

In this issue:

- 3 Medicare-Medicaid Coordinated Plan and Service Coordination
- 4 Reminder: Policy on Retrospective Rate Increases or Decreases for Nursing Facilities
- 5 Attention: Providers of Flu Vaccine
- 5 Using the 'Agent' Option in MAVIS
- 6 Voicemail Messages— Help Us Help You
- 7 Provider Electronic Software (PES) Passwords
- 7 Idaho Medicaid Provider Resources on CD: January 2008
- 9 Frequently Asked Questions about the 1099 Forms
- 9 Top Reason Paper Claims are Returned Without Processing
- 10 Participant Name/ Number Mismatches
- 11 Submitting Paper Medicare Crossover Claims
- 11 Are You Billing Medicaid Participants?
- 11 Keeping Staff Up to Date in 2008!
- 12 January Office Closures

Information Releases:

Medicaid Information Release MA08-01

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



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

January 2008

January 1, 2008

MEDICAID INFORMATION RELEASE MA08-01

TO: Primary Care Physicians, Mental Health Clinics and Hospitals

FROM: Leslie M. Clement, Administrator

SUBJECT: Telemedicine

This information release describes billing and service requirements for providing limited Medicaid mental health services through telemedicine technology and replaces information release MA04-37 (TELEMEDICINE). Medicaid will pay for telemedicine services that meet the requirements detailed in this release for **dates of service beginning January 1, 2008.** The following codes and modifier may only be used for telemedicine services provided by a physician:

- 90862 (pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy).
- 90805 (psychotherapy, 20-30 minute session with the participant).
- 90801 (psychiatric diagnostic interview examination, includes history, mental status, and disposition).

Claims must include modifier "GT".

Physicians providing such services must bill Medicaid utilizing their Physician Provider Number. The service may occur wherever the telehealth equipment is located. This represents a change in policy from allowing telemedicine services to be provided exclusively in mental health clinics as the "place of service."

Technology

For Medicaid payment to occur, interactive audio and video telecommunications must be used permitting real-time communication between the distant site Physician and the Medicaid participant. This communication must have sufficient quality to assure the accuracy of the assessment, diagnosis, and visible evaluation of symptoms and potential medication side effects. As a condition of payment, the patient must be present and participating in the telemedicine visit. All interactive video telecommunication must comply with HIPAA patient privacy regulations at the originating site where the participant is located, the distant site where the physician is located, and in the transmission process. If distortions in the transmission make adequate diagnosis and assessment improbable and a presenter at the originating site where the participant is located is unavailable to assist, the visit must be halted and rescheduled. It is not appropriate to bill for portions of the evaluation unless the exam was actually performed by the billing provider.

The originating site may bill the following code with no modifier for reimbursement for the transmission of the telehealth services:

Q3014 Telehealth originating site facility fee (1 unit = 1 site transmission).

Continued on Page 2 (IR MA08-01)

Continued from Page 1 (IR MA08-01)

The distant site may bill the following code with no modifier for reimbursement for the transmission of the telehealth services:

• T1014 Telehealth distant site facility fee (1 unit = 1 site transmission).

Effective 01/01/2008 - Revenue code 780 will be payable to hospital providers only on outpatient bill type 13X. It will require the corresponding HCPC code from above. Reimbursement will be a fixed rate for the facility fee for site transmission.

Standards

In order to obtain Medicaid reimbursement for services delivered through telehealth technology the following standards must be observed:

- The referring physician is responsible to maintain standards of care within his identified scope of practice.
- The services must be medically necessary and follow generally accepted standards of care.
- Physicians providing care at a distance are required to maintain current Idaho licensure.
- Services are to be billed in accordance with applicable sections of the IDAPA.
- Claims must be made according to Department billing instructions.
- The same procedure codes and rates apply as for services delivered in person.
- Quality assurance/improvement activities relative to telemedicine delivered services need to be identified, documented, and monitored.
- Providers need to develop and document evaluation processes and participant outcomes related to the telemedicine program, visits, provider access, and participant satisfaction.
- All service providers are required to develop and maintain written documentation in the form of progress notes. The notes should be the same as is originated during an in-person visit or consultation, with the exception that the mode of communication (i.e. teleconference) should be noted.
- Participant consent and other releases should be developed and maintained in the participant's permanent record.
- If an operator who is not an employee of the involved agency is needed to run the teleconferencing equipment or is present during the conference/consultation, he/she should sign a confidentiality agreement. This statement should be filed with other documentation of the teleconference, such as a post-conference evaluation form.
- Before an initial visit using telemedicine, the practitioner who delivers the service to a
 participant shall ensure that written information is provided to the participant in a form
 and manner which the participant can understand using reasonable accommodations
 when necessary.
- If the participant (or legal guardian) indicates at any point that he wants to stop using the technology, the service should cease immediately and an alternative appointment set up.

If you have any questions regarding this information, please contact Diane Miller, Mental Health Policy Specialist, at: (208) 364-1844. Thank you for your continued participation in the Idaho Medicaid program.

IDAHO MEDICAID HANDBOOK

This information release adds information to the following sections of your Idaho Medicaid Provider Handbook dated January 1, 2008: *Physician Guidelines 3.8.3*.

LMC/pg

DHW Phone Numbers

Addresses
Web Sites

DHW Websites www.healthandwelfare. idaho.gov

Idaho Careline 2-1-1 (available throughout Idaho) (800) 926-2588 (toll free)

Medicaid Fraud and Program Integrity Unit P.O. Box 83720 Boise, ID 83720-0036 Fax (208) 334-2026

Email: 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) 642-7006 (800) 494-4133

Region IV - Boise (208) 334-0717 or (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 (toll free)

Prior Authorization Phone Numbers Addresses Web Sites

Prior Authorizations:

DME Specialist
Medical Care
P.O. 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

Transportation Prior Authorization:

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

Other Non-emergent and Outof-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

Insurance Verification:

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

Medicare-Medicaid Coordinated Plan and Service Coordination

Effective January 1, 2008, participants on the Medicare-Medicaid Coordinated Plan (MMCP) will not be able to get service coordination through companies that offer this plan. Service coordination will be paid directly by Medicaid and participants will have to cancel their Medicare-Medicaid Coordinated Plan in order to obtain service coordination through Medicaid. Please contact the appropriate insurance plan to cancel services.

- Blue Cross Customer Service: (888) 492-2583; TDD/TTY (800) 377-1363.
- United Healthcare Customer Service: (888) 223-1092; TDD/TTY (888) 685-8480.

Effective on January 1, 2008, the following services are covered under the Medicare-Medicaid Coordinated Plan. Most of the services are covered under the Medicare Advantage Plan. Providers should bill the Medicare Advantage Plan directly for these services. Any claims sent to Medicaid for services covered under the Medicare Advantage Plan will be denied. Medicaid covered services, shown on the table below, should be billed directly to Medicaid.

Medicare-Medicaid Coordinated Plan Services		
Benefit	Medicare Advantage Plan	Medicaid
Hospital Services	X	
Outpatient Services	X	
Emergency Hospital Services	X	
Ambulatory Surgical Center Services	X	
Physician Medical Services	Х	
Physician Surgical Services	Х	
Certified Pediatric or Family Nurse Practitioner Services	Х	
Physician Assistant Services	Х	
Chiropractor Services	Х	
Podiatrist Services	X	
Optometrist Services	Х	
Certified Nurse-Midwife Services	Х	
Primary Care Case Management	X	
Adult Physicals	X	
Service Coordination: For people with mental illness, for people receiving personal care services, and for people with developmental disabilities		X (Must be enrolled in the Medicaid Enhanced Plan)
Screening Mammography Services	X	
Prevention and Health Assistance Benefits (includes health/wellness education and intervention services such as disease management, tobacco cessation programs, or weight management)	х	
Laboratory and Radiological Services	X	
Prescribed Drugs under Medicare Part D	X	

Continued on Page 4 (Medicare-Medicaid)

1	<u> </u>	
Benefit	Medicare Advantage Plan	Medicaid
Prescribed Drugs not covered by Medicare Part D	Χ	
Family Planning Services	X	
Inpatient Psychiatric Services	X	
Outpatient Mental Health Services	Χ	
Psychosocial Rehabilitative Services		X
Home Health Care	Х	
Therapy Services	Х	
Speech, Hearing, and Language Services	X	
Medical Equipment and Supplies	X	
Specialized Medical Equipment and Supplies	X	
Prosthetic Devices	X	
Vision Services	X	
Dental, Medical, and Surgical Services	X	
Dentures	X	
Rural Health Clinics	X	
Federally Qualified Health Center Services	Х	
Indian Health Services	Х	
Emergent Medical Transportation	X	
Routine Transportation		X
Skilled Nursing Facility Services <= 100 days	X	
Nursing Facility Services		X
Personal Care Services		X
Other Home & Community-Based Services		Х
Hospice Care	X	
Intermediate Care Facility Services (ICF/MR)		X
Developmental Disability Agency Services		Х
Medicare Advantage Cost Sharing (deductibles and coinsurance)	X (included in the premium payment)	

EDS Phone Numbers Addresses

MAVIS

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

EDS Correspondence P.O. Box 23 Boise, ID 83707

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

Medicaid Claims P.O. Box 23 Boise, ID 83707

PCS & ResHab Claims P.O. 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

Reminder: Policy on Retrospective Rate Increases or Decreases for Nursing Facilities

Idaho Medicaid reimburses claims at the lower of the billed amount or Medicaid allowed amount; therefore, nursing facilities should always bill their usual and customary charges, rather than the Medicaid allowed per diem.

When there are retrospective rate increases or decreases for nursing facilities, the adjusted rates are added to the system and the Department of Health and Welfare (DHW) initiates mass adjustments to previously paid claims for that facility for the time period that the rates have been adjusted.

Continued on Page 5 (Retrospective Rate Increases or Decreases)

EDS Phone Numbers Addresses

Provider Relations Consultants

Fax (208) 666-6856

Region 1 Prudie Teal 1120 Ironwood Dr., Suite 102 Coeur d'Alene, ID 83814 EDSPRC-Region1@eds.com (208) 666-6859 (866) 899-2512 (toll free)

Region 2
Darlene Wilkinson
1118 F Street
P.O. Drawer B
Lewiston, ID 83501
EDSPRC-Region2@eds.com
(208) 799-4350
Fax (208) 799-5167

Region 3 Mary Jeffries 3402 Franklin Caldwell, ID 83605

EDSPRC-Region3@eds.com (208) 455-7162 Fax (208) 454-7625

Region 4 Angela Applegate 1720 Westgate Drive, # A Boise, ID 83704

EDSPRC-Region4@eds.com (208) 334-0842 Fax (208) 334-0953

Region 5 Penny Schell 601 Poleline, Suite 3 Twin Falls, ID 83303

EDSPRC-Region5@eds.com (208) 736-2143 Fax (208) 678-1263

Region 6 Janice Curtis 1070 Hiline Road Pocatello, ID 83201

EDSPRC-Region6@eds.com (208) 239-6268 Fax (208) 239-6269

Region 7 Ellen Kiester 150 Shoup Avenue Idaho Falls, ID 83402

EDSPRC-Region7@eds.com (208) 528-5728 Fax (208) 528-5756 Continued from Page 4 (Retrospective Rate Increases or Decreases)

If the original claim was billed at the Medicaid allowed amount and the rate is increased retrospectively, the adjusted claim will pay at the original billed amount so the provider will not receive additional reimbursement.

Attention: Providers of Flu Vaccine

New Guidance: Both the FDA and the Advisory Committee on Immunization Practices have issued revised recommendations. The nasal-spray flu vaccine is approved for use only in healthy* people 2-49 years of age† who are not pregnant.

Clarification: Information Release (IR) MA06-39, entitled 'Change in Policy on Billing for Immunizations' replaced both IR #2003-45 (Immunization Guidelines) and IR MA04-02 (Medicaid Medical Necessity Requirements for the Administration of Flumist™). The guidance given in IR MA06-39 instructs providers to bill for all vaccines using the most appropriate CPT code. FluMist™ should be billed using CPT code '90660, Influenza virus vaccine, live, for intranasal use'. There is no requirement to bill with a paper claim and prove medical necessity when billing with these codes.

* "Healthy" indicates persons who do not have an underlying medical condition that predisposes them to influenza complications.

† On September 19, 2007, the **U.S. Food and Drug Administration (FDA)** approved use of the nasal influenza vaccine LAIV (FluMist®) for healthy children ages 2-4 years old (24-59 months old) without a history of recurrent wheezing, as well as for healthy persons ages 5-49 years who are not pregnant. Previously, approval was for healthy persons ages 5-49 years who are not pregnant.

Using the 'Agent' Option in MAVIS

The following describes what will happen when you call the EDS provider help line, MAVIS at: (800) 685-3757, or 383-4310 in the Boise calling area and select the 'Agent' option:

- First, you will hear this message: "Please hold while I transfer you to a Provider Services Representative"
- You might be directly connected to an 'Agent'

OR

- After thirty seconds you will hear a 'Hold' message.
 - The 'Hold' messages contain information that is beneficial to you. Hold messages are updated and changed on a regular basis.

You can continue to hold, <u>or</u> you can **press '1'** on your phone keypad to leave a voicemail message.

- If you choose to continue to hold, you will hear the 'Hold' message repeated through the next seven minutes.
- After seven minutes on hold, if an agent is unavailable because of other provider's calls, you will automatically be connected to voicemail to leave a message.

The following information will explain how the voicemail is handled after you leave a message.

- Calls are returned on a first come/first serve basis.
- The first callback attempt is made on the same or next business day.
- If required, the second and third callback attempts are made each day on the following two business days.
- If the third call back attempt is unsuccessful, EDS will leave a message stating that if you need assistance you will need to call the EDS provider help line again.

For helpful hints on what information is most beneficial to leave on voice messages, please see the article on the next page titled "Voicemail Messages - Help Us Help You".

Voicemail Messages - Help Us Help You

In our ongoing efforts to improve service to Idaho Medicaid providers we have identified ways to better assist you when you call the EDS provider helpline, MAVIS at: (800) 685-3757, or 383-4310 in the Boise calling area and leave a voicemail.

If your office has a confidential, secure and password-protected voicemail system, agents can leave answers to your questions on your voicemail. Because the information needed to answer your questions related to Medicaid eligibility and claims contains Protected Health Information (PHI), the Health Insurance Portability and Accountability Act (HIPAA) mandates that messages regarding health information cannot be recorded to non-secure phone lines. If we are unable to reach you directly, we can leave answers to your questions in a voicemail if you tell us you have a secure line and you leave a detailed message with all required information to research your question. If we were able to leave a message answering your question we will not attempt to call you again.

We can better assist you if you are prepared with the following information when calling, or leaving voicemail:

- Always state your name, provider name, your 9-digit Idaho Medicaid provider identification number, and phone number
 - When leaving a voicemail, provide an alternate name in case you are unavailable.

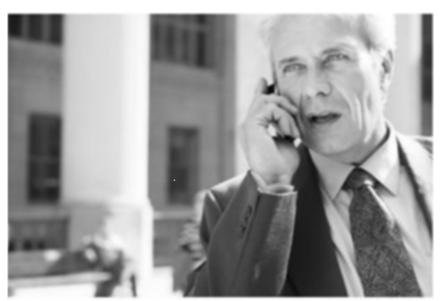
Appendix C: MAVIS in the *Idaho Medicaid Provider Handbook* includes guidelines for calling MAVIS. For each of the following types of calls, have the listed information ready.

For questions about claims:

- Participant's 7-digit Medicaid Identification number (MID)
- Date(s) of service
- o Internal Control Number (ICN) from Remittance Advise (RA), if known
- Prior authorization (PA) number, if known
- Billed amount
- For questions about Medicaid participant eligibility or any other Medicaid participant information for claim billing purposes:
 - Participant's 7-digit Medicaid Identification number

OR

- Participant's date of birth or Social Security number and
- Participant's name (first and last)
- For questions about procedure codes:
 - Appropriate national procedure code
 - Required modifiers (if applicable)



Remember, the length of time you have to record your message is limited. A brief and concise message that includes the data needed for research will help us resolve your question quickly and easily.

Provider Electronic Software (PES) Passwords

If you use Provider Electronic Solutions (PES) software to submit your batch or interactive transactions using the Web server method, you will now have two different passwords that the PES software will prompt you to change. Each password is associated with different functions and connects to different areas in the PES software. The following describes the purpose for each type of password.

Logon Password

This password allows you to open the PES software. The logon password expires every 30 days unless otherwise indicated in the retention settings, which can be found in the **Tools/Options/Retention** menu in PES.

Web Password

This password allows you to submit your transactions over the internet. PES will prompt you to change the Web password every 30 days. To locate the old web password, click the Batch tab in **Tools/Options** menu. The Batch tab is for reference only.

If you don't remember your correct password, after three attempts you will be locked out. If this occurs you need to call the Electronic Data Interchange (EDI) Helpdesk toll-free at: (800) 685-3757 toll-free or in the Boise area at: 383-4310; ask for 'Technical Support'.

NOTE: When using the Web server method to submit batch or interactive transaction, it is recommended that you have a different Logon ID and Password on each computer that has the PES software installed. You can request multiple logon IDs and passwords through the EDI Helpdesk.

Idaho Medicaid Provider Resources on CD: January 2008

The most recent version of the *Idaho Medicaid Provider Resources* CD is set to mail in January 2008. This CD includes the following sections:

Acrobat Reader Section

ECS Agreements Section

- With National Provider Identifier (NPI)
- Without NPI

Provider Electronic Solutions (PES) Section

- PES Handbook
- PES Quick Start Guide
- PES Taxonomy

Point of Service (POS) Section:

- POS Device Areas
- POS Installation Guide
- POS Quick Reference Card
- POS User Guide

Qualis Manual Section

Quick Reference Card Section

Provider Handbook Section (Described in more detail on Page 8)

The electronic handbook is used regularly by the EDS Provider Service Representatives (PSRs) to answer provider questions.



Continued on Page 8 (Resources CD)

Contents of Provider Handbook

The handbook includes a directory of addresses, phone numbers and Websites for important Idaho Medicaid contacts including Healthy Connections regional representatives, prior authorization contacts, DHW regional offices, and EDS.

The handbook is divided into five sections and four appendices.

Section 1: Presents the basic information all providers need to serve Idaho Medicaid participants.

General provider information is listed under the following subsections:

Section 1.1: Provider Participation

Section 1.2: Services for Providers

Section 1.3: Participant Eligibility

Section 1.4: Restricted Medical Coverage

Section 1.5: Healthy Connections (HC)

Section 1.6: Early and Periodic Screening, Diagnosis, and

Treatment (EPSDT)

Section 2: Presents the basic information all providers need to submit claims.

General billing information is listed under the following subsections:

Section 2.1: General Billing Information

Section 2.2: Claims Submission

Section 2.3: Prior Authorization (PA)

Section 2.4: Third Party Recovery (TPR)

Section 2.5: Crossover Claims

Section 2.6: Adjustments

Section 3: Contains specific information for each of the different provider types.

Section 4: Presents information on Remittance Advice (RA) forms based upon your provider type.

Section 5: Is a glossary of terms and acronyms used in this handbook.

Appendix A (Healthy Connections (HC) Providers):

Contains detailed information on HC for providers enrolled in the program.

Appendix B (Taxonomy)

Appendix C (Medicaid Automated Voice Information Service (MAVIS)):

Contains information on how to use MAVIS to obtain current information on participant status and claims.

Appendix D (Forms):

Contains a list of forms available from EDS at no charge to the provider. There are also samples of forms you can use to make as many copies as you need, whenever you need them.

Frequently Asked Questions about 1099 Forms

- 1. If I am tax exempt, why did I receive a 1099 form?
 - ♦ All providers receive a 1099 form regardless of exempt status.
- 2. What makes a provider tax exempt?
 - ◆ 24-hour personal care and residential habilitation service providers are exempt if:
 - · Services are rendered in the provider's home
 - A State agency, (e.g. DHW) is paying for the services
 - The clients require a high level of care and supervision and without the personal care of residential habilitation services, the client would need care in a nursing home or intermediate care facility for the mentally retarded
 - The Medicaid payment is only for the care provided and not for room and board.
- 3. Do I have to file my 1099 if I am tax exempt?
 - ♦ Yes. Everyone must file the 1099. For more information, please go to the IRS website, www.irs.gov, search for Publication 17, pages 88 and 89.

Refer to: Foster Care Providers, Difficulty-of-care payments, Reporting taxable payments.

Top Reason Paper Claims are Returned Without Processing

When paper claims arrive at EDS, the Document Control team looks at each claim to validate that it contains the basic information needed for processing. The single most common reason claims are returned to the provider without processing is the Provider ID number or qualifier, 1D (one-D), is missing from field 33b on the CMS-1500 (08/05) form.

Each paper claim must have the Idaho Medicaid Provider ID number on the claim for it to be processed, and to ensure that any payment is sent to the correct provider. This is not the National Provider Identifier (NPI) number which is used for electronic claims processing.

The new CMS-1500 (08/05) form requires the use of a qualifier, 1D (one-D), that indicates to the claims processing system that the number immediately following it (with no space between) is the Idaho Medicaid Provider number which is used to process paper claims. Complete instructions for filling out the new CMS-1500 (08/05) claim form are located on the Department of Health and Welfare (DHW) website at: **www.healthandwelfare.id.gov** under the Medicaid Provider Information link on the right side of the page.

Billing Provider Information Fields

)
)
L 4D4004F0700
b. 1D123456789

Participant Name/Number Mismatches

Claims submitted to Idaho Medicaid will be denied for edit 101 "Client name and/or number does not match client file" if the name submitted on the claim does not exactly match the name as it is contained within the claims processing system.

The top reasons that cause claims to set the participant name/number mismatch edit are:

- Claims are submitted using a nickname or some other variation of the participant's name. Example: Mike vs. Michael, Sue vs. Susan, Edward vs. Ed, etc.
- Claims are submitted with a different last name. The participant may have changed names and not informed their Self Reliance Worker, so the change has not been made within the claims processing system.
- Claims are submitted with the first or last name misspelled.
- Claims are submitted with a space between letters. Example: OConnor is submitted as O Connor, McDonald is submitted as Mc Donald, etc.
- Claims are submitted with special characters such as an apostrophe ('), hyphen (-), period (.), comma (,), or asterisk (*).

Entering the participant name exactly as it appears on the Medicaid identification card will prevent these errors from occurring. Be sure to enter the last name first, followed by the first name and middle initial.

An identification card is issued at the time a participant becomes eligible for Medicaid benefits or whenever a name change is reported. The number in the lower right hand side of the identification card is updated anytime a new card is



issued for that participant. When eligibility is being verified, the participant's card number should also be verified to ensure that the card being presented is the participant's most current card. If the number on the identification card matches the number reported by the eligibility verification system, then the name on the card will also match what is in the system on the date that the eligibility is checked. If the number is lower than what is reported by the eligibility verification system, then the participant's most current card should be requested from the participant. Providers should request the card with picture identification and retain copies of this documentation for their records.

When verifying eligibility via the Medicaid Automated Voice Information Service (MAVIS), providers have the option to request that the eligibility information be faxed to them. The faxed information will report the participant's name exactly as it is listed on the system which is how it should also be submitted on the claim. This information is also reported on the printout when verifying information via the Point of Service (POS) device.

There is a possibility that the participant's name might change between the time that eligibility is verified and the claim is submitted. Unfortunately there is no way to prevent

these types of mismatches from occurring. The claim will be denied for edit 101 and providers will need to resubmit the claim with the updated name.

If you have any questions concerning the information contained here, please contact EDS toll free at: (800) 685-3757, or in the Boise calling area at: 383-4310.

Submitting Paper Medicare Crossover Claims

Each paper Medicare crossover claim must be submitted with a Medicare Remittance Notice (MRN) attached. The MRN must clearly state what was applied to the Medicare payment and any adjustments made to the claim. MRN forms are being submitted that don't have any wording on them to identify that the insurance carrier is Medicare. If the MRN doesn't clearly identify that it is a Medicare document, please write 'Medicare Crossover' on the top right margin of the claim, or the MRN, to ensure that your claim is batched as a Medicare Crossover and processed correctly.



This information is located in the Idaho Medicaid Provider Handbook, Section 2.5.1. Claims that aren't clearly identified on the top of the claim form, or the MRN, might be denied or incorrectly processed.

You can bill Medicare crossover claims electronically with the Provider Electronic Solution (PES) software. Electronic billing is faster and more efficient than billing on paper. Please call the Electronic Data Interface (EDI) Help Desk toll free at: (800) 685-3757, or in the Boise area at: (208) 383-4310, and say 'Technical Support', from 8 a.m. to 6 p.m. MT, to request PES software and training at no cost.

Are You Billing Medicaid Participants?

Please remember...in order to bill a Medicaid participant for services you provide, you must inform the Medicaid participants that they are responsible for the charges before services are rendered.

Example: If a Medicaid participant shows up for specialty treatment without a Healthy Connections (HC) referral, you must tell them that they will be responsible for payment before they receive any services. This is to allow the Medicaid participants to decide whether or not to incur the debt. This is similar to the Medicare requirement, but Medicare participants must sign a waiver.

Billing a Medicaid patient only after receipt of a denial of payment from Medicaid is not acceptable practice. The Medicaid Provider Agreement states you will adhere to the policy of informing Medicaid participants of non-covered services prior to rendering services.

Keeping Staff Up to Date in 2008!

EDS Provider Relations Consultants continue to offer a series of provider workshops. Each consultant conducts a 2-hour regional workshop every two months to help providers in their region. The topics include:

- Learn more about NPI
- General Medicaid Billing
- Provider Resources
- Using PES Software
- CMS 1500 (08/05)

The next workshop is scheduled for all regions Tuesday, January 08, 2008, from 2:00 to 4:00 pm.

These training sessions are provided at no cost to providers, but space is limited so please pre-register with your local consultant. Their phone numbers are listed on Page 5.

EDS P.O. BOX 23 BOISE, IDAHO83707



January Office Closures

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

New Year's Day

Tuesday, January 1, 2008

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

Martin Luther King/Idaho Human Rights Day

Monday, January 21, 2008

Reminder that MAVIS

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

MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

Editor: Carolyn Taylor, Division of Medicaid

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

taylorc3@dhw.idaho.gov

Carolyn Taylor DHW MAS Unit

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

Fax: (208) 364-1911