MedicAide

An informational newsletter for Idaho Medicaid Providers

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

September 2009

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

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**. Watch the *MedicAide* newsletter for more information pertaining to the new MMIS. This month's article follows.

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New Idaho Medicaid PBM Vendor

The Idaho Department of Health and Welfare has contracted with First Health Services to provide the Pharmacy Benefits Management (PBM) system. They will provide point-of-sale (POS) claims processing, prior authorization services, call center support services, prospective and retrospective drug utilization review, and drug rebate programs. The target date for the implementation of the PBM will be early in 2010.

First Health Services operates PBM services in 26 state programs. In support of the pharmacy programs, First Health Services brings new tools that Idaho Medicaid can use to improve quality of care, reduce medication errors, and minimize inappropriate drug utilization.

As the transition date approaches, Idaho Medicaid and First Health Services look forward to working with the pharmacy provider community to ensure a smooth transition.

Details of the transition will be forthcoming throughout the fall. Communications will include:

- Vendor specification information for switching companies, software vendors, and for the National Council for Prescription Drug Programs.
- Notifications about training sessions, which will be held in early 2010, will be provided along with a provider manual as part of that training.
- The opportunity for providers to conduct POS tests in advance of the implementation date.

The Most Up-to-Date MMIS Information

Up-to-date MMIS information is available on the Web at **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.
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July 6, 2009

MEDICAID INFORMATION RELEASE MA09-14

To: Aged and Disabled Waiver Providers
Aged and Disabled Service Coordination Providers

From: Leslie M. Clement
Administrator

Subject: **Participant Contribution Changes**

This Information Release is to provide you with important information regarding the Aged and Disabled (A&D) Waiver. Participants on the A&D Waiver have not been charged a co-pay for their first 16 hours of personal care services. To comply with our current waiver requirements, starting October 1, 2009, a participant contribution responsibility will be calculated against personal care services (S5125) as authorized. You will no longer be authorized T1019 for billing personal care services.

The current A&D Waiver also directs the Department of Health and Welfare to charge a participant contribution on selected waiver services. The department has recently discovered that participant contributions have not been correctly charged for the following A&D waiver services:

G9001 Service Coordination Plan Development
G9002 Service Coordination - PCS
H2016 Residential Habilitation
T1001 U2 Skilled Nursing

The department will be charging a participant contribution for the above codes starting October 1, 2009. Aged and Disabled Waiver services currently requiring a participant contribution charge will continue to require participant contribution.

If you have questions about the information in this release, please contact the alternative care coordinator in the Division of Medicaid's Bureau of Long-Term Care at (208) 287-1156.

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

LMC/rs

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Policy Reminders for the Pregnant Women (PW) Program

The Code of Federal Regulations (CFR) Title 42, Volume 4 states that the PW Program must cover the following:

- All pregnancy-related services and services for other conditions that might complicate the pregnancy.
- Pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services.
- Services for other conditions that might complicate the pregnancy including those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus.

DHW Contact Information

- **DHW Web site**
  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

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
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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/idahomedicaid.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

Diagnosis Codes

The primary diagnosis code on your claim must be pregnancy related or indicate the woman is in a pregnancy or postpartum status (ICD-9 codes 630-679).

The **procedure** code must also be clearly pregnancy related. If the procedure code is **not** clearly pregnancy related you must attach sufficient documentation to show that:

- The services are caused or related to the pregnancy.
- Failure to treat the condition could result in complications of pregnancy for the mother and/or fetus, or threaten the carrying of the fetus to full term or a safe delivery of the fetus.
- Services are necessary as a result of the woman having been pregnant.

Family Planning

Family planning services are covered post partum as long as the woman is eligible under the PW Program. Healthy Connections referral is not required for family planning.

PW Eligibility

The eligibility period for PW extends to the end of the month of delivery plus two more full months. For example, if a woman delivers on 7/1/09, her eligibility would end on 9/30/09. If she delivers on 7/29/09, her eligibility would still end on 9/30/09.

There are no exceptions to this rule – claims with dates of service after the woman's PW eligibility ends will be denied.

If you have questions about claims you are submitting for a PW participant, please call Arla Farmer at (208) 364-1958.

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Update to Psychosocial Rehabilitation Prior Authorization (PA) Process and Service Plan Authorization Form (SPA)

New Procedure

Effective immediately, when Psychosocial Rehabilitation (PSR) providers request a PA for treatment plans that contain at least one service above baseline amounts, the Medicaid mental health care managers will issue a PA for the entire amount of **all** the services that clinically match the participant's health care need as represented in the participant's assessment. Baseline service hours are included in the prior authorization in order to facilitate simplified billing for providers. The current system limitations dictate the following procedure:

- The care manager will determine the appropriate service amounts among the services that are requested.
- The care manager will PA **each** service that they deem appropriate, not just those that are above baseline.
- The care manager will then fax the SPA containing the PA back to the provider. The care manager will not process, and will discard any requests for, authorizations for service amounts that do not exceed baseline amounts because such treatment plans do not require an authorization.

This new method has now been applied to any requests that have been submitted beginning July 2, 2009.

Continued on page 4
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History

This is a change from the practice that has been in effect since May 8, 2009. The care managers had only been issuing authorizations for the service amounts above baselines. For example, if the request and appropriate service need was for 24 units of skill training per week and one encounter of pharmacological management, the care managers were issuing a PA for only four units of skill training since 20 units could be delivered without a PA, and authorizing zero encounters of pharmacological management because the request and appropriate amount of that service was below baseline. This resulted in the provider having to engage in additional administrative tasks in order to secure payments for their claims, including submitting two separate billings, one for the services below the baseline, and one for the services above.

Example

Medicaid has determined a way for the system to manage this utilization management process with greater efficiency and a reduction in the administrative tasks for the provider. Using the same example from above of a 24 unit service need for skill training, after the change being announced herein, the care manager will issue a PA for 24 units, not four units. Additionally, the care manager will issue a PA for the one encounter of pharmacological management even though that service amount is below baseline.

Remedy Applicable to Providers with Denials

Providers who have received denials for their claims for reasons “B04: Psycho-social rehab limited to 5 hours/calendar week,” **or** “B09: Procedure code 90887 is limited to 6 hours (24 units) per calendar year,” **or** “A02: Suspect duplicate of previously submitted claim” should re-submit their original SPA to the care management unit under this new format. Supporting documentation does not have to be re-submitted.

Remedy Applicable to Providers Who Have Not Had Denials

Many providers have successfully had their claims paid using the method put in place May 8, 2009. Those providers do not need to take any action. As the treatment year unfolds for each of those participants served by such providers, and these providers want to submit medically necessary amendments, those providers should submit **the original SPA** and the amendment request. The participant’s PA will be modified to the new method at that time.

New Look for SPA

In the “Plan Authorization” section of the SPA, the total number of units requested will appear as well as the total number of units being authorized **across all of the services if among any of the services there is at least one service being authorized above baseline**. The total number of units authorized, if above baseline amounts, will include the baseline amounts allowed by rule. In those cases in which only the baseline amount of services is needed to match the participant’s health care needs among all services being requested, a zero will appear in the line “Prior Authorized Units.” In those instances in which an authorization is not being made because baseline amounts or less are appropriate, an “X” will appear in the service column in the row containing the message, “Baseline amounts or less: PA not needed.” Please see the modified SPA form on page 6.

Denial Notification

When the request for authorization exceeds the amount necessary to match the participant’s health care need, the subsequent authorization will trigger the system to automatically generate a letter to the provider and the participant announcing the “denial” of the excess services. This “denial” message pertains only to the request for excess services, not the request for the participant to obtain services from the program.

Please call (866) 681-7062 or 334-0767 if you have any questions about any of the information contained in this article.

Please see modified SPA form sample on page 6

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

Attention All Providers ...

We have all of our provider information posted on the Idaho Health and Welfare Web site at **http://www.healthandwelfare.idaho.gov/default.aspx**.

You can access it by clicking on the Medicaid Provider Information link on the right side of the page. This page gives you access to all Medicaid Newsletters, Information Releases and Provider Handbooks along with other useful information. Please share this information with your staff and billing service.

Remember the Provider Resources CD will no longer be mailed to providers. Starting with the January 2009 release all handbook sections will be posted on the Web site listed above.

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Keep Your Staff Up-to-Date on Accurate Claims Processing

EDS provider relations consultants (PRCs) continue to offer a series of provider workshops. Each consultant conducts a two-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, and CMS-1500.

The next workshop is scheduled from 2 to 4 p.m. for all regions on September 8, 2009.

These training sessions are provided at no cost to providers, but space is limited so please pre-register with your local consultant. Phone numbers for the PRCs are listed in the sidebar on this page.
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Modified SPA form sample

MEDICAID MENTAL HEALTH SERVICES
PRIOR AUTHORIZATION

Please complete all applicable sections and fax this form to 334-0766 or (866) 467-1549

Participant's Information

Participant's Name:	MID #:
Medicaid Eligibility Confirmation: ◻ YES ◻ PENDING	

Provider's Information

Provider/Region:	Provider #:
Agency's Phone #:	Agency's Fax #:

Reason for Request – attach all supporting documentation

- ◻ New
- ◻ Reassessment
- ◻ Agency Transfer
- ◻ Diagnosis Change
- ◻ PSR Community Crisis
- ◻ Amendment
- ◻ Hospital Discharge
- ◻ Secondary Agency
- ◻ Change from Child to Adult
- ◻ Service Coordination Community Crisis

Medicaid OMHSA Use Only

Prior Authorization Start Date:	Prior Authorization #:
Plan Start Date:	Plan End Date:

◻ Plan is Authorized as Submitted ◻ Plan is Authorized with Modifications (**Modify the participant's plan as noted.**)

Reason for Modifications:

Plan Authorization: The units below include baseline amounts in all services. If services are PA'd, all claims must include the PA number identified above. IMPORTANT: Keep this form in the front of the participant's file.

Service:	Individual Skill Training	Group Skill Training	Community Reintegration	Pharm. Mgmt.	Collateral Contact *Telephone: Use HE modifier*	Community Crisis PSR ◻ SC ◻	Other
Code:	H2017	H2014 HQ	H0036	90862 Encounter	90887	H2011	
Requested Units							
Prior Authorized Units							
Units At or Below Baselines: No PA Required							

This is an authorization for the participant named on this form to obtain services from your agency in the amounts described herein. It is not a confirmation that the submitted documents comply with IDAPA requirements.

Care Manager: ______________________ Date: ______________

Office of Mental Health and Substance Abuse
July 24, 2009

Why Is It Necessary to Bill Usual and Customary Charges?

There is a risk involved in only billing what you expect Medicaid to pay. When there is a rate increase, if you have not billed the new rate, your claims will not pay at the higher rate. When automated mass adjustments are initiated to repay claims at a new, higher rate, your claim will not be automatically adjusted for more than your billed amount.

Adjust claims electronically or on paper using an Adjustment Request form found in the *Provider Handbook, Appendix D, Forms*, to request the higher payment when you find you billed the lower charge.

Billing your "usual and customary" charges routinely will help ensure that your claims are paid at the highest rate for which they qualify, without the extra work of adjusting claims.

The Idaho Medicaid Provider Handbook,
Section 2 - General Billing Information, item 2.1.1 Medicaid Billing Policies states:
"Providers should charge their usual and customary fee for services and submit those charges
to Medicaid for payment consideration."

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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 identification number or qualifier **1D** (one-D) is missing from field **33b** on the CMS-1500 form.

Each paper claim must have the Idaho Medicaid provider identification 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 that is used for electronic claims processing.

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

Billing Provider Information Fields

33. BILLING PROVIDER INFO & PH# ( )	
a.	b. 1D123456789
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EDS
PO BOX 23
BOISE, IDAHO 83707

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

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

Monday, September 7, 2009

LABOR DAY

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

or

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

Fax: (208) 364-1911

Reminder that MAVIS (Medicaid Automated Voice Information Service) is available at:
(800) 685-3757 (toll-free) or
(208) 383-4310 (Boise local)