



# MedicAide

An informational newsletter for Idaho Medicaid Providers

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

August 2009

## In this issue:

- 1 New MMIS Coming in 2010!
- 1 Idaho MMIS Transition News
- 2 Inappropriate Use of Healthy Connections (HC) Referral Number Leads to Recoupment
- 3 Mental Health Clinic Owner Ordered to Repay \$40,874 for Medicaid Fraud
- 4 Double-Check Your Paper Claims to Avoid Delays
- 5 Principles of Mental Health Reform
- 6 To All Providers: It's PERM Time Again!
- 6 Adjust or Resubmit?

## New Medicaid Management Information System (MMIS) Coming in 2010!

The most up-to-date MMIS information is available on the Web at [www.idahommis.dhw.idaho.gov](http://www.idahommis.dhw.idaho.gov). Watch the *MedicAide* newsletter for more information pertaining to the new MMIS. This month's article is below.

### Idaho MMIS Transition News

#### New System Contractors

In 2010, Idaho Medicaid will replace its Medicaid claims processing system, which is currently supported by EDS. The new system is a Medicaid Management Information System, referred to as the Idaho MMIS. The new MMIS will be supported by Unisys Corporation and First Health Services.

**Unisys Corporation** will provide the Base component of the MMIS, which will receive and process prior authorizations, referrals, claims, and remittance advices for medical and dental services. Unisys will also manage provider enrollment for all Idaho Medicaid providers. Unisys will provide day-to-day operational support for providers, including coordination of training and communication. Unisys will also station Provider Regional Consultant staff throughout the state to assist providers.

**First Health Services** will provide the new Pharmacy Benefits Management (PBM) portion of the MMIS, which will receive and process drug prior authorizations, adjudicate drug claims, and produce remittance advices for drug claims. First Health Services will provide technical call center support to pharmacy providers.

#### New Features for All Providers

If you currently submit claims using PES software provided by EDS, in the future you will have the option to submit claims using the new Web portal. This online, secure, claim submission option is available to all providers even if you currently submit claims on paper.

Additional Web-based functionality of the new MMIS will allow providers to:

- Check the status of claims
- Check member eligibility and verify member benefit information
- Download your remittance advice
- Access provider handbooks and training materials
- Chat interactively with a provider services agent

The new MMIS will also feature a call center with an interactive voice response system and toll-free numbers to provide information and technical support for all providers.

*Continued on page 2 (Idaho MMIS Transition News)*

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Department of  
Health and Welfare  
State of Idaho

Pharmacy providers will have a separate toll-free number for contacting the First Health call center for drug claim issues.

### The Most Up-to-Date MMIS Information

Up-to-date MMIS information is available on the Web at: [www.idahommis.dhw.idaho.gov](http://www.idahommis.dhw.idaho.gov). Continue to watch the *MedicAide* newsletter for monthly MMIS updates and check your weekly paper remittance advice (RA) for additional MMIS information.

### Receive MMIS Informational Updates by E-mail

Would you like to receive MMIS updates by e-mail? We are building an "MMIS Updates" e-mail distribution list and would be happy to add you. To join the list, send an e-mail to [IdahoMMIS@dhw.idaho.gov](mailto:IdahoMMIS@dhw.idaho.gov) with "MMIS Updates" in the subject line for each e-mail account you want added to the list. You only need to submit your e-mail request one time. Your e-mail address will be kept private and will not be shared with anyone for any purpose.

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## Inappropriate Use of Healthy Connections (HC) Referral Number Leads to Recoupment

Idaho Medicaid has been receiving complaints from HC Primary Care Providers (PCPs) concerning use of their HC referral number when a referral was not obtained. It is very difficult for PCPs to effectively coordinate their patients' care if they are unaware of the services their patients are receiving. Knowingly using an HC referral number without a referral is **fraudulent** and all claims paid without a referral in place are subject to **recoupment**. Whether you are a Specialist or a Primary Care Provider, use of an HC referral number on a claim indicates you have a documented referral from the participant's HC PCP.

Complete information regarding HC requirements is contained in Chapter 1, Section 5, of the *Idaho Medicaid Provider Handbook*. Both the HC PCP and the provider receiving referral are required to **document the details** of the referral in the participant's record. Those details include who made the referral, date of referral, scope of services to be provided, and the duration of referral.

It is very important to **always** verify a participant's Medicaid eligibility and HC enrollment **prior** to rendering services. If a participant is enrolled in HC, the name and phone number of the HC PCP is provided when using any of the following options:

- PES (software)
- MAVIS (800) 685-3757
- POS device

We encourage you to review procedures with your staff to ensure that billing personnel are not inserting a referral number on claims prior to the referral being obtained and documented. You will also want to make sure that you obtain the referral from the correct PCP by checking who the participant is enrolled with for the date the service. When a participant changes his/her HC PCP, referrals from the former PCP are no longer valid.

Medicaid Health Resource Coordinators are available to provide training on HC requirements. For further information, or to schedule HC training, please contact the Health Resource Coordinator in your area as listed in the sidebar on this page.

### DHW Contact Information

◆ **DHW Web site**  
[www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov)

◆ **Idaho Careline**  
2-1-1  
Toll free: (800) 926-2588

◆ **Medicaid Program Integrity Unit**  
PO Box 83720  
Boise, ID 83720-0036  
Fax: (208) 334-2026  
[prvfraud@dhw.idaho.gov](mailto:prvfraud@dhw.idaho.gov)

### 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) 455-7244  
(208) 642-7006  
(800) 494-4133

◆ **Region IV - Boise**  
(208) 334-0717  
(208) 334-0718  
(800) 354-2574

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

◆ **Region VI - Pocatello**  
(208) 235-2927  
(800) 284-7857

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

◆ **In Spanish (en Español)**  
(800) 378-3385

## Prior Authorization Contact Information

◆ **DME Specialist, Medical Care**  
 PO Box 83720  
 Boise, ID 83720-0036  
 Phone: (866) 205-7403  
 Fax: (800) 352-6044  
 (Attn: DME Specialist)

◆ **Pharmacy**  
 PO Box 83720  
 Boise, ID 83720-0036  
 Phone: (866) 827-9967  
 (208) 364-1829  
 Fax: (208) 364-1864

◆ **Qualis Health (Telephonic & Retrospective Reviews)**  
 10700 Meridian Ave. N.  
 Suite 100  
 Seattle, WA 98133-9075  
 Phone: (800) 783-9207  
 Fax: (800) 826-3836  
 (206) 368-2765  
  
[www.qualishealth.org/idaho/medicaid.htm](http://www.qualishealth.org/idaho/medicaid.htm)

## Transportation

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

◆ **Other Non-emergent and Out-of-State**  
 Phone: (800) 296-0509, #1173  
 (208) 287-1173  
 Fax: (800) 296-0513  
 (208) 334-4979

◆ **Ambulance Review**  
 Phone: (800) 362-7648  
 (208) 287-1157  
 Fax: (800) 359-2236  
 (208) 334-5242

## Insurance Verification

◆ **HMS**  
 PO Box 2894  
 Boise, ID 83701  
 Phone: (800) 873-5875  
 (208) 375-1132  
 Fax: (208) 375-1134

# Mental Health Clinic Owner Ordered to Repay \$40,874 for Medicaid Fraud

A 42-year-old Boise woman accused of fraudulently billing Medicaid was sentenced to three months in prison and ordered to pay \$40,874 in restitution to Medicaid in June.

On June 3, 2009, Lesa McConnel was sentenced in the United States District Court by Judge A. Wallace Tashima after pleading guilty in March to one count of health care fraud. McConnel's sentence also includes three years of supervised release. She paid \$25,000 in restitution prior to sentencing.

A joint investigation by the US Department of Health and Human Services Office of the Inspector General and Idaho Health and Welfare's Medicaid Program Integrity Unit revealed that McConnel billed Medicaid for mental health clinic services without valid treatment plans. Medicaid requires a licensed physician to approve and sign off on treatment plans for mental health clinic services. A valid treatment plan is required for payment.

At the time of the investigation, McConnel was the director, co-owner, and licensed clinical social worker of Alta Addictions and Mental Health Services, Alta Counseling Associates, and Alta Services in Boise.

The Medicaid Program Integrity Unit is dedicated to pursuing fraud and abuse in the Medicaid program and referring suspected fraud to the Medicaid Fraud Control Unit. Providers who alter, falsify, and/or destroy records will be referred for possible prosecution.

Medicaid fraud and abuse can be reported by different methods. By telephone, call (208) 334-5754. To mail a complaint, fill out a provider fraud complaint form found on the Health Care Fraud Web site. Complaints can also be sent via e-mail to: [prvfraud@dhw.idaho.gov](mailto:prvfraud@dhw.idaho.gov)

For more information on Medicaid provider fraud, go to the Health and Welfare Web site at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov) and select *Providers* and, under Resources, select *File a Fraud Complaint*.

File fraud complaints

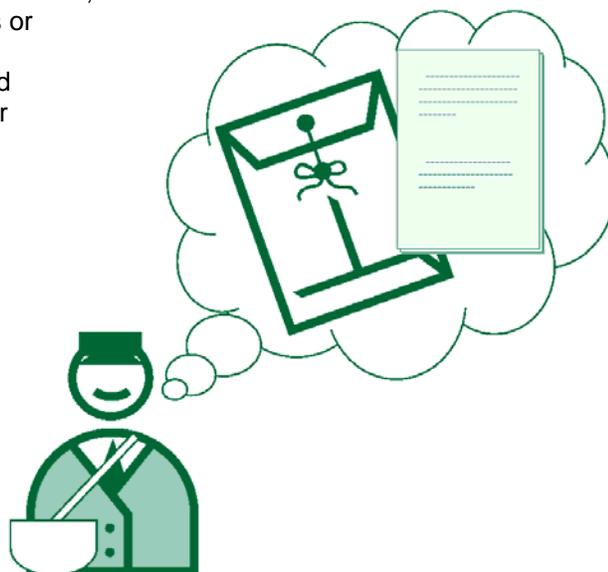
Find resources concerning fraud

Read general information

# Double-Check Your Paper Claims to Avoid Delays

Here are a few simple things you can check before you send your paper claims that may help speed processing:

- Is your 9-digit Idaho Medicaid provider identification number in the appropriate field? And, is it preceded by the 1D (one-D) qualifier on CMS-1500 forms?
- Is all the data aligned within the fields on the claim form so it can be “read” by the scanning software program?
- Is the print legible for scanning, in black ink, and at least an 8-pt font without being too light or excessively bold or blurry?
- Is all hand-printed data legible, in black ink, and without write-overs?
- Does your supporting Explanation of Benefits (EOB) match the claim data?
- Does your EOB have column headers and a paid date? Is it legible?
- Does your Medicare EOB clearly state it is a “Medicare” document? If not, you must write “Medicare” or “MRN” on the top of the EOB or in the remarks field of the claim.
- Do participants’ names appear on the claim as they do on their Idaho Medicaid identification card, that is, in the sequence of last name, first name, and then middle initial, and with commas indicating the separation between last and first name when the name may be confusing?
- If you use highlighters, use yellow or pink only. Other highlighter colors will block out the highlighted print when scanned.
- Are all attachments printed as single-sided? Double-sided documents cannot be scanned on both sides.
- Are claim attachments placed directly behind the associated claim form, with each form having its own attachments?
- Are claims placed flat into a 8.5 X 11-inch, or larger, envelope without staples or paper clips? Claims folded into a small envelope risk being mutilated when they are machine-opened, or being stuck to the envelope flap and tearing. All staples and paper clips must be removed before scanning each page. Save postage and avoid damage to claims by sending multiple claims in a large envelope.



## EDS Contact Information

◆ **MAVIS**  
Phone: (800) 685-3757  
(208) 383-4310

◆ **EDS Correspondence**  
PO Box 23  
Boise, ID 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

◆ **Participant Assistance Line**  
Toll free: (888) 239-8463

## Provider Relations Consultant Contact Information

### ◆ Region 1

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

Phone: (208) 666-6859  
(866) 899-2512  
Fax: (208) 666-6856

EDSPRC-Region1@eds.com

### ◆ Region 2

Darlene Wilkinson  
1118 F Street  
PO Drawer B  
Lewiston, ID 83501

Phone: (208) 799-4350  
Fax: (208) 799-5167

EDSPRC-Region2@eds.com

### ◆ Region 3

Mary Jeffries  
3402 Franklin  
Caldwell, ID 83605

Phone: (208) 455-7162  
Fax: (208) 454-7625

EDSPRC-Region3@eds.com

### ◆ Region 4

Angela Applegate  
1720 Westgate Drive, # A  
Boise, ID 83704

Phone: (208) 334-0842  
Fax: (208) 334-0953

EDSPRC-Region4@eds.com

### ◆ Region 5

Trudy DeJong  
601 Poleline, Suite 3  
Twin Falls, ID 83303

Phone: (208) 736-2143  
Fax: (208) 736-2116

EDSPRC-Region5@eds.com

### ◆ Region 6

Abbey Durfee  
1070 Hiline Road  
Pocatello, ID 83201

Phone: (208) 239-6268  
Fax: (208) 239-6269

EDSPRC-Region6@eds.com

### ◆ Region 7

Ellen Kiester  
150 Shoup Avenue  
Idaho Falls, ID 83402

Phone: (208) 528-5728  
Fax: (208) 528-5756

EDSPRC-Region7@eds.com

# Principles of Mental Health Reform

There is good news for participants and providers of mental health and substance abuse services. Last year stakeholder workgroups (see *MedicAide*, June 2008) identified several principles and standards of care that should be reflected in Medicaid policy. Some of these principles and standards of care have been translated into rule.

- As part of mental health treatment, all participants should have the opportunity for their primary care physician to determine if their symptoms are of a physical origin so that the subsequent prescribed treatment matches their true healthcare need.
- Participants seeking enhanced mental health services should have the opportunity to undergo a thorough diagnostic assessment by a qualified professional in order to establish an accurate picture of what is going on with the participant mentally and how this links to certain types and amounts of treatment.
- Participants should not undergo evaluation or assessment processes that are not clinically indicated. For participants whose treatment goes beyond twelve months the participant should have the opportunity to be re-assessed to the extent that is clinically necessary. Participants should only be assessed for skill deficits when they are seeking skill training.
- Participants have the right to self-determine their treatment services, as in what support and treatment would reinforce their quest for healing, transformation, and recovery, so they can live meaningful lives in a community of their choice while striving to achieve their full potential. For child participants this includes the family's choices.
- Participants should have the opportunity for a team approach to their treatment needs to assure that a variety of professionals who represent different disciplines and the participants' natural supports all work together to contribute to the overall plan of care.
- Participants should have the opportunity for their plan of care to be updated and reviewed in a timely manner as needed according to the standards of mental health treatment, ensuring that, if the participant has not responded positively to his/her plan of care after an amount of time has passed, the situation is re-assessed and the plan of care is newly developed or modified accordingly.
- Participants should have the opportunity to obtain services delivered by professionals in settings that afford them the individual attention that is warranted by their situation and condition; for children this means experiencing staffing patterns that match the needs of the child's developmental stage.
- Child participants should have parental involvement in their treatment to the greatest extent possible as appropriate for the child's age, condition, and situation.
- All participants should be protected from the use of aversive or harmful techniques; if extraordinary intervention is warranted in order to protect the participant from harming himself or others, then the participant should have the opportunity for such intervention to be delivered by a professional specifically trained to do it. As a follow-up to such intervention, the participant should have the opportunity to work on the behaviors that warranted the intervention so that there is a decreased probability that the need for intervention will occur again.
- Participants should have the opportunity to obtain treatment that matches the signs and symptoms of their healthcare need.

Some providers, by their own professional standards, have previously embraced these principles and standards of care in their agencies even though they were not required by rule. By putting this into rule, we obtain greater assurance that all mental health participants will have the opportunities afforded by these ideas. The actual policies that are needed to support all the principles and standards of care listed above are a work in progress which is expected to span the next several years. If you have any questions regarding this or are interested in participating in the Mental Health and Substance Abuse Reform project please contact Pat Guidry at (208) 364-1813 or [guidryp@dhw.idaho.gov](mailto:guidryp@dhw.idaho.gov).

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## To All Providers: It's PERM Time Again!

The Improper Payments Information Act of 2002 directs federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review its programs that are susceptible to significant erroneous payments and report the improper payment estimates to Congress. The OMB identified Medicaid and the state Children's Health Insurance Program (SCHIP) as programs at risk for significant erroneous payments.

The Centers for Medicare and Medicaid Services (CMS) will measure the accuracy of Medicaid and SCHIP payments made by states for services rendered to participants through the Payment Error Rate Measurement (PERM) program. Under the PERM program, CMS uses three national contractors to measure improper payments in Medicaid and SCHIP. Provider interactions in this process will be primarily with the documentation/database contractor (DDC) and Livanta, who will collect medical policies from the state and medical records from providers either in hardcopy or electronic format.

Medical records are needed to support required medical reviews for PERM, which the review contractor will conduct on the fee-for-service Medicaid and SCHIP claims to determine if the claims were correctly paid. If a claim is selected in a sample for a service that a provider rendered to either a Medicaid or SCHIP participant, Livanta will contact that provider for a copy of the required medical records to support the medical review of the claim. These contacts will begin in August 2009.

In order to obtain medical records for a claim sampled for review, Livanta will contact providers to verify the correct name and address information and to determine how they want to receive the request (i.e., facsimile or U.S. mail) for medical records. Once providers receive the request for medical records, they must submit the information electronically or in hard copy within 60 days. Please note that it is the responsibility of the provider to ensure that any and all supporting medical records, from any and all provider(s) who rendered a service for which the claim payment under review was requested, are submitted in a timely manner. During this 60-day timeframe, Livanta and possibly state officials will follow up to ensure that providers submit the documentation before the timeframe has expired. For reviews that require extra information, Livanta will contact providers for additional documentation. Providers will then have 15 days to respond to the request for additional documentation.

Understandably, providers are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS or their contractor with information regarding any payments claimed by the provider for rendering services. The furnishing of information includes medical records. As for SCHIP, section 2107(b)(1) of the Act requires a SCHIP state plan to provide assurances to the Secretary that the state will collect and provide to the Secretary any information required to enable the Secretary to monitor program administration and compliance and to evaluate and compare the effectiveness of states' SCHIP plans. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes **is permissible** by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

It is important that providers cooperate with submitting all requested documentation in a timely manner because no response or insufficient documentation will count against the state as an error. Past studies have shown that the largest cause of error in medical reviews is no documentation or insufficient documentation. As such, it is important that information be sent in a timely and complete manner. If you have any questions about this matter, please contact your state PERM contact, Billie Schell-Ruby, at (208) 364-1963 or [schellb@dhw.idaho.gov](mailto:schellb@dhw.idaho.gov). Thank you for your support of the PERM program.

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## Adjust or Resubmit?

One way to faster claim resolution and payment is knowing when to make an adjustment request and when to resubmit a claim for payment. It is important to understand the status of the claim to make that decision. Once a claim is submitted to EDS processing for payment, it falls into one of three categories: paid, denied, or pending.

A claim with a paid status has been processed, checked for errors, finalized, and approved for payment. A claim with a denied status cannot be paid for the reason stated on the remittance advice (RA). A claim with a pending status has been suspended (pending) in the system for a claims adjudicator to perform a manual review for compliance with Medicaid policy to determine if the claim can be paid, or if it must be denied.

*Continued on page 7 (Adjust or Resubmit?)*

**Note:** Pending claims cannot be corrected and resubmitted until processing has been finalized by the system. While pending, they have not completed processing. Do not resubmit pending claims.

Billing errors that result in an incorrect payment can be corrected as follows.

- Electronic claims that have been paid incorrectly can be quickly and easily **voided** and replaced by using the EDS billing software, Provider Electronic Solution (PES), or another vendor's billing software. See the *Idaho PES Handbook* or other vendor software instructions.
- Denied claims or denied claim details can be rebilled with the correction. A denied claim or denied claim detail can only be corrected by submitting a new claim. Remember, the new claim will need to include any necessary attachments and any internal control number (ICN) from previous claims that may be required to document timely filing.

**Note:** Do not use an Adjustment Request Form when rebilling a denied claim or denied claim detail.

- Paid claims with an incorrect paid amount must be adjusted. A paid claim can be corrected using an Adjustment Request Form; but a new claim cannot be used to correct a paid claim. Writing "corrected claim" on a paper claim will not fix the earlier error because this new claim will be denied by the system as a duplicate claim. Instead, use an Adjustment Request Form to notify EDS of the billing error and to request further payment if the provider was underpaid for the service, apply a third-party payment received after the original Medicaid payment, or send a refund if the provider was overpaid for the service. The Adjustment Request Form is used to correct either an entire claim or just a particular line of detail on a claim.

**Note:** Provider identification numbers or participant Medicaid numbers cannot be changed. These claims must be voided and rebilled with the correct information.

Adjustment Request Forms are in the *Medicaid Provider Handbook*, Appendix D; Forms, and on the Web at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov). Click the *Providers* tab at the top of the screen, click *Medicaid Providers* under Medical Professionals, and click *Provider Handbook* in the list on the left side of the next screen. Scroll down to Appendices/Forms and click on *Forms*. Instructions are included in the appendix with the form. Print and copy the form as needed.

Complete the following Adjustment Request Form fields:

- Provider's Idaho Medicaid provider identification number
- Provider's name
- Claim ICN (one claim per form)
- Participant's Medicaid identification number
- Participant's name
- Remittance Advice number and date (these fields are helpful but not required)
- Field 10: Write what the incorrect information on the claim was and what the correct information should have been.  
No other explanation is needed. If there is more than one detail line, specify which line needs correction.
- Field 11: Mark the appropriate selection to make a refund by check (made out to the State of Idaho). Request that the overpayment be deducted from a future warrant, or ask for additional payment.
- Signature and Date

Mail the completed form to EDS at the address on the top of the form. Faxed copies are not accepted and will be returned to the provider.

If you have questions about adjustments, contact your regional EDS provider relations consultants listed in the sidebar on page 5.

Remember, denied claims and denied claim details can be corrected by rebilling a new claim. Paid claims are adjusted with an Adjustment Request Form.

EDS  
PO BOX 23  
BOISE, IDAHO 83707

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



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**



## **Reminder that MAVIS**

**(Medicaid Automated Voice Information Service)**

**is available at:**

**(800) 685-3757 (toll-free) or**

**(208) 383-4310 (Boise local)**

*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@dhw.idaho.gov](mailto:taylorc3@dhw.idaho.gov)**

**or**

**Carolyn Taylor**  
**DHW MAS Unit**  
**PO Box 83720**  
**Boise, ID 83720-0036**  
**Fax: (208) 364-1911**