



MedicAide

An informational newsletter for Idaho Medicaid Providers

In this issue:

- 1 NPI. Get it. Share it. Use it.
- 2 Updated/New NPI FAQs
- 3 Nampa MHC Owners and Employee Sentenced
- 3 Prevent Accidental PHI Disclosure
- 4 CMS 1500 (08/05) Claim Form FAQs
- 5 New Procedure Codes Requiring PA
- 5 Reminders for Dental and Orthodontic Providers
- 6 Nursing Home & PCS Claims Get Priority Handling
- 7 Preventive Health Assistance is Here!
- 11 Select Pre-Authorization List of Diagnoses and Procedures
- 13 Using PES Rejected & Accepted Transaction Reports
- 13 Regional Provider Workshops
- 14 Forms Available From EDS
- 14 Services in Excess of Remaining PA Units
- 15 Submitting Paper Claims
- 15 Medicaid Eligibility & Benefit Plan Information
- 16 January Office Closures

Information Releases:

- 6 Update to Medicaid Information Release MA06-25
- 6 Update to Medicaid Information Release MA06-37
- 7 Medicaid Information Release MA06-38
- 8 Medicaid Information Release MA06-39
- 9 Medicaid Information Release MA06-40
- 10 Medicaid Information Release MA06-42

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 2007

NPI. Get it. Share it. Use it.

Today, you need an Idaho Medicaid provider number to conduct business with the Idaho Medicaid program. On May 23, 2007, the National Provider Identifier (NPI) will become the primary provider identification number most providers will use. Every month we will be sharing more NPI information with you. The topic for January is **subparts**.

Before a health care provider applies for an NPI, the provider needs to know if they are a Type 1 or Type 2 Entity. Organizations are defined as a Type 2 Entity and may be composed of a number of smaller health care providers also called **subparts**. Individual health care providers are defined as a Type 1 Entity and are not composed of subparts.

Each health care organization must determine which of their subparts need a unique NPI on transactions to ensure claims are processed correctly. If a provider is unsure if they are a subpart of an organization, the provider should consult their organizational leadership.

Examples of organizational subparts may include but are not limited to:

- Hospitals may identify components of their organization as subparts; these can include rehabilitation units, psychiatric units, acute care services, therapy services, renal dialysis, surgical centers, etc.
- Pharmacies, Home Health Agencies, laboratories, group practices, etc., may determine each physical location to be a subpart. DME providers must have an NPI for each location unless they are an individual person or sole proprietorship.

Additional information on subparts can be obtained at The Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.hhs.gov/NationalProidentStand/>.

Important:

Time is running out, so act today and apply for your organization's NPI(s)!

Getting an NPI is free . . . not having one can be costly!

Information provided by Idaho Medicaid is not intended to be used in place of information from the Federal Government and other organizations, but is designed to help providers understand what NPI is and how it may impact their business practices.

Updated and New NPI FAQs

(See December newsletter for previous FAQs)

1. Will every Idaho Medicaid provider need an NPI?

Some Idaho Medicaid providers will be able to continue using their current Idaho Medicaid Provider number. “Atypical” providers will not be expected to send an NPI on their claims. Idaho Medicaid has interpreted the NPI rule to designate the following providers as “atypical”:

- Non-Emergency Commercial Transportation
- Transportation Broker
- Individual Transportation Provider
- Agency Transportation Provider
- Personal Emergency Response Systems
- Home Modifications
- 24 Hour PCS Home for Children – (Foster Care)
- Personal Care Service (PCS)/Aged & Disabled (A&D) Agency
- Adult Day Care
- Residential Assisted Living Facility (RALF)
- Behavior Consultation/Crisis Management
- Chore Services
- Home Delivered Meals
- Self Determination Fiscal Employer Agent
- Residential Habilitation Agency
- Certified Family Homes
- Respite Care
- Supported Employment Service

2. Can “atypical” providers still bill Idaho Medicaid?

Idaho Medicaid providers who are “atypical” can still participate in the Idaho Medicaid program by using their current Idaho Medicaid provider number.

3. What is a subpart?

Subparts are components of a health care provider that is an organization, also known as a Type 2 Entity, which may function independently of the organization. Please refer to the article on Page 1 of this newsletter for more information on subparts.

4. Where can I get information on the new CMS 1500 (08/05)?

There is additional information about the new CMS 1500 (08/05) at the following website: www.NUCC.org. Please refer to the article on Page 4 for information that is specific to Idaho Medicaid.

Getting an NPI is free . . . not having one can be costly!

Information provided by Idaho Medicaid is not intended to be used in place of information from the Federal Government and other organizations, but is designed to help providers understand what NPI is and how it may impact their business practices.

DHW Phone Numbers

Addresses

Web Sites

DHW Websites

www.healthandwelfare.idaho.gov

Idaho Careline

211 (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) 455-7244
(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) 239-6270
(800) 284-7857

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

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

Nampa Mental Health Clinic Owners and Employee Sentenced in Federal Court for Medicaid Fraud

DME Prior Authorizations:

DME Specialist
Bureau of 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](http://www.qualishealth.org/idahomedicaid.htm)

Insurance Verification:

HMS
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

On October 27, 2006, Rodger Dearing and Art Dearing, co-owners of Life Springs, a Nampa Mental Health Clinic which provided mental health services to Medicaid participants, were sentenced in U.S. District Court to 5 months federal prison, 5 months community confinement, and Medicaid restitution of \$111,259.77. Mike Adamson, a Life Springs employee, was sentenced to 3 years supervision and restitution of \$2,418.07.

Rodger Dearing pleaded guilty to one count of executing a scheme to defraud the government. Art Dearing was convicted of 32 counts health care fraud, aiding and abetting in connection with fraudulent billings between December 12, 2001, and September 20, 2003. Mike Adamson pleaded guilty to one misdemeanor count of embezzling from a health care benefit program.

The crime occurred when fraudulent billings were submitted to Medicaid for mental health clinic services while clients were at doctor appointments, working, sleeping or running personal errands. They also billed for services provided by unlicensed staff, activities outside the clinic such as bowling, going to movies, fishing, camping, state and local fairs, sight seeing trips, and berry/pumpkin picking.

As much as one hour per day per client was billed for documenting charts. As many as 20 hours were billed in a single day for chart documentation. Life Springs failed to have required treatment plans signed by physicians. They continued to submit fraudulent billings after being warned such activities were not reimbursable.

The case was investigated by the Idaho Department of Health and Welfare, Division of Management Services, Medicaid Fraud & Program Integrity Unit. The Medicaid Fraud & Program Integrity Unit, formerly known as the Fraud Unit and the Surveillance and Utilization Review Unit (SUR), is dedicated to pursuing fraud and abuse in the Medicaid program. Providers who alter, falsify, or destroy records will be referred for possible prosecution.

For more information on Medicaid Provider Fraud, go to the Health and Welfare website at www.healthandwelfare.idaho.gov and select "Reporting Fraud and Abuse" from the help menu. Medicaid fraud and abuse can be reported using any of the following methods:

- By telephone: Call (208) 334-5754 and leave a message.
- By mail: Obtain a Provider Fraud Complaint form found on the Health and Welfare website at www.healthandwelfare.idaho.gov under "Reporting Fraud and Abuse."
- By e-mail: Send a message to prvfraud@dhw.idaho.gov.

Prevent Accidental PHI Disclosure

Did you know that you could disclose Protected Health Information (PHI) to an unauthorized party by entering incorrect information on your claim? If an incorrect provider ID number is entered on a claim and that incorrect number has been assigned to another provider, that claim information will appear on the incorrect provider's Remittance Advice (RA) report. The client's PHI will then be disclosed to a provider who has not provided care to him or her and is therefore not authorized to receive the information.

When PHI is disclosed in error, a Security Incident Report is filled out by whomever discovers the disclosure at EDS/DHW. Remember, HIPAA regulations governing the protection of health information is a federal law, punishable by fines and imprisonment!

CMS 1500 (08/05) Claim Form FAQs

1. When can I begin to use the new CMS 1500 (08/05) claim form?

The new CMS 1500 (08/05) claim form is available as of December, 2006. Here are some important dates to remember when using the new claim form:

- Both the old and new versions of the CMS 1500 claim form will be accepted through **May 22, 2007**.
- Only the new CMS 1500 (08/05) will be accepted after **May 23, 2007**.
- Any re-billing of claims submitted on or after **May 23, 2007** must be on the new CMS 1500 (08/05) claim form, even though earlier submissions may have been submitted on the old CMS 1500 claim form.

2. Can I still use the old CMS 1500 claim form?

The old CMS 1500 can be used to submit claims until May 22, 2007. After May 23, 2007, any paper claims received on the old CMS 1500 claim form will be returned to the provider.

3. Why will the old CMS 1500 claim forms be returned to the providers after May 23, 2007?

They will be returned because the old CMS 1500 claim form does not support NPI and taxonomy codes.

4. How do I complete the new CMS 1500 (08/05) claim form?

Instructions for completion of the new CMS 1500 (08/05) and a sample of the new claim form have been posted on the Health and Welfare website under Medicaid Providers: <http://www.healthandwelfare.idaho.gov/site/3348/default.aspx>.

5. What is a qualifier?

A qualifier is a 2-character modifier that identifies the information that follows it.

6. What qualifiers must be used when billing paper claims on the CMS 1500 form?

The qualifiers that should be used are 1D and ZZ.

- 1D precedes the Idaho Medicaid number
- ZZ precedes the provider taxonomy code.

Example 1

33. BILLING PROVIDER INFO & PH. # ()	
a. NPI	b. 1DYYXXXXXX

Example 1 illustrates the correct use of a qualifier: the provider entered **1DYYXXXXXX** in field 33b. The system will read **1D** and it will identify the characters following it (**YYXXXXXX**) as the Idaho Medicaid Provider Number. Thus, the first two characters identified the remaining characters as the Idaho Medicaid Provider number. The system will place the **YYXXXXXX** in the billing provider number field.

Note: The qualifier is intended for use only on the new CMS 1500 (08/05) claim form. Using the qualifier on the old CMS 1500 form will cause the claim to deny.

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

Client Assistance Line
Toll free: (888) 239-8463

Continued on Page 5 (FAQs for CMS 1500)

**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 Trent
1720 Westgate Drive, # A
Boise, ID 83704
jane.trent@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

Example 2

33. BILLING PROVIDER INFO & PH. # ()	
a. NPI	b. YYXXXXXXXX

Example 2 illustrates an incorrect use of a qualifier: The provider entered **YYXXXXXXXX** in field 33b. The first two characters are supposed to represent the qualifier. Since only **1D** and **ZZ** are valid qualifiers, the system will not recognize any information that follows the **YY**. When an incorrect qualifier is entered in field 33b, the system will place **XXXXXXXX** in the billing provider number field. Since **XXXXXXXX** is not a valid 9-digit Idaho Medicaid provider number, the claim will deny due to a missing or invalid provider number.

**Attention Physician and Hospital Providers:
New Procedure Codes Requiring Prior
Authorization**

Medical Care Unit Review: The following 2007 CPT® codes for gastric neurostimulators require prior authorization by the Medicaid Medical Care Unit: 43647, 43648, 43881, 43882. Fax requests to (208) 332-7280.

Qualis Health Review: The updated Select Pre-Authorization List of Diagnoses and Procedures codes that require prior authorization by Qualis Health is included in this issue on Page 11. New codes and changes are in bold type. Fax requests to (800) 826-3836.

**Reminders for Dental and Orthodontic
Providers**

A Reminder When Billing “Flippers” (Partial Dentures)

Flippers must be billed with the appropriate American Dental Association (ADA) **interim** partial denture codes (D5820 or D5821). D5820 and D5821 are only covered for children up to age 21 and require prior authorization.

Partial dentures are limited to once every 5 years. Billing flippers with the wrong partial denture code can cause a client to be denied partial dentures in error within 5 years of receiving flippers.

Comprehensive Orthodontic Treatment

Comprehensive Orthodontic treatment of transitional, adolescent, and adult dentitions (D8070, D8080, and D8090) includes arch treatment appliances. According to Idaho Code IDAPA 16.03.09.802.12, which can be found at <http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf>, comprehensive orthodontic treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. This means that whenever Medicaid issues a prior authorization for comprehensive orthodontic treatment, headgear and removable or expansion appliances are included in the provider’s reimbursement.

If you accept a client’s Medicaid card, you may not bill the client for any services that are covered by Medicaid. **Even if you believe a client’s orthodontic services are not covered by Medicaid, please request review by Medicaid’s Dental Authorization Unit so that you can get a denial in writing before billing the client.**

Update to Information Release MA06-25 (August MedicAide Newsletter)

Medicaid Information Release MA06-25 in the August issue of MedicAide contained an error in the new rate for one procedure code. The rate in the system reflects the correct amount and remains the same. The correct rate is listed below for your reference.

Provider	Code	Description	New Rate
DD	H0004	Psychotherapy Individual Medical, 1 unit = 15 Min	\$12.84

If you have any questions, please contact Gynna Loper with the Idaho Medicaid Office of Reimbursement Policy at (208) 364-1994. Thank you again for your participation in the Idaho Medicaid program.

Update to Information Release MA06-37 - Hospice Rates (November MedicAide Newsletter)

Medicaid Information Release MA06-37 in the November issue of MedicAide contained errors in the revised hospice rates effective for dates of service on or after 10/01/06. The correct rates are listed below for your reference:

Revenue Code	Description	Rural	Urban Ada/ Canyon Counties
651	Routine Care	\$117.89	\$127.59
652	Continuous Care	\$687.42	\$744.04
655	Respite Care	\$131.22	\$139.54
656	General inpatient Care	\$527.71	\$567.89

If you have any questions, please contact Sheila Pugatch with the Idaho Medicaid Office of Reimbursement Policy at (208) 364-1817. Thank you for your continued participation in the Idaho Medicaid program.

Nursing Home and Personal Care Services (PCS) Claims Get Priority Handling

When paper claims are submitted to EDS by nursing homes and PCS providers, they are given priority handling so they can be processed as quickly as possible. Our goal is to include these claims in the most current weekly financial cycle. The following description will help you understand our priority handling process.

EDS picks up the mail from the post office Monday through Friday early in the morning for claims processing. Claims can also be dropped off in person and placed in the drop box located in the lobby of our building at 390 E. Parkcenter Blvd. EDS collects claims from the drop box at 10:00 a.m. every Friday. These claims are processed the same day they are collected.

The financial cycle runs every Friday night, which processes payments and generates the Remittance Advice (RA) report. The RA report is sent every Monday to those providers that have had claim activity during the previous week. Claims that arrive at EDS, either by mail or collected at the drop box by 10:00 a.m. on Friday, will be included in the current week's cycle and reported on the RA the following week.

Please note that only claims from nursing homes and PCS providers are treated as priority. Other provider types may use the drop box, but these claims will be processed using our standard processing procedures and may not get included in the current week's financial cycle. If you have any questions, please call MAVIS and ask for an agent.

November 22, 2006

MEDICAID INFORMATION RELEASE MA06-38

TO: Physicians, Osteopathic Physicians, Hospitals and Anesthesiologists

FROM: Leslie M. Clement, Administrator

SUBJECT: **Change in Medicaid Policy for Bariatric Surgeries**

Effective immediately, Medicaid will only cover bariatric surgeries that are performed in a Medicare approved Bariatric Surgery Center (BSC) or Bariatric Surgery Center of Excellence (BSCE). A list of facilities approved by Medicare for bariatric surgery is available online from the Centers for Medicare and Medicaid Services (CMS) website at: <http://www.cms.hhs.gov/MedicareApprovedFacilitie/>.

Prior Authorization is required for all bariatric surgeries as outlined in Information Release **IR MA04-57, Bariatric Surgery, Panniculectomy/Abdominoplasty**, available online at: <http://www.healthandwelfare.idaho.gov/DesktopModules/ArticlesSortable/ArticlesSrtView.aspx?tabID=0&ItemID=1346&mid=10309>. Prior authorization requests should be directed to Qualis Health at (800) 783-9207.

Idaho Medicaid rules concerning bariatric surgery are found in sections 431-434 of Idaho Code **IDAPA 16.03.09, Medicaid Basic Plan Benefits**, available online at: <http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf>. As a reminder, Current Procedural Terminology (CPT) code 43770 - **Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric bands** - is not covered by Medicaid.

This information is in addendum to the following sections of the provider handbooks:

- Section 2 – General Billing Information, Section 2.3.2 – Medicaid Prior Authorization
- Section 3 – Physician/Osteopathic Guidelines, Section 3.2.5.1 – Bariatric Surgery
- Section 3 – Hospital Guidelines, Section 3.6.2.3 – Obesity

If you have questions concerning this IR, please contact Frutoso Gonzalez at (208) 364-1833.

LMC/af

Preventive Health Assistance is Here!

Help us help your patients by giving them a brochure about the Preventive Health Assistance (PHA) benefit.

Beginning January 1, 2007 Medicaid will offer a new benefit program called Preventive Health Assistance (PHA) to eligible participants. PHA consists of two types of benefits, Wellness and Behavioral.

- **Behavioral Benefit** -- Participants with a qualifying Body Mass Index (BMI) that is less than 18.5 or greater than 30 and who have a desire to improve their health through weight management, or participants who want to quit tobacco, can earn points by signing up to participate in tobacco cessation or weight loss activities. Participants can use the points to help pay for the programs or for weight management/tobacco cessation supports.
- **Wellness Benefit** -- Participants who pay a premium for their child's Medicaid coverage can earn points for keeping their child's well child checks and immunizations current. If their premiums are current, they can use the points for gym memberships, exercises classes, sports fees or sports safety equipment. Participants must use points to pay for any delinquent premiums before they can use the points for any other purpose.

Additional information is available on our website at www.medicaid.idaho.gov. For brochures or more information about the program contact the PHA Plan Administrator, Cindy Brock at (208) 364-1843, toll free at (877) 364-1843, or at Medicaidphaprogram@dhw.idaho.gov. Please provide your patients with a PHA brochure if you think they need assistance in weight management, smoking cessation, or if they participate in well child checks or immunizations!

MEDICAID INFORMATION RELEASE MA06-39

TO: Physicians, Osteopaths, Mid-level Practitioners, Public Health Departments
 FROM: Leslie M. Clement, Administrator
 SUBJECT: **Change in Policy on Billing for Immunizations**

This IR replaces IR 2003-45 (Immunization Guidelines)

Medicaid is changing the reimbursement policy for administration of free vaccines. For claim dates of services on or after **February 1, 2007**, use the following guidelines when billing for vaccines and/or administration services. All vaccine services should be billed at the Usual and Customary Rate providers use to bill for non-Medicaid patients.

Vaccine Services Provided	Billing Instructions for Children (Free vaccine program is available for participants until their 19th birthday.)	Billing Instructions for Adults (Free vaccine is not available for those who have reached their 19th birthday.)
Administration of free vaccine only	<ul style="list-style-type: none"> • Bill the appropriate CPT code for the vaccine(s) using modifier SL with a zero dollar (\$0.00) amount; and • The CPT code in the range of 90465 to 90474 that accurately reflects the administration of the vaccine(s). 	<ul style="list-style-type: none"> • Not applicable – there is no free vaccine program for adults
Administration of free vaccine and , if there is a <i>significant</i> , separately identifiable service, Evaluation and Management (E&M) visit	<ul style="list-style-type: none"> • Bill the appropriate CPT code for the vaccine(s) using modifier SL with a zero dollar (\$0.00) amount; and • The CPT code in the range of 90465 to 90474 that accurately reflects the administration of the vaccine(s), and • The appropriate CPT code for the E/M visit with modifier 25. 	<ul style="list-style-type: none"> • Not applicable – there is no free vaccine program for adults
Administration of provider-purchased vaccine only	<ul style="list-style-type: none"> • Bill the appropriate CPT code for the vaccine(s) without a modifier, and • The CPT code in the range of 90465 to 90474 that accurately reflects the administration of the vaccine. 	<ul style="list-style-type: none"> • Bill the appropriate CPT code for the vaccine(s) without a modifier, and • The CPT code in the range of 90471 to 90474 that accurately reflects the administration of the vaccine.
Administration of provider-purchased vaccine and , if there is a <i>significant</i> , separately identifiable service, Evaluation and Management (E&M) visit	<ul style="list-style-type: none"> • Bill the appropriate CPT code for the vaccine(s) without a modifier, and • The CPT code in the range of 90465 to 90474 that accurately reflects the administration of the vaccine, and if applicable, • The appropriate CPT code for the E/M visit with modifier 25. 	<ul style="list-style-type: none"> • Bill the appropriate CPT code for the vaccine(s) without a modifier, and • The CPT code in the range of 90471 to 90474 that accurately reflects the administration of the vaccine, and if applicable, • The appropriate CPT code for the E/M visit with modifier 25.

Note: The U7 modifier is no longer necessary. Effective February 1, 2007 claims with the U7 modifier will be denied.

IDAHO MEDICAID PROVIDER HANDBOOK

This Information Release updates Section 3 of your Idaho Medicaid Provider Handbook.

If you have questions regarding this information, please contact Jeanne Siroky in the Bureau of Medical Care at (208) 364-1897. Thank you for your continued participation in the Idaho Medicaid program.

MEDICAID INFORMATION RELEASE MA06-40

TO: Commercial Transportation Providers; Service Coordination Agencies; Waiver Adult Day Care Providers; and Waiver Community Supported Employment Providers

FROM: Leslie M. Clement, Administrator

SUBJECT: **Waiver Commercial Transportation Reimbursement**

Beginning January 1, 2007, commercial transportation providers may request prior authorization (PA) at the commercial rate for non-medical, waiver transportation. Agency and individual transportation providers will continue to be reimbursed at the agency or individual rate, respectively.

Commercial transportation providers with existing PA who want to be paid at the commercial rate must submit a written request for a PA change to their local Regional Medicaid Services (RMS) office. Providers that do not request a change will continue to be paid according to their existing PA. No retroactive PA changes will be made. Additional information about provider reimbursement for all non-emergency transportation services, including non-medical transportation under waiver programs, is described at IDAPA 16.03.09.875.

Providers must use the prior authorization number and the appropriate procedure code and modifiers to be reimbursed for services:

Service	Code	PA Required	Description
Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization) with no vested interest. (A&D non-medical transportation)	A0080 U2 and SE modifiers required	Yes	A&D non-medical transportation, per mile as authorized by the RMS. One unit = 1 mile The maximum allowable units per year are 1800. Requires modifier U2 to report services for the A&D waiver
Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization) with no vested interest. (DD non-medical transportation)	A0080 U8 and SE modifiers required	Yes	DD non-medical transportation, per mile as authorized by the RMS. One unit = 1 mile The maximum allowable units per year are 1800. Requires modifier U8 to report services for the DD waiver

Specific requirements, qualifications, and limitations for non-medical, waiver transportation are described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." Non-medical, waiver transportation is described in Subsection 326.04 for A&D waiver participants and Subsection 703.05 for DD/ISSH waiver participants.

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 replaces information in your Idaho Medicaid Provider Handbook.

MEDICAID INFORMATION RELEASE 2006-42

TO: School Districts, Charter Schools, and the Idaho Infant Toddler Program; Developmental Disabilities Agencies (DDA); and Psychosocial Rehabilitation (PSR) Agencies

FROM: Leslie M. Clement, Administrator

SUBJECT: **Medicaid Billing Policy for Rehabilitative Services Provided in Schools**

Medicaid has had a long-standing policy that only schools may bill Medicaid for services provided in those schools. It has come to our attention that some Developmental Disabilities Agencies (DDA) and Psychosocial Rehabilitation (PSR) agencies have been billing Medicaid directly for services they provide in schools.

Schools are federally obligated to provide free and appropriate public education to all children and must meet the individualized needs of each child. If a child requires specialized services, then the school must assure that the child receives them. Schools may meet this obligation in a variety of ways, including using their own staff or contracting with a private DDA or PSR agency. Schools can then bill Medicaid for many of these services to recoup expenses.

Both schools and state Medicaid agencies are under increased federal scrutiny for both school-based services and rehabilitative services. These are important service areas and we must ensure that billing is within applicable federal and state guidelines to maintain federal funding of these services.

In order to better communicate the billing policy for school-based services, Medicaid has modified the school-based services section in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." During the public comment period on these rule changes, stakeholders recommended additional language in the DDA and PSR agency sections of IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" to make billing limitations explicit. That additional language will be published in the January edition of the Idaho Administrative Bulletin.

Rules Added to Clarify Billing Policy

- IDAPA 16.03.09.245

Only school districts, charter schools, and the Idaho Infant Toddler Program can be reimbursed for the services described in Sections 850 through 856 of these rules.

- IDAPA 16.03.10.124.05.c

Prior to delivering any services in a school-based setting, the PSR agency must have a contract with the school or the Infant Toddler program. The PSR agency must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Section 850 through 856.

- IDAPA 16.03.10.653.05.e

Prior to delivering any services in a school-based setting, the DDA must have a contract with the school or the Infant Toddler Program. The DDA must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856.

Providers may review the requirements for school-based services in the "Medicaid Basic Plan Benefits" chapter online at <http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf> and the requirements for DDAs and PSR agencies in the "Medicaid Enhanced Plan Benefits" chapter at <http://adm.idaho.gov/adminrules/rules/idapa16/0310.pdf>. If you have questions about this billing policy or the rule changes made to clarify this policy, please contact Shannon Carlin at the Division of Medicaid at (208) 364-1903. Thank you for your continued participation in the Idaho Medicaid program.

LMC/sc

Select Pre-Authorization List of Diagnoses and Procedures

**FOR IDAHO MEDICAID
AND DIVISION OF FAMILY AND COMMUNITY SERVICES CLIENTS
Revised November 2006**

PRE-AUTHORIZATION LIST REQUIRING QUALIS HEALTH REVIEW

Phone 1 800-783-9207 Fax 1 800-826-3836

All surgical procedures on this list require pre-authorization for inpatient and outpatient services.

Procedure	ICD-9-CM Code October 2006	CPT® Code January 2007
Arthrodesis (Spinal Fusion)	78.59 81.00 through 81.08	22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280
Note: Artificial disc not a covered benefit.	81.30 through 81.39 81.62, 81.63, 81.64	
Unlisted neck, thorax procedure	78.41	21899
Unlisted spine procedure	78.71	22899
Laminectomy/Discectomy	03.02	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200
Laminoplasty	03.09 03.1 03.6 80.50 80.51	
Hysterectomy		
Abdominal	68.3, 68.31, 68.39 68.41, 68.49, 68.61, 68.69 (effective 10/01/2006)	58180, 59135, 59525 58150, 58152, 58200, 58951, 59135, 59525 58210 58550, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58548 (effective 01/01/2007)
Vaginal	68.51 68.59	
Laparoscopic	68.71, 68.79 (effective 10/01/2006)	58953, 58954
Radical		
Other and Unspecified	68.9	
Reduction Mammoplasty		
Unilateral, Bilateral	85.31, 85.32	19318
Total Hip Replacement	81.51	27130
Revision	81.53 00.70-00.76, 00.77, 00.85, 00.86, 00.87 (effective 10/01/2006)	27132, 27134, 27137, 27138
Partial Hip Replacement	81.52	27125
Total Knee Replacement	81.54	27445, 27446, 27447
Revision	81.55 00.80-00.84	27486, 27487

Continued on Page 12 (Select PA List)

Procedure	ICD-9-CM Code October 2006	CPT® Code January 2007
Transplants		
Bone Marrow Transplant		
Autologous	41.00, 41.01, 41.04, 41.07, 41.09	38241
Allogenic	41.02, 41.03, 41.05, 41.06, 41.08	38240, 38242
Liver Transplant	50.59	47135, 47136, 47143, 47144, 47145, 47146, 47147
Note: Liver from live donor not a covered benefit		
Kidney Transplant	55.61 55.69	50323, 50325, 50327, 50328, 50329, 50360, 50365, 50380
Intestinal Transplant	46.97	44133, 44135, 44136, 44715, 44720, 44721
Heart Transplant (Note: Transplant facilities must be Medicare approved.)	37.5, 37.51, 37.52, 37.53, 37.54	33945
Bariatric Surgery	44.31	43644, 43645, 43845, 43846, 43847, 43848
Note: Procedure must be performed in a Medicare approved Bariatric Surgery Center (BSC) or Bariatric Surgery Center of Excellence (BSCE).		Note: Adjustable gastric bands are not a covered benefit.
Panniculectomy	86.83	15831, 15877 15830, 15847 (effective 01/01/2007)
Alcohol and Drug Rehabilitation and Detoxification		
Inpatient Only		
Alcohol Rehabilitation	94.61	90899
Alcohol Detoxification	94.62	90899
Alcohol Rehabilitation and Detoxification	94.63	90899
Detoxification		
Drug Rehabilitation	94.64	90899
Drug Detoxification	94.65	90899
Drug Rehabilitation and Detoxification	94.66	90899
Combined Alcohol and Drug Rehabilitation	94.67	90899
Combined Alcohol and Drug Detoxification	94.68	90899
Combined Alcohol and Drug Rehabilitation and Detoxification	94.69	90899
Psychiatric Admissions	291.0 through 314.9 (Diagnosis Codes)	
Inpatient Only		
Physical Rehabilitation	V57.0 – V57.9 (Diagnosis Code)	
Care involving use of rehabilitation procedures	This includes admission to all rehabilitation facilities, regardless of diagnosis.	
Inpatient Only		

Current Procedural Terminology (CPT®) is copyright American Medical Association 2007. All rights reserved. CPT is a registered trademark of the American Medical Association.

Approved List of V-Codes That May Be Used for Principal Diagnoses

The V-Codes in the current ICD-9 CM book, Tabular List for V-Codes, listed as acceptable codes for use as a principal diagnosis will be used for pre-authorization and concurrent review purposes. Only these V-Codes will be accepted by the Qualis Health nurse reviewers when performing pre-authorization or concurrent review for Idaho Medicaid clients.

Using PES Rejected and Accepted Transaction Reports

Have you ever wondered why your claims do not show up in the system or on your remittance advice?

When you use PES software to submit your claims, you will receive a confirmation message that indicates the submission was successful. This message means that your claims have been successfully transmitted. The next step is a preliminary review, which ensures that basic information on the claims is accurate. Once claims pass the preliminary review process, the claim information is added to the Accepted Transaction Report. If claims do not pass the preliminary review process, the claims are rejected and the claim information is added to the Rejected Transaction Report. Rejected claims will not be processed.

An example of basic information that may cause the claim to be rejected is the name of a state. If a new client is entered into the PES system and the client's state is entered as "IS", instead of "ID", the system will not recognize "IS" as a valid state name and the transaction will be rejected.

Information on the Rejected and Accepted Transaction Reports is important and should be referenced regularly. To download your Rejected and Accepted Transaction Reports, please refer to your PES Handbook or contact the EDI Helpdesk at (800) 685-3757 and ask for Technical Support.

Regional Provider Workshops

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 General Medicaid Billing, Provider Resources, and Using PES Software.

The next workshop is scheduled for Tuesday, January 9, 2007, from 2:00 to 4:00 p.m. These workshops are free but please pre-register with your local Provider Relations Consultant. Their phone numbers are listed in the Medicaid newsletter.

Forms Available From EDS

The Idaho Medicaid Provider Handbook, Appendix D, includes several forms that can be copied and used by providers, as needed. In addition, there are other forms that can be ordered from EDS. The forms that can be ordered from EDS are listed below: Please refer to Appendix D of the Idaho Medicaid Provider Handbook for instructions on how to order these forms from EDS. A copy of the handbook can be found on the Idaho Medicaid Provider Resources CD or online at <http://www.healthandwelfare.idaho.gov/site/3438/default.aspx>.

Form Name	Form Number
Drug Claim Form	352-023
Finger Print Cards	FD258
Notice of Admit or Discharge: NF or ICF/MR	HW0458
PASARR Screen Form	HW0087
PCS Assessment and Care Plan	RMU 14.01
PDN Flow Charts	HW0622
PDN Assessments	HW0622A
Physicians Medical Care Evaluation for PCS	HW0603 3/98
QMRP Assessment	HW0615
QMRP Visit	HW0621
Sterilization Consent Form	HW0034
Visit Notes for Supervising Nurses	HW0620

Services in Excess of Remaining Prior Authorization Units

Effective February 1, 2007, Medicaid will deny services/claims that are billed in excess of the remaining prior authorized units. These claims currently pend for manual processing for edit 806 "No Prior Authorization on File". This change is being implemented in response to requests from providers seeking quicker turn around times on processing of their claims.

Currently, as a courtesy to providers, claims are manually "cut back" in order to process the claim and provide payment to the provider. Depending on the number of claims requiring manual processing in the system, a claim has the potential of waiting up to 120 days to be processed. Cutback is a process where the units billed on the claim are manually compared against the units remaining on the prior authorization, and the units on the claim are reduced to match the number of remaining units in the prior authorization. By eliminating this process, a claim will generally be processed and denied within the same week of receipt. This will allow providers to research and re-bill with the proper units and receive payment in a timelier manner.

Providers who wish to check on the number of remaining units within a prior authorization can call the MAVIS line at (800) 685-3757 and request to speak with an EDS agent, or they can contact the authorizing agency at the phone number listed at the bottom of the Prior Authorization notice.

Submitting Paper Claims

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

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

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

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

Understanding Medicaid Eligibility and Benefit Plan Information

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

When an eligibility inquiry is submitted, participants who are eligible for the full range of Medicaid services will have their benefit plan reported as "Medicaid" only in the eligibility response. Participants who are not eligible for the full range of Medicaid services will have their restrictions reported according to their benefit plan. For example:

- The eligibility response for clients who are eligible for the full range of Medicaid services will be:
 - Client 9999999 is eligible for Medicaid from September 1, 2006 to September 1, 2006 (for regular Medicaid).
 - Client 9999999 is eligible for Medicaid from September 1, 2006 to September 1, 2006 with additional coverage for Medicare paid services (for QMB+).
- The eligibility response for clients who are not eligible for the full range of Medicaid services will be:
 - Client 9999999 is eligible for Medicaid from September 1, 2006 to September 1, 2006 **with benefits restricted to Medicaid basic plan services only.**
- The benefit plans for Presumptive Eligibility, Pregnant Women, and Qualified Medicare Beneficiary programs remain unchanged and the restrictions for participants on these plans will be reported accordingly:
 - Client 9999999 is eligible for Medicaid from September 1, 2006 to September 1, 2006 **with benefits restricted to pregnancy related services only.**
 - Client 9999999 is eligible for Medicaid from September 1, 2006 to September 1, 2006 **with benefits restricted to outpatient pregnancy related services only.**
 - Client 9999999 is eligible for Medicaid from September 1, 2006 to September 1, 2006 **with benefits restricted to Medicare paid services.**

EDS
P.O. Box 23
Boise, Idaho 83707

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

January Office Closures

- Monday, January 1, 2007, the Department of Health and Welfare and EDS offices will be closed on New Year's Day.
- Monday, January 15, 2007, the Department of Health and Welfare will be closed for the Martin Luther King/Idaho Human Rights Day .

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

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
P.O. Box 83720
Boise, ID 83720-0036
Fax: (208) 364-1911