MedicAide
An informational newsletter for Idaho Medicaid Providers

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

In this issue:

35 Provider Handbook Updates

41 Corrections to Reimbursement of Bilateral (Modifier 50) Procedure Codes for Hospital Ambulatory Surgical Center Providers

44 Billing Preventive Medicine Procedures for Adults as of July 1, 2006

Information Releases:

1 Medicaid Information Release 2006-19

30 Medicaid Information Release MA06-21

31 Medicaid Information Release MA06-22

33 Medicaid Information Release MA06-23

33 Medicaid Information Release MA06-24

34 Medicaid Information Release MA06-25

36 Medicaid Information Release MA06-26

37 Medicaid Information Release MA06-27

38 Medicaid Information Release MA06-28

42 Medicaid Information Release MA06-29

43 IDHW H0002 Form

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

June 19, 2006

MEDICAID INFORMATION RELEASE 2006-19

TO: All Medicaid Providers

FROM: Leslie Clement, Deputy Administrator

SUBJECT: **Preferred Agents for Drug Classes Reviewed at May 19, 2006 Pharmacy and Therapeutics Committee Meeting**

Drug/Drug Classes: Noted below

Implementation Date: Effective for dates of service on or after July 1, 2006

Idaho Medicaid is designating preferred agents and prior authorization criteria for the following drug classes as part of the Enhanced Prior Authorization Program. The information is included in the attached Preferred Drug List.

Drug Classes Reviewed at May 19, 2006 P&T Meeting	
ACE Inhibitors/Calcium Channel Blockers	Injectable Anticoagulants
Angiotensin-2 Receptor Antagonists	Lipotropics
Anticonvulsants	Meglitinides
Benign Prostatic Hyperplasia (BPH) Treatments	Multiple Sclerosis Agents
Bladder Relaxant Preparations	Narcotic Analgesics, Long-Acting and Short-Acting
Cephalosporins and Related Antibiotics	Otic Antibiotics
Cytokine and CAM Antagonists	Phosphate Binders
Erythropoiesis Stimulating Proteins	Proton Pump Inhibitors
Growth Hormones	Sedative Hypnotics
Hepatitis C Agents	Thiazolidinediones (TZDs)

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 and prior authorization criteria is also available online at **www.medicaidpharmacy.idaho.gov**.

IDAHO MEDICAID PROVIDER HANDBOOK

This Information Release does not replace information in your Idaho Medicaid Handbook.

Continued on Page 2 (IR 2006-19)

Continued from Page 1 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
ACE Inhibitors	**ACE Inhibitors**		
	ALTACE (ramipril)	ACEON (perindopril)	Non-preferred agents may be approved if the patient has a history of one preferred agent in the last 6 months.
	captopril	benazepril	
	enalapril	fosinopril	
	lisinopril	MAVIK (trandolapril)	
		quinapril	
		UNIVASC (moexepril)	
	ACE Inhibitor / Diuretic Combinations		Non-preferred agents may be approved if the patient has a history of one preferred agent in the last 6 months.
	captopril/HCTZ	benazepril/HCTZ	
	enalapril/HCTZ	fosinopril/HCTZ	
	lisinopril/HCTZ	quinapril/HCTZ	
		UNIRETIC (moexepril/HCTZ)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 3 (IR 2006-19)

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)

Continued from Page 2 (IR 2006-19)

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)

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

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

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

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
ACE Inhibitor/Calcium Channel Blocker Combinations **(Effective 07/01/06)**	LOTREL (benazepril/amlodipine)	LEXXEL (enalapril/felodipine)	Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
	TARKA (trandolapril/verapamil)		
Alheimer's Agents [CL]	**Cholinesterase Inhibitors**		Cholinesterase inhibitors will be approved only for patients meeting both of the following criteria: • Diagnosis of dementia (ICD-9=290.xx, 294.1, 331.0) • Mini Mental State Exam (MMSE) score of <23 or equivalent scale documenting mild to moderate dementia Non-Preferred agents will be approved for patients meeting at least one of the following criteria: • Documented history of failure to Preferred agent within previous 6 months • More than 120 days of therapy with the same non-preferred agent in the previous 6 months
	ARICEPT (donepezil)	COGNEX (tacrine)	
		EXELON (rivastigmine)	
		RAZADYNE (galantamine)	
	NMDA Receptor Antagonist		Namenda will be approved only for patients meeting both of the following criteria: • Diagnosis of dementia (ICD-9=290.xx, 294.1, 331.0) • Mini Mental State Exam (MMSE) score of ≤15 or equivalent scale documenting moderate to severe dementia
	NAMENDA (memantine)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 4 (IR 2006-19)

Continued from Page 3 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Analgesics, Narcotic (Non-parenteral)	**Short-Acting**		Non-preferred agents will be approved only after documented failure of 3 preferred agents.
	acetaminophen/codeine	ACTIQ (fentanyl)	
Effective 7/1/06	aspirin/codeine	butalbital/APAP/caffeine/codeine	Actiq will be approved only for breakthrough cancer pain in patients already receiving, and tolerant to, opioid therapy.
	codeine	butalbital/ASA/caffeine/codeine	
	hydrocodone/APAP	COMBUNOX (oxycodone/ibuprofen)	
	hydromorphone	dihydrocodeine/ APAP/caffeine	
	morphine	hydrocodone/ibuprofen	
	oxycodone	meperidine	
	oxycodone/APAP	PANLOR (dihydrocodeine/ APAP/ caffeine)	
	oxycodone/aspirin	pentazocine/APAP	
	pentazocine/naloxone	propoxyphene	
	propoxyphene/APAP	propoxyphene/ASA/caffeine	
	tramadol	tramadol/APAP	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued On Page 5 (IR 2006-19)

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

Continued from Page 4 (IR 2006-19)

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

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Analgesics, Narcotic (Non-parenteral) **Effective 7/1/06**	**Long-Acting**		Duragesic patches will be approved for patients meeting one of the following criteria: • Inability to swallow capsules or tablets • Allergy to morphine and/or methadone • History of a preferred oral agent in previous 6 months Non-preferred agents will be approved for patients meeting one of the following criteria: • Documented failure of at least a 30 day trial of a Preferred agent within previous 6 months • Diagnosis of malignant pain (ICD-9=140-208, 99.25 or chemotherapy administration related CPT code)
	morphine SR	AVINZA (morphine)	
	methadone	oxycodone ER	
	levorphanol	fentanyl patches	
	KADIAN (morphine)		
	DURAGESIC (fentanyl)[CL]		
Angiotensin II Receptor Blockers (ARBs) **Effective 07/01/06**	**Angiotensin II Receptor Blockers**		Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
	AVAPRO (irbesartan)	ATACAND (candesartan)	
	BENICAR (olmesartan)	TEVETEN (eprosartan)	
	COZAAR (losartan)		
	DIOVAN (valsartan)		
	MICARDIS (telmisartan)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 6 (IR 2006-19)

Continued from Page 5 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Angiotensin II Receptor Blockers (ARBs) (continued)	**ARB / Diuretic Combinations**		Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
	AVALIDE (irbesartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ)	
(Effective 07/01/06)	BENICAR-HCT (olmesartan/ HCTZ)	TEVETEN-HCT (eprosartan/HCTZ)	
	DIOVAN-HCT (valsartan/HCTZ)		
	HYZAAR (losartan/HCTZ)		
	MICARDIS-HCT (telmisartan/ HCTZ)		
Anticoagulants, Injectable	ARIXTRA (fondaparinux)		
	FRAGMIN (dalteparin)		
Effective 07/01/06	INNOHEP (tinzaparin)		
	LOVENOX (enoxaparin)		
Antidepressants, Second Generation	**SSRIs**		Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months. Mirtazapine soluble tablets will be approved for patients unable to swallow tablets or capsules.
	citalopram	PEXEVA (paroxetine)	
	fluoxetine	PROZAC WEEKLY (fluoxetine)	
	fluvoxamine		
	LEXAPRO (escitalopram)		
	paroxetine		
	PAXIL CR (paroxetine)		
	ZOLOFT (sertraline)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 7 (IR 2006-19)

Continued from Page 6 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Antidepressants, Second Generation (continued)	**Other**		Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
	bupropion IR	mirtazapine soluble tablets	
	bupropion SR		
	CYMBALTA (duloxetine)		
	EFFEXOR IR (venlafaxine)		
	EFFEXOR XR (venlafaxine)		
	mirtazapine tablets		
	nefazodone		
	WELLBUTRIN XL (bupropion)		
Antiemetics	**5HT3 Receptor Blockers**		$5HT_3$ Receptor Blockers will be approved only for patients meeting one of the following criteria: • Chemotherapy-induced nausea and vomiting • Radiation-induced nausea and vomiting • Hyperemesis gravidarum (ICD-9=643.1) that has failed at least 72 hours of at least one of the following therapies: – promethazine 150 mg/day – prochlorperazine 20 mg/day – trimethobenzamide 1200 mg/day – metoclopramide 80 mg/day
	ALOXI (palonosetron)	ANZEMET (dolasetron)	
	ZOFRAN (ondansetron)	KYTRIL (granisetron)	
	NMDA Receptor Antiagonist		Emend will be authorized only for patients who have had a prescription for Anzemet, Kytril or Zofran within the past 30 days.
	EMEND (aprepitant)[CL]		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 8 (IR 2006-19)

Continued from Page 7 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Antiepileptic Drugs	**Barbiturates**		
	MEBARAL (mephobarbital)		
	phenobarbital		
	primidone		
	Hydantoins		
	DILANTIN (phenytoin)		
	PEGANONE (ethotoin)		
	phenytoin		
	Succinimides		
	CELONTIN (methsuximide)		
	ethosuximide		
	Benzodiazepines		
	lonazepam		
	DIASTAT (diazepam rectal)		
	Adjuvants		Gabapentin will be approved only for patients with one of the following diagnosis within the previous 2 years: • Seizure disorder (ICD-9=345) • Neuropathic pain associated with one of the following: – Hereditary and idiopathic peripheral neuropathy (ICD-9=356) – Inflammatory and toxic neuropathy (ICD-9=357)
	carbamazepine		
	CARBATROL (carbamazepine)		
	DEPAKOTE (divalproex)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 9 (IR 2006-19)

Continued from Page 8 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Antiepileptic Drugs (continued)	**Adjuvants (continued)**		– Disorders of autonomic nervous system (ICD-9=337.0, 337.1) – Amyloidosis (ICD-9=277.3) – Diabetes with neurologic manifestations (ICD-9=250.6) – Mononeuritis of lower limb and mononeuritis multiplex (ICD-9=354) – Mononeuritis of upper limb and mononeuritis multiplex (ICD-9=355) – Neuralgia, neuritis, and radiculitis, unspecified (ICD-9=729) Keppra and zonisamide will be approved for patients with a diagnosis of seizure disorder (ICD-9=345) wihin the previous 2 years. Lamictal and Trileptal will be approved for patients with one of the following diagnoses within the previous 2 years: • Seizure disorder (ICD-9=345) • Bipolar disorder (ICD-9=296) Lyrica will be approved for patients meeting one of the following criteria: • Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (ICD-9=250.6) or postherpetic neuralgia (ICD-9=053.1) which has failed treatment with gabapentin in the last 2 years. • Diagnosis of epilepsy (ICD-9=345) which has failed treatment with at least 2 antiepileptic agents in the last 2 years. Topamax will be approved for patients with one of the following diagnoses within the previous 2 years: • Seizure disorder (ICD-9=345) • Migraine headache (ICD-9=296)
	EQUETRO (carbamazepine)		
	gabapentin[CL]		
	GABITRIL (tiagabine)		
	KEPPRA (levetiracetam)[CL]		
	LAMICTAL (lamotrigine)[CL]		
	LYRICA (pregabilin)[CL]		
	TOPAMAX (topiramate)[CL]		
	TRILEPTAL (oxcarbazepine)[CL]		
	valproic acid		
	zonisamide[CL]		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 10 (IR 2006-19)

Continued from Page 9 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Antifungals, Oral	ANCOBON (flucytosine)	griseofulvin	Itraconazole and Lamisil will be approved for patients meeting one of the following criteria: • Diagnosis of aspergillosis (ICD-9=117.3), blastomycosis (ICD-9=116.xx) or histoplasmosis (ICD-9=115.xx). • Diagnosis of onychomycosis (ICD-9=110.1) with confirmation by microbiological or histological test and extensive nail involvement resulting in significant debilitation or secondary infection. Griseofulvin will be approved for patients meeting one of the following criteria: • Diagnosis of tinea capitis • Tinea corporis, cruris or pedis failing to respond to at least 2 weeks of a topical agent
	clotrimazole	itraconazole	
	fluconazole	LAMISIL (terbinafine)	
	ketoconazole		
	MYCOSTATIN (nystatin)		
	nystatin		
	VFEND (voriconazole)		
Antifungals, Topical	**Antifungals**		Penlac will be approved for patients meeting all fo the following criteria: • Diagnosis of onychomycosis (ICD-9=110.1) within the last year • Contraindication to oral itraconazole and Lamisil as defined by presence of heart failure, hepatic impairment or viral hepatitis • Proof from prescriber that therapy is not for cosmetic purposes
	ciclopirox	PENLAC (ciclopirox)	
	econazole		
	ERTACZO (sertaconazole)		
	EXELDERM (sulconazole)		
	ketoconazole		
	LOPROX GEL (ciclopirox)		
	LOPROX SHAMPOO (ciclopirox)		
	MENTAX (butenafine)		
	NAFTIN (naftifine)		
	nystatin		
	OXISTAT (oxiconazole)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 11 (IR 2006-19)

Continued from Page 10 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Antifungals, Topical (continued)	**Antifungal / Steroid Combinations**		
	clotrimazole/betamethasone		
	nystatin/triamcinolone		
Antihistamines, Minimally Sedating [CL]	**Antihistamines**		Class Criteria: • Age <20 years • Diagnosis of allergic rhinitis or chronic urticaria • Failure of treatment with at least 2 first generation antihistamines (brompheniramine, carbinoxime, chlorpheniramine, clemastine, cyproheptadine, dex-chlorpheniramine, diphenhydramine, hydroxyzine) • Patient is not receiving other sedating medications (anticholinergics, TCAs, opiates, skeletal muscle relaxants, benzodiazepines, conventional antipsy-chotics) Prescription is required for all agents. Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agent within the last 6 months.
	CLARITIN (loratadine)	CLARINEX (desloratadine)	
	loratadine	fexofenadine	
		ZYRTEC (cetirizine)	
	Antihistamine / Decongestant Combinations		
	CLARITIN-D (loratadine/ pseudoephedrine)	ALLEGRA-D (fexofenadine/ pseu-doephedrine)	
	loratadine/pseudoephedrine	ZYRTEC-D (cetirizine/ pseudoephedrine)	
Antimigraine Agents, Triptans [CL] **Effective 7/1/06**	**Oral**		Class Criteria: • Age ≥12 years • No history of CAD, angina, uncontrolled HPT, CVD, PVD, ischemic bowel disease Non-preferred agents will be authorized only if patient has tried and failed therapy with all of the preferred agents within the last 6 months.
	AMERGE (naratriptan)	AXERT (almotriptan)	
	IMITREX (sumatriptan)	FROVA (frovatriptan)	
	MAXALT (rizatriptan)		
	RELPAX (eletriptan)		
	ZOMIG (zolmitriptan)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 12 (IR 2006-19)

Continued from Page 11 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Antimigraine Agents [CL] **(continued)** **Effective 7/1/06**	**Nasal**		
	IMITREX (sumatriptan)	ZOMIG (zolmitriptan)	
	Injectable		
	IMITREX (sumitriptan)		
Antivirals, Oral	**Anti-CMV Agemts**		
	ganciclovir		
	VALCYTE (valganciclovir)		
	Anti-Herpes Agents		
	acyclovir		
	FAMVIR (famciclovir)		
	VALTREX (valacyclovir)		
	Anti-Influenza Agents		
	amantadine		
	RELENZA (zanamivir)		
	rimantadine		
	TAMIFLU (oseltamivir)		
Atopic Dermatitis	ELIDEL (pimecrolimus)		
	PROTOPIC (tacrolimus)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 13 (IR 2006-19)

Continued from Page 12 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Beta Blockers	**Beta Blockers**		Innopran XL and Levatol will be approved for patients with documented failure to one of the preferred agents within the past 6 months.
	acebutolol	INNOPRAN XL (propranolol)	
	atenolol	LEVATOL (penbutolol)	
	betaxolol		
	bisoprolol		
	INDERAL LA (propranolol)		
	metoprolol		
	nadolol		
	pindolol		
	propranolol		
	sotalol		
	timolol		
	TOPROL XL (metoprolol)		
	Beta and Alpha blockers		Coreg (carvedolol) will be approved only for patients with a documented diagnosis of heart failure.
	COREG (carvedilol)[CL]		
	labetalol		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 14 (IR 2006-19)

Continued from Page 13 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Bladder Relaxant Preparations **Effective 07/01/06**	DITROPAN XL (oxybutynin)	DETROL (tolterodine)	Non-preferred agents will be approved for patients with documented failure (inability to maintain continence) or intolerance (dry mouth) on a preferred agent.
	ENABLEX (darifenacin)	DETROL LA (tolterodine)	
	oxybutynin		
	OXYTROL (oxybutynin)		
	SANCTURA (trospium)		
	VESICARE (solifenacin)		
Bronchodilators, Beta Agonist	**Inhalers, Short-Adting**		Non-preferred agents will be approved for patients with documented failure of albuterol.
	albuterol	ALUPENT (metaproterenol)	
		MAXAIR (pirbuterol)	
		XOPENEX HFA (albuterol)	
	Inhalers, Long-Acting		
	FORADIL (formoterol)		
	SEREVENT (salmeterol)		
	Inhalation Solution		Non-preferred agents will be approved for patients with documented failure of albuterol.
	albuterol	ACCUNEB (albuterol)	
		metaproterenol	
		XOPENEX (levalbuterol)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 15 (IR 2006-19)

Continued from Page 14 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
BPH Agents	**Alpha Blockers**		
	doxazosin		
	FLOMAX (tamsulosin)		
	terazosin		
	UROXATRAL (alfuzosin)		
	5-Alpha-Reductase (5AR) Inhibitors		
	AVODART (dutasteride)		
	PROSCAR (finasteride)		
Calcium Channel Blockers, Oral	**Short-Acting**		
	diltiazem		
	DYNACIRC (isradipine)		
	nicardipine		
	nifedipine		
	NIMOTOP (nimodipine)		
	verapamil		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 16 (IR 2006-19)

Continued from Page 15 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Calcium Channel Blockers—Oral (continued)	**Long-Acting**		
	CARDENE SR (nicardipine)	COVERA-HS (verapamil)	
	CARDIZEM LA (diltiazem)	VERELAN (verapamil)	
	diltiazem ER		
	DYNACIRC CR (isradipine)		
	felodipine ER		
	nifedipine ER		
	NORVASC (amlodipine)		
	SULAR (nisoldipine)		
	TIAZAC 420 mg (diltiazem)		
	verapamil ER		
	VERELAN PM (verapamil)		
Cephalosporins and Related Antibiotics, Oral	**Beta Lactam / Beta Lactamase Inhibitor Combinations**		
	amoxicillin/clavulanate		
	AUGMENTIN XR (amoxicillin/ clavulanate)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 17 (IR 2006-19)

Continued from Page 16 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Cephalosporins and Related Antibiotics, Oral	**Cephalosporins—First Generation**		
	cefadroxil		
	cephalexin		
	cephradine		
	PANIXINE (cephalexin)		
	Cephalosporins—Second Generation		
	cefaclor		
	cefprozil		
	cefuroxime		
	LORABID (loracarbef)		
	RANICLOR (cefaclor)		
	Cephalosporins—Third Generation		
	CEDAX (ceftibuten)		
	cefpodoxime		
	OMNICEF (cefdinir)		
	SPECTRACEF (cefditoren)		
	SUPRAX (cefixime)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 18 (IR 2006-19)

Continued from Page 17 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	**Preferred Agents**	**Non-Preferred Agents**	**Prior Authorization / Class Criteria**
Cytokine and CAM Antagonists	AMEVIVE (alefacept)		
	ENBREL (etanercept)		
	HUMIRA (adalimumab)		
	KINERET (anakinra)		
	RAPTIVA (efalizumab)		
	REMICADE (infliximab)		
Erythropoiesis Stimulating Proteins **Effective 07/01/06**	ARANESP (darbepoetin)	EPOGEN (rHuEPO)	Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agent within the last 6 months.
	PROCRIT (rHuEPO)		
Estrogens	**Oral**		
	CENESTIN (conjugated estrogens		
	estradiol		
	estropipate		
	GYNODIOL 1.5 mg (estradiol)		
	MENEST (estrogens		
	PREMARIN (estrogens		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 19 (IR 2006-19)

Continued from Page 18 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Estrogens	**Transdermal**		
	ALORA (estradiol)		
	CLIMARA (estradiol)		
	ESCLIM (estradiol)		
	ESTRADERM (estradiol)		
	estradiol		
	ESTROGEL (estradiol)		
	VIVELLE (estradiol)		
	VIVELLE-DOT (estradiol)		
	Vaginal		
	ESTRING (estradiol)	ESTRACE (estradiol)	
	FEMRING (estradiol)		
	OGEN (estropipate)		
	PREMARIN (estrogens, conjugated)		
	VAGIFEM (estadiol)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 20 (IR-2006-19)

Continued from Page 19 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Fluoroquinolones, Oral	AVELOX (moxifloxacin)		
	CIPRO Suspension (ciprofloxacin)		
	CIPRO XR (ciprofloxacin)		
	ciprofloxacin		
	FACTIVE (gemifloxacin)		
	LEVAQUIN (levofloxacin)		
	ofloxacin		
Blucocorticoids, Inhaled	FLOVENT (fluticasone)	AEROBID (flunisolide)	Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agents within the last 6 months.
	PULMICORT (budesonide)	AEROBID-M (flunisolide)	
		AZMACORT (triamcinolone)	
		QVAR (beclomethasone)	
Growth Hormone [CL] **Effective 07/01/06**	GENOTROPIN (somatropin)	UMATROPE (somatropin)	Growth hormone will be approved for patients with any of the following diagnoses and meeting the criteria defined on the PA Form: • Chronic Renal Impairment awaiting renal transplantation (ICD-9 585) • Growth Hormone Deficiency (ICD-9=253.2, 253.3) • Prader-Willi Syndrome (ICD-9=759.81) • Turner Syndrome (ICD-9=758.6) • HIV plus Cachexia (ICD-9=042, 079.53, V08 or 795.71 plus 799.4) Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agents within the last 6 months. Patients currently on a Non-preferred agent will be authorized to continue therapy with that agent.
	NORDITROPIN (somatropin)	NUTROPIN (somatropin)	
	NUTROPIN AQ (somatropin)		
	SAIZEN (somatropin)		
	SEROSTIM (somatropin)		
	TEV-TROPIN (somatropin)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 21 (IR 2006-19)

Continued from Page 20 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	**Preferred Agents**	**Non-Preferred Agents**	**Prior Authorization / Class Criteria**
Hepatitis C Treatments **Effective 07/01/06**	PEG-INTRON (pegylated interferon alfa-2b)	COPEGUS (ribavirin)	Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agents within the last 6 months.
	PEGASYS (pegylated interferon alfa-2a)	INFERGEN (consensus interferon ribavirin)	
	REBETOL (ribavirin)		
Hypoglycemics, Meglitinides	PRANDIN (repaglinide)		
	STARLIX (nateglinide)		
Hypoglycemics, Sulfonylureas	acetohexamide	tolazamide	
	chlorpropamide	tolbutamide	
	glimepiride		
	glipizide		
	glyburide		
Hypoglycemics, TZDS	**Thiazolinediones**		
	ACTOS (pioglitazone)		
	AVANDIA (rosiglitazone)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on page 22 (IR 2006-19)

Continued from Page 21 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Hypoglycemics, TZDS	**TZD Combinations**		
	ACTOPLUS MET (pioglitazone/metformin)		
	AVANDAMET (rosiglitazone/metformin)		
	AVANDARYL (rosiglitazone/glipizide)		
Leukotriene Receptor Modifiers [CL]	ACCOLATE (zafirlukast)		Leukotriene receptor modifiers will be approved for patients with one of the following diagnosis: • asthma (ICD-9=493.00, 493.01, 493.02) AND – are ≤16 years of age – are >16 years of age and are currently on or have failed therapy with an inhaled corticosteroid
	SINGULAIR (montelukast)		
Lipotropics, Other (non-statins) **Effective 07/01/06**	**Bile Acid Sequestrants**		
	holestyramine	WELCHOL (colesevalam)	
	COLESTID (colestipol)		
	Cholesterol Absorption Inhibitors		Zetia will be approved for patients who have a diagnosis of hypercholesterolemia and have either failed HMG-CoA reductase monotherapy or have a documented intolerance to HMG-CoA reductase treatment. Zetia treatment is only approved as an adjunct to concurrent HMG-CoA reductase therapy unless there is a documented intolerance to the HMG-CoA reductase inhibitors.
		ZETIA (ezetimibe)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 23 (IR 2006-19)

Continued from Page 22 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Lipotropics, Other (non-statins) **Effective 07/01/06**	**Fibric Acid Derivatives**		
	fenofibrate	ANTARA (fenofibrate)	
	gemfibrozil	TRIGLIDE (fenofibrate)	
	TRICOR (fenofibrate)		
	Niacin		
	NIASPAN (niacin)	NIACELS (niacin)	
		NIADELAY (niacin)	
		SLO-NIACIN (niacin)	
Lipotropics, Statins	**Statins**		Statins will be authorized only for patients ≥8 years of age Crestor will be approved for patients with documented failure of 2 preferred agents or 2 different doses of a single preferred agent for at least 150 days in the last 6 months. A quantity limit of one dosage per day applies to all but the highest strength of each agent.
	ALTOPREV (lovastatin)	CRESTOR (rosuvastatin)	
	LESCOL (fluvastatin)	simvastatin	
	LESCOL XL (fluvastatin)		
	LIPITOR (atorvastatin)		
	lovastatin		
	pravastatin		
	ZOCOR (simvastatin)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 24 (IR 2006-19)

Continued from Page 23 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Lipotropics, Statins	**Statin Combinations**		Caduet will be approved for patients with documented failure of 2 preferred agents or 2 different doses of a single preferred agent for at least 150 days in the last 6 months. Vytorin will be authorized for patients failing a minimum 3 month trial of standard dose statin.
	ADVICOR (lovastatin/niacin)	CADUET (atorvastatin/amlodipine)	
		VYTORIN (simvastatin/ezetimibe)	
Ketolides and Macrolides	**Ketolides**		Ketek will be approved if there is documentation of any antibiotic use within the past 28 days.
		KETEK (telithromycin)	
	Macrolides		
	azithromycin		
	BIAXIN XL (clarithromycin)		
	clarithromycin		
	erythromycin		
	ZITHROMAX Powder Packet (azithromycin)		
	ZITHROMAX Suspension (azithromycin)		
Multiple Sclerosis Agents	AVONEX (interferon beta-1a)		
	BETASERON (interferon beta-1b)		
	COPAXONE (glatiramer)		
	REBIF (interferon beta-1a)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 25 (IR 2006-19)

Continued from Page 24 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	**Preferred Agents**	**Non-Preferred Agents**	**Prior Authorization / Class Criteria**
NSAIDS, COX-II Selective [CL]	CELEBREX (celecoxib)		Celebrex will be approved for patients with rheumatoid arthritis, osteoarthritis, acute pain or dysmenorrhea and who have any of the following risk factors for a gastrointestinal bleed: • Previous or current PUD or GI bleed • Concurrent therapy with corticosteroids, anticoagulants or antiplatelets • Inability to tolerate at least two nonselective NSAIDs • Familial Adenomatous Polyposis Acute pain treatment is limited to 14 days
Otic AntibioticC Preparations **Effective 07/01/06**	CIPRODEX (ciprofloxacin/ dexamethasone)	CIPRO HC (ciprofloxacin/hydrocortisone)	Non-preferred agents will be authorized for patients failing to respond to the preferred agents.
	COLY-MYCIN S (neomycin/ hydrocortisone)	CORTISPORIN TC (neomycin/ hydrocortisone)	
	FLOXIN (ofloxacin)		
	neomycin/polymyxin/ hydrocortisone		
Phosphate Binders	FOSRENOL (lanthanum)		
	MAGNEBIND 400 (magnesium/calcium carbonate)		
	PHOSLO (calcium acetate)		
	RENAGEL (sevelame		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 26 (IR 2006-19)

Continued from Page 25 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	**Preferred Agents**	**Non-Preferred Agents**	**Prior Authorization / Class Criteria**
Platelet Aggregation Inhibitors	AGGRENOX (dipyridamole/ aspirin)		
	dipyridamole		
	PLAVIX (clopidogrel)		
	ticlopidine		
Proton Pump Inhibitors, Oral [CL]	NEXIUM (esomeprazole)	ACIPHEX (rabeprazole)	Proton pump inhibitors will be approved for patients meeting one of the following criteria: • Non-selective NSAID treatment with: – History of peptic ulcer disease or GI bleed – Concurrent use of warfarin or corticosteroids • Diagnosis of: – Zollinger-Ellison Syndrome – Systemic mastocytosis – Esophageal reflux – Esophagitis – Perforation, stricture or ulceration of esophagus – Concurrent or history of GI bleed, obstruction or perforation – Concurrent or history of complicated PUD – Cystic fibrosis and on pancreatic enzyme treatment – GI organ cancer – NSAID-induced ulcer that requires continued non-selective NSAID therapy – Current H. pylori associated with PUD as part of a 2-4 drug eradication regimen (limited to 3 month duration) Non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last 6 months. Quantity limits of one dose per day apply to this class
	PREVACID Capsules (lansoprazole)	omeprazole	
	PREVACID Suspension (lansoprazole)	PREVACID Solutabs (lansoprazole)	
	PRILOSEC OTC (omeprazole)	PROTONIX (pantoprazole)	
		ZEGERID (omeprazole / sodium bicarbaonate)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 27 (IR 2006-19)

Continued from Page 26 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Sedative Hypnotics **Effective 07/01/06**	**Benzodiazepines**		Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agents within the last 6 months.
	DORAL (quazepam)	flurazepam	
	estazolam		
	RESTORIL 7.5 mg (temazepam)		
	temazepam		
	triazolam		
	Others		
	AMBIEN (zolpidem)	AMBIEN CR (zolpidem)	
	chloral hydrate	ROZEREM (ramelteon)	
	LUNESTA (eszopiclone)	SONATA (zaleplon)	
Stimulants and Related Agents [CL]	**Stimulants**		Stimulants will be authorized for patients with one of the following diagnoses in the previous 2 years: • ADD/ADHD (ICD-9=314) – amphetamine salt combination products, dextroamphetamine, methylphenidate products, Focalin, Focalin XR, Desoxyn • Narcolepsy (ICC-9=347) - amphetamine salt combination products, dextroamphetamine, methylphenidate products, Focalin, Focalin XR Stimulants will not be authorized for patients with any of the following diagnoses in previous 2 years: • opiate abuse (ICD-9=305.5) • drug dependence: opioids (ICD-9=304.0), cocaine (ICD-9=304.2), amphetamine (ICD-9=304.4), hallucinogen (ICD-9=304.5) • hypertension (ICD-9=401-405) • hyperthyroidism (ICD-9=242) • glaucoma (ICD-9=365)
	ADDERALL XR (amphetamine salt combination)		
	amphetamine salt combination		
	CONCERTA (methylphenidate)		
	DESOXYN (methamphetamine)		
	dextroamphetamine		
	FOCALIN (dexmethylphenidate)		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 28 (IR 2006-19)

Continued from Page 27 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Stimulants and Related Agents [CL] (continued)	**Stimulants (continued)**		Amphetamine salt combination products, dextroamphetamine and Desoxyn will be authorized only for patients ≥3 years of age. Methylphenidate products, Focalin and Focalin XR will be authorized only for patients ≥6 years of age.
	FOCALIN XR (dexmethylphenidate)		
	METADATE CD (methylphenidate)		
	methylphenidate		
	RITALIN LA (methylphenidate)		
	Non-Stimulants		Strattera will be approved for patients meeting at least one of the following criteria: • documented trial and failure of 2 stimulants within 2 months • diagnosis of tics, anxiety disorder or a history of substance abuse Provigil will be approved for patients ≥16 years of age with any of the following diagnoses in the previous 2 years: • diagnosis of narcoloepsy (ICD-9=347) • obstructive sleep apnea (ICD-9=780.51, 780.53)
		PROVIGIL (modafanil)	
		STRATTERA (atomoxetine)	
Ulcerative Colitis Agents **Effective 07/01/06**	**Oral**		
	ASACOL (mesalamine)		
	COLAZAL (balsalazide)		
	DIPENTUM (olsalazine)		
	PENTASA (mesalamine)		
	sulfasalazine		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

[CL] – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 29 (IR 2006-19)

Continued from Page 28 (IR 2006-19)

Idaho Medicaid
Preferred Drug List with prior Authorization Criteria

Updated June 2, 2006

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	Prior Authorization / Class Criteria
Ulcerative Colitis Agents	**Rectal**		
Effective 07/01/06	CANASA (mesalamine)		
(continued)	mesalamine		

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

Continued on Page 30 (IR 2006-19)

July 6, 2006

MEDICAID INFORMATION RELEASE MA06-21

TO: DDA, Residential Habilitation Providers

FROM: Leslie M. Clement, Administrator

SUBJECT: **RATE INCREASE DEVELOPMENTAL DISABILITY SERVICES AND RESIDENTIAL HABILITATION SERVICES EFFECTIVE JULY 1, 2006**

This Information Release replaces the letter sent out to the Medicaid Developmental Disability Services Providers dated June 20, 2006.

Beginning July 1, 2006, the Department of Health and Welfare is authorized to increase the rates paid to providers of developmental disability services for certain services not to exceed 1.9% for fiscal year 2007. These services include developmental therapy evaluation, developmental therapy for groups and individuals, supported living for groups and individuals, comprehensive community support/daily, and community-based services/daily.

Effective July 1, 2006, the new rates for these services will be as follows:

Procedure Code	Modifier	Procedure Description Short	Current Rate	New Rate
H2000		Developmental Therapy Evaluation—C	$4.45	$4.53
H2014*	HQ	Developmental Therapy/Group	$1.77	$1.80
H2014*		Developmental Therapy/Individual	$4.45	$4.53
H2014*	HQ/U4	Dev. Therapy/Group for N.F.R.	$2.10	$2.14
H2014*	U4	Dev. Therapy/Ind. for N.F. Rec.	$4.92	$5.01
H2015	U8	Supported Living - 1 Consumer-Adults	$3.18	$3.24
H2015	HQ/U8	Supported Living - 2 Consumers-Adults	$1.87	$1.91
H2016 **		School Days High Support	$175.00	$178.33
H2016 **		School Days Intense Support	$208.50	$212.46
H2016 **		Non-School Days Intense Support	$263.66	$268.66
H2016	U8	Supported Living Intense for Adults	$263.66	$268.66
H2021 *	HQ	Developmental Therapy Group	$2.10	$2.14
H2021 *		Developmental Therapy Individual	$4.92	$5.01
H2022	U8	Supported Living High for Adults	$221.12	$225.32
H2022*		Non-School Days High Support	$221.12	$225.32
H2032		Developmental Therapy/Individual-Adults	$4.45	$4.53
H2032	HQ	Developmental Therapy/Group-Adults	$1.77	$1.80
H2032	U4	Dev. Therapy/Individual for N.F. Rec.	$4.92	$5.01
97537		Dev. Therapy/Individual–Home or Comm-Adults	$4.92	$5.01
97537	HQ	Dev. Therapy/Groups of 2 In-Home or Comm-Adults	$2.10	$2.14

* Procedure code for services to children
** New rates effective July 2, 2006

Continued on Page 31 (IR MA06-21)

Continued from Page 30 (IR MA06-21)

Providers will be able to bill the new prices starting July 2006 without submitting an addendum to the participants plan.

If you have any questions please contact Gynna Loper, Senior Financial Specialist in the Division of Medicaid Office of Reimbursement Policy, at (208) 364-1994.

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

LMC/gl/sw

~~~~~~

July 6, 2006

MEDICAID INFORMATION RELEASE MA06-22

TO: Personal Care Services Agencies, Aged and Disabled Waiver Agencies, Traumatic Brain Injury Waiver Agencies, Developmentally Disabled Waiver Agencies, Assisted Living Facilities, Certified Family Homes

FROM: Leslie M. Clement, Administrator

SUBJECT: **CHANGES TO BILLING FOR INDIVIDUALS WITH A CLIENT CONTRIBUTION**

There has been confusion in the past in billing for individuals with a client contribution. This occurs most often when the billing week spans a month; that is, when the week starts in one month but changes to a new month somewhere within that week. When this occurred, all services rendered for the complete week were applied against the contribution amount for the new month making it difficult to clearly see what portion was allocated to prior month.

Effective August 1, 2006 changes have been made to the billing system to eliminate this confusion.

In order to facilitate this change, **when billing the codes listed below, it will be necessary to bill the code only within the month the service was delivered**. If the service spans two months, it will be necessary to bill on two lines, one for each month. The client contribution will be deducted for the month in which the service occurred.

This change should make it easier for individuals to understand how their client contribution is being applied and to aid providers in explaining the client contribution.

Aged and Disabled Waiver

Procedure Code	Service Name
S5100 U2	Adult Day Care
S5125 U2	Attendant Care
S5135 U2	Companion Services
S5130 U2	Homemaker
S5140 U2	Adult Residential Care
T1001 U2	Nursing RN Oversight
G9002 U2	Case Management

Procedure Code	Service Name
T1005 U2	Respite
S5120 U2	Chore Services
S5115 U2	Consultation
T1002 U2	Nursing RN
T1003 U2	Nursing LPN
G9001 U2	Case Management

Continued on Page 32 (IR MA06-22)
~~~~~~

Continued from Page 31 (IR MA06-22)

Developmental Disabilities Waiver

Procedure Code	Service Name
0919B U8 H2015 U8 H2015 HQ U8 H2022 U8 H2016 U8	Residential Habilitation
S5121 U8	Chore Services
H2023 U8	Supported Employment
T1000 U8	Skilled Nursing RN
T1000 TD U8	RN
H2019 U8	Case Management

Procedure Code	Service Name
S5140 U8	Agency Affiliation for Certified Family Home
T1005 U8	Respite
T1001 U8	RN Independent
T1000 TE U8	LPN
S5100 U8	Adult Day Care

Traumatic Brain Injury

Procedure Code	Service Name
H2016 U3	TBI Daily Rate
97110 U3	Physical Therapy
97535 U3	Occupational Therapy
T1005 U3	Respite
S5140 U3	Certified Family Home
S5125 U3	Attendant Care
T1000 TE U3	LPN
S5120 U3 S5121 U3	Chores
H2015 U3 H2023 U3	Supported Living

Procedure Code	Service Name
T1019 U3	Personal Care
0930T U3	Coordinator
90899 U3	Consultation
T2021 U3	Day Rehabilitation
T1001 U3	RN Supervisor
T1000 TD U3	RN
G9002 U3	Evaluation
92507 U3 92508 U3	Speech Therapy

If you have questions regarding this information, please contact Christine Baylis at 208-364-1891. We appreciate your continued participation in the Idaho Medicaid Program.

LMC/cb/sw

July 6, 2006

MEDICAID INFORMATION RELEASE MA06-23

TO: Physicians, DME Providers, and Hearing Services Providers

FROM: Leslie M. Clement, Administrator

SUBJECT: REIMBURSEMENT FOR HEARING AID BATTERIES

Effective August 1, 2006, the Idaho Medicaid Reimbursement rate for procedure code V5266, battery for use in hearing device, will change to $1.00 per each from the current rate of $5.00. In order to obtain proper reimbursement, providers will need to bill for each individual battery rather than billing per package (for example, if providing two packages of 5 batteries each, bill for ten units rather than two units).

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.

LMC/ea/sw

July 3, 2006

MEDICAID INFORMATION RELEASE MA06-24

TO: Developmental Disabilities Agencies (DDA)

FROM: Leslie M. Clement, Administrator

SUBJECT: **NEW DDA PROCEDURE CODES EFFECTIVE JULY 1, 2006**

Beginning July 1, 2006, DDAs may bill for Pharmacological Management and a Comprehensive Intensive Behavioral Intervention (IBI) Assessment when provided in accordance with IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)". These services will be subject to current DDA limitations and the limitations outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" that will be published in the August edition of the Idaho Administrative Bulletin.

These services will be as follows:

Service	CPT or HCPCS Code	Description	Place of Service	Rate
Pharmacological Management	90862	Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy. 1 unit = 1 visit	11 – Office 12 – Home 99 – Other	$50.26/visit

Continued on Page 34 (IR MA06-24)

Continued from Page 33 (IR MA06-24)

Service	CPT or HCPCS Code	Description	Place of Service	Rate
Comprehensive IBI Assessment	T2024	Service Assessment. Specify exact time. 1 unit = 15 minutes PA required	11 – Office 12 – Home 99 – Other	$11.35/unit

The Department is continuing to work on developing an additional DDA service called Supportive Counseling. Further information will be provided as it becomes available through a separate Information Release and in the August edition of the Idaho Administrative Bulletin.

If you have questions regarding this 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.

IDAHO MEDICAID PROVIDER HANDBOOK

This Information Release updates Section 3.3 of your Idaho Medicaid Provider Handbook – Rehabilitative and Health Related Services Guidelines.

LMC/ds/sw

~~~~~~

July 7, 2006

MEDICAID INFORMATION RELEASE MA06-25

TO: Developmental Disability Centers (DD), Mental Health Clinic (MHC) and Mental Health Rehabilitation (MHR) Providers

FROM: Leslie M. Clement, Administrator

SUBJECT: **CHANGES TO MEDICAID REIMBURSEMENT RATES**

Effective July 1, 2006, the following table reflects increases to reimbursement rates for the following services:

These rates are being adjusted in order to bring them into alignment with rates paid to other community-based providers.

Provider	HCPCS Code	Modifier	Description	New Rate
DD	97003		Occupational Therapy Evaluation - 1 UNIT=15 MIN	$14.00
DD	97535	HQ	Occupational Therapy/Group - 1 UNIT=15 MIN	$3.59
DD	97535		Occupational Therapy/Individual - 1 UNIT=15MIN.	$14.00

Continued on Page 35 (IR MA06-25)
~~~~~~

Continued from Page 34 (IR MA06-25)

Provider	HCPCS Code	Modifier	Description	New Rate
DD	97001		Physical Therapy Evaluation - 1 UNIT=15 MIN	$14.00
DD	97150		Physical Therapy/Group - 1 UNIT=15 MIN	$3.59
DD	97110		Physical Therapy/Individual - 1 UNIT=15 MIN	$14.00
DD	90801		Psychiatric Diagnostic Interview Exam - 1 UNIT=15 MIN	$16.46
DD	90847	U4	Psychotherapy Family FOR NF Recipient - 1 UNIT=15 MIN	$12.84
DD	90847		Psychotherapy Family Medical - 1 UNIT=15 MIN	$12.84
DD	90853		Psychotherapy Group Medical - 1 UNIT=15 MIN	$3.89
DD	H0004		Psychotherapy Individual Medical - 1 UNIT=15 MIN	$14.35
DD	92506		Speech Evaluation - 1 UNIT=15 MIN	$14.00
DD	92508		Speech Therapy Group - 1 UNIT=15 MIN	$4.37
DD	92507		Speech Therapy Individual - 1 UNIT=15 MIN	$14.00
MHC	97535		Occupational Therapy - Individual - 1 UNIT=15 MIN	$14.00
MHC	90847	U4	Psychotherapy Family for NF Recipient - 1 UNIT=15 MIN	$12.84
MHC	90899	U4	Psychotherapy Individual Interactive NF Recipient - 1 UNIT=15	$16.74
MHR	97003		Occupational Therapy Evaluation - 1 UNIT=15 MIN	$14.00
MHR	97535		Occupational Therapy/Individual - 1 UNIT=15MIN.	$14.00
MHR	90847		Psychotherapy Family	$12.84
MHR	90847	U4	Psychotherapy Family for NF Recipient - 1 UNIT=15 MIN	$12.84
MHR	H0004	U4	Psychotherapy Individual for NF Recipient - 1 UNIT=15 MIN	$12.84

If the market analysis results show that payment increases were not warranted, the Department may make additional changes to these reimbursement rates to reflect the results of the market analysis.

If you have any questions please contact Gynna Loper, Senior Financial Specialist in the Office of Medicaid Reimbursement Policy, at (208) 364-1994.

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

LMC/gl/sw

Provider Handbook Updates

Medicaid Modernization changes and other updates have been incorporated into the Provider Handbooks.

For information regarding these changes, please refer to the most current version of the Provider Handbooks on the following web site: **http://www.healthandwelfare.idaho.gov/site/3438/default.aspx**.

July 6, 2006

MEDICAID INFORMATION RELEASE MA06-26

TO: Providers of School Based Services

FROM: Leslie M. Clement, Administrator

SUBJECT: CHANGES TO MEDICAID COVERAGE AND REIMBURSEMENT

Note: This information release replaces the letter mailed to all Idaho Medicaid School-Based Service providers dated June 26, 2006.

This information release is to notify providers of School-Based Services (SBS) of upcoming changes to Idaho Medicaid coverage and reimbursement. SBS providers have been recently informed of new administrative process requirements, referred to as intergovernmental transfer (IGT). The IGT process requires new procedures for both schools and Medicaid regarding payment transactions. A requirement related to the IGT process is that rates paid to schools are aligned with other community-based rates to non-school providers. The following table reflects the adjustments which will be effective on July 1, 2006 consistent with IGT regulations:

Code	MOD	Description	New Rate
90801		Psych Diag Interview Exam, 1 UNIT = 15 MIN	$16.46
90847		Family Psych Therapy, 1 UNIT = 15 MIN	$12.84
90853		Group Psych Therapy, 2 Students, 1 UNIT = 15 MIN	$3.89
90899		Ind. Psych Therapy, 1 UNIT = 15 MIN	$16.74
V5008		Hearing Eval, 1 UNIT = 15 MIN	$14.00
92506		Speech Eval, 1 UNIT = 15 MIN	$14.00
92507	HO	Ind. Spch/Hearing Prof Therapy, 1 UNIT = 15 MIN	$14.00
92507	HM	Ind. Sp/Hear Therapy Tech, 1 UNIT = 15 MIN	$8.00
97001		Physical Therapy Eval, 1 UNIT = 15 MIN	$14.00
97110	HO	Ind. Physical Therapy Prof, 1 UNIT = 15 MIN	$14.00
97110		Ind. Physical Therapy/Tech, 1 UNIT = 15 MIN	$8.00
97003		Occ. Therapy Eval, 1 UNIT = 15 MIN	$14.00
97530	HO	Ind. Occ. Therapy/Prof, 1 UNIT = 15 MIN	$14.00
97530		Ind. Occ. Therapy/Tech, 1 UNIT = 15 MIN	$8.00

There are other policy changes that impact schools as well:

- CMS has informed the State of Idaho that it will no longer share in the cost of IEP plan development. Effective July 1, 2006, Idaho Medicaid will remove IEP plan development from its covered services.

Continued from Page 36 (IR MA06-26)

- CMS has approved Idaho's request to share in the costs of its Healthy Schools grant program. This program will provide grants to school districts that have a disproportionately high number of low-income students. Initially, grants will offset the cost of 10 full-time equivalent (FTE) professional nurses to provide prevention and wellness services in schools. The design of this program is being finalized this summer in partnership with the State Department of Education and the initial grant will be made this fall.

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.

LMC/ea/sw

~~~~~~

July 21, 2006

MEDICAID INFORMATION RELEASE MA06-27

TO: Service Coordination Agencies for Adults with Mental Illness

FROM: Leslie M. Clement, Administrator

SUBJECT: TRANSITION OF PARTICIPANTS FROM MEDICAID BASIC PLAN TO MEDICAID ENHANCED PLAN FOR SERVICE COORDINATION

The purpose of this Information Release is:

- to describe how participants covered under the Idaho Medicaid Basic Plan become eligible for Service Coordination for Individuals With Severe and Persistent Mental Illness and
- to describe how providers fulfill their role in helping to ensure that the service coordination services are reimbursable.

No Change to Medical Necessity Criteria for Receiving Service Coordination

In order to receive service coordination, a participant covered by the Medicaid Basic Plan must first obtain the required assessment to establish eligibility for service coordination services. Although the assessment of the need for service coordination is covered under the Basic Plan, service coordination is only reimbursable under the Medicaid Enhanced Plan (see Information Release # MA 2006-15). The eligibility criteria for service coordination is presently described at IDAPA 16.03.17.300. New rules publishing August 2, 2006 will describe the same criteria at IDAPA 16.03.10.722-726.

New Process and Form Effective July 1, 2006

When the Service Coordinator has determined that an adult participant is eligible for service coordination, the provider must complete IDHW form H0002 and submit it via fax or electronically to the Family Medicaid Unit. The provider should maintain the original H0002 and the assessment in the participant's medical record. Upon receipt of form H0002, the Family Medicaid Unit will enroll the participant in the Medicaid Enhanced Plan so that the provider's claims for enhanced services may be reimbursed. The provider must keep the original signed copy of form H0002 in the participant's medical record.

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
~~~~~~

July 1, 2006

MEDICAID INFORMATION RELEASE MA06-28

TO: Mental Health Clinics, Psychosocial Rehabilitation (PSR) Agencies, Primary Care Physicians (PCP)

FROM: Leslie M. Clement, Administrator

SUBJECT: TRANSITION OF PARTICIPANTS FROM BASIC TO ENHANCED MEDICAID MENTAL HEALTH SERVICES

The purpose of this Information Release is to inform providers of:

- the procedure for identifying whether or not a participant requires enrollment in the Medicaid Enhanced Plan based on health needs,
- the provider's role in determining that a participant's mental health needs are best served by the Medicaid Enhanced Plan,
- communication with the Department when a provider identifies a participant who should be assigned to the Medicaid Enhanced Plan, and
- reimbursement process requirements.

All participants who are enrolled in the Medicaid Basic Plan who require enhanced mental health services must first obtain a comprehensive assessment, code H0031, to establish medical necessity for the Medicaid Enhanced Plan.

Role of the PCP

Medicaid participants must obtain a Healthy Connections referral to obtain mental health services of any kind. There are basically two types of referrals the PCP may make:

- If the medical situation warrants it, the PCP may make the referral to a Mental Health Clinic or a PSR agency for an immediate comprehensive assessment to establish the medical necessity for Enhanced Plan mental health services such as psychotherapy services up to 45 hours per year or psychosocial rehabilitation or partial care.

- The PCP may choose to refer the participant to a Mental Health Clinic for any of the general Basic Plan mental health services such as psychotherapy, psychological testing, psychopharmacology or any combination of those services or other services and defer the decision about whether or not the participant needs an immediate comprehensive assessment to the Clinic professionals who will then take sufficient time to work with the participant to determine if Basic Plan services are adequate to meet the participant's mental health needs.

Once a participant has obtained a referral from his PCP and is engaged in treatment at a Mental Health Clinic another PCP referral for obtaining a comprehensive assessment or obtaining further treatment in the Enhanced Plan is not necessary unless the participant switches mental health providers.

Continued on Page 39 (IR MA06-28)

Continued from Page 38 (IR MA06-28)

Criteria for Enhanced Plan Placement

Medical necessity for Enhanced Plan placement for child participants is established by the child meeting the criteria for severe emotional disturbance (SED) as presently described at IDAPA 16.03.09.450.01. Medical necessity for Enhanced Plan placement for adult participants is established by the adult meeting the criteria for severe and persistent mental illness (SPMI) as presently described at IDAPA 16.03.09.450.02. New IDAPA rules publishing August 2, 2006 will describe the same eligibility requirements at 16.03.10.111.

Prior to a participant's annual Medicaid renewal date the Department will review the participant's utilization of mental health services in the current year. If the participant has a current (within the past twelve (12) months) comprehensive assessment that indicates the SED or SPMI criteria has been met the participant will be placed in the Medicaid Enhanced Plan. If there is no evidence of the criteria having been met but the participant has been a high utilizer of mental health services the Department will refer the participant for a comprehensive assessment to determine appropriate plan placement based on health needs.

Comprehensive Assessments

Professional staff in Mental Health Clinics and Psychosocial Rehabilitation agencies must perform comprehensive assessments to determine whether participants need enhanced mental health services. The comprehensive assessment benefit is covered in Medicaid Basic Plan and counts toward the 26 service limitation and is also part of the 12 hour diagnosis and evaluation benefit (see IR # MA 2006-15). Comprehensive assessments must meet the requirements presently described in IDAPA 16.03.09.453.01. New IDAPA rules publishing August 2, 2006 will describe the requirements at 16.03.10. 112. Comprehensive assessments must not be a duplication of social histories which are still required to be a part of all medical records as a part of the intake process in Mental Health Clinics as presently described in IDAPA 16.03.09.468.01.

In addition to requirements described at 453.01, comprehensive assessments must include a statement describing whether the criteria for enhanced services have been met or not. Additionally, the comprehensive assessment must include either (a) or (b):

(a) Specific treatment recommendations, if clinically appropriate, for any or all of the following services if eligibility for enhanced services is met:
- Psychotherapy
- Partial Care
- Psychosocial Rehabilitation

(b) Specific treatment recommendations for the participant who does not meet criteria and will remain in the Medicaid Basic Plan.

Comprehensive assessments and treatment plans do not require prior authorization, effective July 1, 2006.

New Form and Process Effective July 1, 2006

The Clinic or PSR agency that has determined that a participant is eligible for enhanced mental health services as a result of the comprehensive assessment is responsible for notifying the Department that the participant's Medicaid Plan placement should change. This provider must complete IDHW form H0002 and submit it via fax or electronically to the Family Medicaid Unit. Upon receipt of form H0002 the Family Medicaid Unit will change the eligibility classification of the participant so that providers' claims for enhanced services will be reimbursed. The change in eligibility classification will occur within seventy-two (72) hours of receipt of form H0002 which will expedite the claims reimbursement process. The assessment provider must keep the original signed copy of form H0002 in the participant's medical record.

Continued on Page 40 (IR MA06-28)

Continued from Page 39 (IR MA06-28)

The assessment provider must notify the participant (or the participant's guardian as appropriate) of the outcomes of the comprehensive assessment including plan placement and treatment recommendations. The participant must select a mental health treatment provider who is qualified to provide the recommended treatment. The assessment provider and the treatment provider may be the same provider.

The assessment provider is responsible for providing a copy of the assessment to the chosen treatment provider(s) once one or more are identified if different from the assessment provider. Release of the participant's personal health information must comply with all HIPAA requirements

New Form and Process Effective July 1, 2006

The Clinic or PSR agency that has determined that a participant is eligible for enhanced mental health services as a result of the comprehensive assessment is responsible for notifying the Department that the participant's Medicaid Plan placement should change. This provider must complete IDHW form H0002 and submit it via fax or electronically to the Family Medicaid Unit. Upon receipt of form H0002 the Family Medicaid Unit will change the eligibility classification of the participant so that providers' claims for enhanced services will be reimbursed. The change in eligibility classification will occur within seventy-two (72) hours of receipt of form H0002 which will expedite the claims reimbursement process. The assessment provider must keep the original signed copy of form H0002 in the participant's medical record.

The assessment provider must notify the participant (or the participant's guardian as appropriate) of the outcomes of the comprehensive assessment including plan placement and treatment recommendations. The participant must select a mental health treatment provider who is qualified to provide the recommended treatment. The assessment provider and the treatment provider may be the same provider.

The assessment provider is responsible for providing a copy of the assessment to the chosen treatment provider(s) once one or more are identified if different from the assessment provider. Release of the participant's personal health information must comply with all HIPAA requirements.

Treatment Plans and Multiple Providers

Mental health clinics and PSR providers must develop a treatment plan based on the comprehensive assessment. Only one treatment plan is allowed per participant per benefit period.

Mental Health Clinics

When participants choose more than one provider for clinic services during the same time period, the second provider must coordinate with the first provider by obtaining copies of the comprehensive assessment and treatment plan and addending the treatment plan with appropriate goals and objectives. The second provider is responsible for supplying the first provider with a copy of the addended treatment plan and all updates (120-day reviews). Updates to the treatment plan occur on the schedule of the original treatment plan. Duplication of services is not allowed.

PSR Agencies

If the participant chooses multiple PSR providers during the same time period, the second provider may submit a request for prior authorization to the Mental Health Authority for approval of additional treatment plan goals and objectives to complement the existing treatment plan. Providers, who are one of two that have been selected by participants who received treatment recommendations for clinic and PSR services, must coordinate the development of a single treatment plan between themselves to deliver the appropriate services. The second provider is responsible for supplying the first provider with a copy of the addended treatment plan and all updates (120-day reviews). Updates to the treatment plan occur on the schedule of the original treatment plan. Duplication of services is not allowed.

Continued on Page 41 (IR MA06-28)

Continued from Page 38 (IR MA06-28)

Reimbursement

The comprehensive assessment is code H0031 and is limited to 24 units/yr and is reimbursed to Clinics and PSR providers at $11.35 per fifteen (15) minute unit.
The treatment plan is code H0032 which is limited to 8 units/yr per agency and is reimbursed to Clinics and PSR providers at $11.35 per fifteen (15) minute unit. All PSR services with the exception of HC0031 and HC0032 still require prior authorization by the Mental Health Authority. Incomplete assessments and treatment plans are subject to recoupment.

Psychiatric Hospitalization Access Remains Unchanged

While psychiatric hospitalization benefits for participants are limited to ten (10) days in the Medicaid Basic Plan the pathway for the participant to access psychiatric hospital services at any point, no matter how much of this benefit has already been used, remains the same as it was prior to Medicaid Modernization. Medicaid staff will be monitoring use of this benefit among participants and will adjust plan placements when medically necessary so that providers' claims will reimbursed as appropriate.

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

Corrections to Reimbursement of Bilateral (Modifier 50) Procedure Codes for Hospital Ambulatory Surgical Center Providers

Currently, Idaho Medicaid does not permit hospital providers to bill with Modifier 50 (bilateral) for surgical procedure codes CPT 10000 – 69999. Effective July 1, 2006, a change has been made to price Hospital Outpatient Ambulatory Surgical Centers (ASCs) in alignment with existing rules for freestanding ASCs. Hospital providers will be paid 150% of the standard reimbursement amount for procedures that are performed bilaterally. Any claim details billed since HIPAA implementation (October 2003) with Modifier 50 that were denied can be resubmitted. For those claims resubmitted that are over the one year billing limitation, please include the original paid claim ICN.

If there are any questions please contact Eric Anderson at the Idaho Medicaid Office of Reimbursement Policy at (208) 364-1918.

July 1, 2006

MEDICAID INFORMATION RELEASE MA06-29

TO: Developmental Disabilities Agencies

FROM: Leslie M. Clement, Administrator

SUBJECT: TRANSITION OF PARTICIPANTS FROM BASIC TO ENHANCED DEVELOPMENTAL DISABILITIES AGENCIES (DDA) SERVICES

The purpose of this Information Release is to describe how participants covered under the Idaho Medicaid Basic Plan become eligible for DDA services and how providers fulfill their role in helping to ensure that the DDA services are reimbursable.

All participants enrolled in the Medicaid Basic Plan who require enhanced DDA services must first obtain the required assessments to establish eligibility for DDA services under the Medicaid Enhanced Plan presently described at IDAPA 16.03.09.120. New rules publishing August 2, 2006 will describe the same requirements at IDAPA 16.03.10.653.02.

Criteria for Receiving DDA Services Still Remains

The criteria for establishing the need for DDA services for both adults and children remains the same as it has been prior to Medicaid Modernization. The assessments to establish DDA service eligibility are covered under the Medicaid Basic Plan (see Information Release # MA 2006-15). New rules publishing August 2, 2006 will describe the criteria at IDAPA 16.03.10.500-503.

New Process and Form Effective July 1, 2006

Adults

The Independent Assessment Provider (IAP) will perform a new step for processing enrollment of adults who qualify for DDA services into the Medicaid Enhanced Plan. When the IAP has determined that an adult participant is eligible for DDA services, the IAP must complete IDHW form H0002 and submit it via fax or electronically to the Family Medicaid Unit. The IAP should maintain the original copy of the H0002 and the assessment in the participant's medical record. Upon receipt of form H0002, the Family Medicaid unit will enroll the participant in the Medicaid Enhanced Plan so that the DDA provider's claims for enhanced services may be reimbursed. The IAP must keep the original signed copy of form H0002 in the participant's medical record.

Children

The DDA that determines a child participant's eligibility for DDA services must complete the same process described above. The DDA provider must keep the original signed copy of form H0002 in the participant's medical record. Otherwise the process to determine eligibility for DDA services for children remains the same as described in IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)".

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

Directions: Please fill in all blanks, print and sign the form, submit to Family Medicaid by fax at **208-528-5756**. Maintain original in participant's records. You may choose to submit the form electronically to: **familymedicaid@idhw.state.id.us**.

IDENTIFYING INFORMATION

Name of Participant:_____ Medicaid ID#:_____

Name of Provider Certifying Medicaid Enhanced Plan:

_____

Name of Agency and Agency provider#:_____

RATIONALE FOR ENHANCED PLAN SERVICES

(Provider: please check the appropriate box as indication of the justification for this participant needing Medicaid Enhanced Plan)

Participant needs the following services:

o Additional Psychotherapy
o Partial Care
o Psychosocial Rehabilitation
o Service Coordination
o Developmental Disabilities
o Inpatient Psychiatric Hospitalization

CERTIFICATION

I have assessed _____ on _____ and certify that this
(Name of participant) (date)

participant meets the requirements in IDAPA 16.03.10 for receiving the above indicated

services in the Medicaid Enhanced Plan.

_____

Signature of Provider Certifying Participant's Eligibility Date

EDS
P.O. Box 23
Boise, Idaho 83707

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

Billing Preventive Medicine Procedures for Adults as of July 1, 2006

With Medicaid Reform starting July 1, 2006, well adult examinations that include "routine gynecological exams" must be billed with the age-appropriate adult preventive medicine procedure and diagnoses V700, V723, V7231, or V7232. Only one preventive procedure will be allowed per adult per rolling year. If additional gynecological exams and pap smears are billed due to a medical reason (i.e., not "routine") they can be billed with a regular E & M procedure and a medical diagnosis and there is no limitation.

Pap smears will continue to be paid to the provider of service: the pathologist or the hospital lab. The collection and handling of pap smears by physicians is included in the payment for the preventive procedure or E & M code.

Note: These requirements and limitations do not apply to Medicare Crossover claims.

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

Editor:
Carolyn Taylor,
Division of Medicaid

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

taylorc3@idhw.state.id.us

or

Carolyn Taylor
DHW MAS
PO Box 83720
Boise, ID 83720-0036

Fax: (208) 364-1911