164 165 166 168 169	Screen for individual participation in specific program, project or treatment protocol; PWC-determination presumptive eligibility.
T1028	130 131	Social History & Evaluation: Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs.
H0031	131 176	Rehabilitation evaluation (Mental health assessment by non-physician).
90801	130 131	Psychiatric Diagnostic Interview Examination: includes history, mental status and disposition; may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.
90802	130 131	Interactive psychiatric diagnostic interview examination; using play equipment, physical devices, language interpreter, or other mechanisms of communication; typically furnished to children.
92506	015 141 130	Evaluation speech/language/voice/communication/auditory processing.
96101	130 131	Psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.
96102	130 131	Psychological testing includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, WAIS), with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face.

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Procedure Code	Provider Specialty	Procedure Description
96103	130 131	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified healthcare professional interpretation and report.
97001	130	Physical therapy evaluation.
97003	130	Occupational therapy evaluation.
G9002	177	PCS Assessment: Coordinated Care Fee.

The existing service limitation of twelve (12) hours of diagnostic and evaluation services still applies.

Medicaid Basic Plan Benefit participants will be limited to twenty-six (26) separate outpatient mental health clinic services annually and ten (10) psychiatric inpatient hospital days annually.

Please see Table 2 below for the applicable procedure codes that count toward the twenty-six (26) mental health service limitation allowed in Medicaid Basic Plan Benefits and the applicable procedure descriptions.

Table 2. Procedure Codes and Procedure Descriptions of Mental Health Services included in the Twenty-Six Service Limitation of Medicaid Basic Plan Benefits.

Procedure Code	Procedure Description
90801	Psychiatric Diagnostic Interview Examination: includes history, mental status and disposition; may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.
90802	Interactive psychiatric diagnostic interview examination; using play equipment, physical devices, language interpreter, or other mechanisms of communication; typically furnished to children.
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility. Approximately 20 to 30 minutes face-to-face with the patient.
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient.
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient.
90847	Family Psychotherapy (conjoint psychotherapy) (with patient present).
90853	Group Psychotherapy (other than of a multiple-family group).
90857	Interactive Group Psychotherapy.

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Procedure Code	Procedure Description
90862	Pharmacological Management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.
T1028	Social History Evaluation: Individualized intake assessment based on participant's needs.
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, WAIS), with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face.
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified healthcare professional interpretation and report.

Other codes previously reimbursed by Medicaid in mental health clinics will continue to be reimbursed when provided in mental health clinics but will not count toward the twenty-six (26) service limitation. Please refer to the Provider Handbook for a full list of the services available in mental health clinics.

Billing Instructions for Twenty-six (26) Mental Health Service Limitation

Dates of service on the detail are limited to a single day. If a provider sees the participant more than once on the same day, the provider must bill each procedure as a separate claim detail with the appropriate modifier, 76 or 77, for justification of duplication. Each occurrence of a procedure code on a claim detail will be counted as one service toward the 26 mental health service limitation regardless of the number of units or date of service on the detail. This limitation is based on a calendar year.

To ensure claims are not denied due to eligibility or benefit plan issues, verify the participant's eligibility and benefit plan on the actual date of service.

If you have any questions concerning the information contained in this release, please contact Pat Guidry, at (208) 364-1813.

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

LMC/pg/sw

Submitting Paper Claims

While electronic billing is faster, there are times when a provider may have to bill on paper. The following tips will speed the processing of paper claims:

- Complete only the **required** fields on the claim form. (See your provider handbook for more information on specific fields.)
- Use a typewriter (with the font `Courier 10`) or print legibly using black ink.
- Keep claim form clean. Use correction tape to cover errors.
- Mail claims flat in a large envelope (recommend 9 x 12). Do not fold claims.
- Stack attachments behind the claim to which they belong. Do not use staples or paperclips.

Providers sometimes write notes at the top of the claim form not realizing that this can cause their claim to be rejected. This is particularly true for the CMS-1500, the pharmacy claim form, and the dental claim form, all of which have a blank area at the top of the form. Please do not write in the top half inch on a paper claim form.

An internal control number (ICN) is printed at the top of the claim form and any attachments. If there is any other printing in that space, the ICN number is garbled and the claim cannot be tracked. Paper claims should be mailed to EDS Claims, P.O. Box 23, Boise, ID 83707.

June 2, 2006

MEDICAID INFORMATION RELEASE MA06-17

TO: All Physicians, Osteopaths and Mid-Level Practitioners

FROM: Leslie Clement, Deputy Administrator

SUBJECT: **EPSDT RATE INCREASES AND EXPANDED COVERAGE FOR ADULT PREVENTIVE MEDICINE SERVICES EFFECTIVE JULY 1, 2006**

Idaho Medicaid has updated rates and age limitations for EPSDT and Adult Preventive Medicine procedure codes, in support of the Medicaid Modernization Initiative. Rates for existing EPSDT preventive medicine codes were increased, and additional adult preventive medicine codes became payable to cover well examinations for all Idaho Medicaid participants. (Prior to July 1, 2006, preventive medicine procedures were only covered for participants up to the age of 21.)

Changes to EPSDT and Adult Preventive Medicine Codes

Updated reimbursement rates are listed in the table below. Additionally, the age limitation for codes 99385 and 99395 has been updated to cover adult participants ages 18-39.

New Patient Preventive Medicine Exam		
Code	**Service Description**	**New Rate**
99381	Infant	$ 102.83
99382	Child Age 1-4	$ 115.42
99383	Child Age 5-11	$ 114.69
99384	Adolescent Age 12-17	$ 127.91
99385*	Adult Age 18-39 (see above)	$ 127.91
Established Patient Preventive Medicine Exam		
Code	**Service Description**	**New Rate**
99391	Infant	$ 84.99
99392	Child Age 1-4	$ 97.84
99393	Child Age 5-11	$ 97.47
99394	Adolescent Age 12-17	$ 110.43
99395*	Adult Age 18-39 (see above)	$ 110.79
Newborn Care		
Code	**Service Description**	**New Rate**
99431	History & Exam/Facility Birth	$ 85.50
99432	History & Exam/Home Birth	$ 98.51

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Addition of Payable Codes for Adult Preventive Medicine Over Age 39

The following codes are effective July 1, 2006 to cover well examinations for adult participants over age 39:

New Patient Preventive Medicine Exam		
Code	**Service Description**	**New Rate**
99386*	Adult Age 40-64	$ 127.91
99387*	Adult Age 65+	$ 127.91
Established Patient Preventive Medicine Exam		
Code	**Service Description**	**New Rate**
99396*	Adult Age 40-64	$ 110.79
99397*	Adult Age 65+	$ 110.79

Billing Instructions

* Preventive Medicine procedures billed for participants over age 21 **must** be billed with diagnosis code V700 or the claim will be denied. Please bill the appropriate procedure for the participant's age as listed above.

Adult preventive medicine procedures will be limited to one per rolling year. Evaluation and Management procedures will not be paid on the same day as a preventive medicine procedure for participants over age 21.

If you have any questions please contact Eric Anderson, Senior Financial Specialist for the Medicaid Office of Reimbursement Policy, at (208) 364-1918. Thank you for your continued participation in the Idaho Medicaid program.

LC/ea/sw

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May 17, 2006

MEDICAID INFORMATION RELEASE MA06-13

TO: Adult Day Care Providers

FROM: Leslie M. Clement, Deputy Administrator

SUBJECT: **ADULT DAY CARE PROVIDER BILLING**

Effective immediately, claims for Adult Day Care that do not include the appropriate modifier will be denied. Provider claims must include the prior authorization number and one of the following modifiers when billing procedure code S5100, Adult Day Care:

U2 A&D Waiver Participants

U8 DD or ISSH Waiver Participants

If you have questions regarding the information, please contact David Simnitt in the Bureau of Behavioral Health at (208) 364-1992. Thank you for your continued participation in the Idaho Medicaid Program.

LMC/ds/sw
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May 25, 2006

MEDICAID INFORMATION RELEASE 2006-14

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

FROM: Leslie Clement, Deputy Administrator

SUBJECT: **NEW PCS PAYMENT RATES EFFECTIVE JULY 1, 2006**

Effective July 1, 2006, Medicaid will make some changes to its reimbursement rates for Personal Assistance Services (personal care and attendant services). As required by Idaho Code and IDAPA 16.03.09.148, the Department conducted a salary survey to calculate the new rates. The maximum allowable amounts are based on wages and salaries paid for comparable positions within nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs).

Services provided on or before June 30, 2006 must be billed separately from services provided on or after July 1, 2006. There may be an error in your payment if you do not use separate claim forms.

The new rates are listed below by procedure code:

Supervisory RN Codes		
G9002	Coordinated Care Fee – Maintenance Rate (Agency)	$ 73.03/visit
G9001	Coordinated Care Fee – Initial (School)	$ 73.03/plan
T1001	Nursing Assessment/Evaluation (Agency)	$ 35.59/visit
T1001	Nursing Assessment/Evaluation (School)	$ 35.59/visit
Supervisory QMRP Codes		
G9001	Coordinated Care Fee – Initial (Agency)	$ 91.59/visit
H2020	Therapeutic Behavioral Services (Agency)	$ 30.53/day
Personal Assistance Service Provider Codes		
Agency Providers		
T1019	Personal Care	$ 3.58/15 min. unit
T1004	Services of a Qualified Nursing Aide	$ 3.58/15 min. unit
S5145 U3	Foster Care, Therapeutic – Child	$ 74.77/day
S5145 U3 HQ[1]	Foster Care, Therapeutic – Group	$ 64.23/day per client
Independent Provider's Home (no withholding)		
S5145	Foster Care, Therapeutic – Child (Children under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program only)	$ 71.47/day
S5145 HQ[1]	Foster Care, Therapeutic – Group (Children under EPSDT Program only)	$ 52.49/day per client
Home and Community Based Services		
S5125 U2[1]	Attendant Care Services	$ 3.58/15 min. unit
T1001 U2[1]	Nursing Assessment/Evaluation (Agency)	$ 35.59
Other		
S5140-U2	Adult Residential Care	**

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[1] Procedure code modifier

** For Certified Family Homes and Residential and Assisted Living Facilities that bill this code, you will receive a letter notifying you of the new rate for each participant. If you do not receive a letter for a participant living in your facility, please notify your local Regional Medicaid Services unit. *Approval of service* by the Regional Medicaid Services unit is *still required* prior to delivery of service.

Reminder

Per IDAPA 16.03.09.146.02.b.
"All PCS must be provided under the order of a licensed physician or authorized provider."

If you have questions about this process, please contact your Regional Medicaid Services office. Thank you for your 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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June 6, 2006

MEDICAID INFORMATION RELEASE 2006-16

TO: School Districts

FROM: Leslie Clement, Deputy Administrator

SUBJECT: **NOTICE OF MATCH PAYMENT INSTRUCTIONS**

Due to changes in intergovernmental transfer procedures, the Department of Health and Welfare has changed the way school districts need to put up their estimated annual expenditure match starting on July 1, 2006.

Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. School districts must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner:

- Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings.
- School districts will send Department of Health and Welfare (DHW) the matching funds, either by check or ACH electronic funds transfers.
- Matching funds will be held in an interest bearing trust account. The average daily balance during a month must exceed $100 in order to receive interest for that month.
- The payments to the districts will include both the federal and non-federal share (matching funds).

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- Checks should be sent to DHW at the following address:

  Department of Health and Welfare
  Management Services Business Office
  P.O. Box 83720
  Boise, ID 83720-0036
  (208) 334-5909

- Contact the Fiscal Operations Supervisor at the above address if the school district wants to make electronic fund transfer payments for the matching funds.
- Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle.
- If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle.
- DHW will provide the school districts a monthly statement which will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account.
- The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay DHW.
- The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account.

If you have any questions concerning the information contained in this release, please contact the Fiscal Operations Supervisor for the Management Services Business Office, at (208) 334-5909.

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

LC/sp/jr

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Billing DME Supplies

DME providers are reminded that when billing for supplies they should always use the date the supplies were dispensed as both the from and to dates of service. They should not date span.

Date spanning is used when the **from** date of service is different than the **to** date of service. It is generally used for rented items that are paid for by the day or month such as oxygen and wheelchairs.

DME supplies are **not** paid for by the day; they are paid for by the package and, therefore, date spanning is not used. Disposable items are billed using only the exact date they are dispensed, not the length of time they are used. If DME supplies are billed with a from and to date span, the claim may pend for overlapping services.

As an example:

> "FastPay DME of Idaho" dispenses a box of lancets with a 30 day supply on December 21, 2004. Correctly billing this item, they enter 12/21/2004 in both the from and to date. Their claim is paid in the next processing cycle.
>
> "SloPay DME of Idaho" also dispenses a box of lancets with a 30 day supply on December 21, 2004. Incorrectly billing this item, they use date spanning from December 21, 2004 to January 20, 2005. The client goes to the hospital on December 30, 2004. The claim from "SloPay" pends because they have spanned across the hospital stay even though they dispensed the supplies long before the client went into the hospital. Although the claim will eventually be paid, "SloPay" will have to wait for an adjudicator to research the error and override the edit.

To ensure prompt payment for DME supplies, always bill for just the date the supplies are dispensed.
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What is the Traumatic Brain Injury Waiver?

The Traumatic Brain Injury (TBI) waiver is a Medicaid program that:

- Helps individuals stay out of an institution and in a home of their choice
- Provides for the greatest degree of independence possible
- Enhances the quality of life
- Encourages individual choice
- Achieves and maintains community integration.

Services are available to individuals who sustained a brain injury on or after age 22 and meet certain diagnostic and financial criteria to receive specialized services in their own home or apartment. Traumatically acquired, non-degenerative, structural brain injuries include:

- Anoxic brain damage
- Intra cerebral hemorrhage
- Skull fractures
- Intracranial injury of other/unspecified nature
- Cerebral lacerations/contusions
- Hemorrhage following injury
- Concussions
- Late effects of skull fractures, intracranial injuries

What kind of services are available?

- Skilled nursing
- Chore services
- Non-medical transportation
- Supported employment-competitive work in an integrated work setting
- Residential habilitation, including training in self-direction, daily skills, socialization, behavior shaping and management
- Respite care-provided for non-paid caregivers
- Home modifications-for those who own or rent their own home
- Personal Emergency Response System
- Personal care services
- Home delivered meals
- Specialized medical equipment/supplies (not covered by basic Medicaid but available under the TBI waiver)
- Extended State plan services (physical, occupational, speech therapies)-allows for services beyond service limitations
- Behavioral consultation/crisis management-direct consultation and evaluation
- Day rehab services-includes acquiring, keeping, or improving self-help, socialization and adaptive skills outside the home

How do clients get TBI services?

Clients can call their regional Medicaid office.

Region	Location	Phone Number
Region 1	Coeur d'Alene	(208) 769-1567
Region 2	Lewiston	(208) 799-4430
Region 3	Caldwell	(208) 455-7150
Region 4	Boise	(208) 334-0940
Region 5	Twin Falls	(208) 736-3020
Region 6	Pocatello	(208) 234-7900
Region 7	Idaho Falls	(208) 528-5750

Corrections to Reimbursement Rates

The following CPT codes were previously mispriced in the AIM Medicaid Management Information System. The rates in the system for these codes have been corrected for dates of service (DOS) of 1/1/2006 and later:

Code	Description	New Rate
78459	Myocardial imaging, Positron Emission Tomography (PET), metabolic evaluation	$1,053.67
78491	Myocardial Imaging, Positron Emission Tomography (PET), perfusion, single study at rest or stress	$1,054.50
78492	Myocardial imaging, Positron Emission Tomography (PET), perfusion, multiple studies at rest and/or stress	$1,073.63
78608	Brain imaging, Positron Emission Tomography (PET), metabolic evaluation	$1,051.87
78609	Brain imaging, Positron Emission Tomography (PET), perfusion evaluation	$1,051.87
78811	Tumor imaging, Positron Emission Tomography (PET), limited area	$1,054.91
78812	Tumor imaging, Positron Emission Tomography (PET), skull base to mid-thigh	$1,562.57
78813	Tumor imaging, Positron Emission Tomography (PET), whole body	$1,566.21
78814	Tumor imaging, Positron Emission Tomography (PET), with concurrently acquired Computed Tomography (CT) for attenuation correction and anatomical localization, limited area	$1,087.49
78815	Tumor imaging, Positron Emission Tomography (PET), with concurrently acquired Computed Tomography (CT) for attenuation correction and anatomical localization, skull base to mid-thigh	$2,076.42
78816	Tumor imaging, Positron Emission Tomography (PET), with concurrently acquired Computed Tomography (CT) for attenuation correction and anatomical localization, whole body	$2,079.35
99300	Sub-intensive care, per day for E & M of the recovering infant 2501-5000 gms	$153.05

Providers that have billed these codes for DOS 1/1/2006 or later can adjust their claims by submitting an electronic void and replacement transaction in order to receive the correct reimbursement.

If there are any questions please contact Eric Anderson at the Medicaid Office of Reimbursement Policy at (208) 346-1918.

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Timeline to File Appeals

If you wish to contest a Department decision regarding Medicaid services, you have 28 days from the date the notification decision letter is mailed to file an appeal with the Department's Hearings Coordinator, in accordance with IDAPA 16.05.03.101.
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EDS
P.O. Box 23
Boise, Idaho 83707

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IDAHO DEPARTMENT OF HEALTH & WELFARE

July Office Closures

Tuesday, July 4, 2006, the Department of Health and Welfare and EDS offices will be closed for Independence Day.

MAVIS (Medicaid Automated Voice Information Service) is always available at the following telephone number: (800) 685-3757 (toll-free) or (208) 383-4310 (Boise local).

July Regional Provider Workshops

EDS Provider Relations Consultants continue to offer a series of provider workshops in 2006. Each consultant conducts a 2-hour regional workshop every two months to help providers in their region. Some of the topics include: general Medicaid billing, provider resources, and using PES software.

The next workshop is scheduled for Tuesday, July 11, 2006, from 2:00 to 4:00 pm., with the exception of Twin Falls. The Twin Falls workshop will be held on Thursday, July 13, 2006, from 2:00 to 4:00 pm. These workshops are free but please pre-register with your local Provider Relations Consultant. Their phone numbers are listed on Page 5. Please contact Janice Curtis at (208) 239-6268 to register for the Twin Falls workshop.

Please note that in addition to workshops, Provider Relations Consultants offer in-office support to providers **free of charge**. Contact your local Provider Relations Consultant to schedule an office visit.

***MedicAide* is the monthly informational newsletter for Idaho Medicaid providers.**

Editor:
Kathy Gillingham,
Division of Medicaid

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or

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