MedicAide

An informational newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **June 2011**

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Changes Coming to Idaho Medicaid Reimbursement

The Idaho Legislature has directed Idaho Medicaid to implement important changes that will take place July 1, 2011. These changes include, but are not limited to, reimbursement methods, service limitations and new enrollment requirements for many providers. You can find detailed information about each of these changes by reading the **Information Releases** located in this issue of MedicAide.

HB260 Section 16

HB260 Section 16 requires the Department to prescribe by legislation any changes to provider payment rates through appropriation, so no rates will be inflated effective 7/1/11.

MedicAide Newsletter Online

Beginning July 1, 2011, the MedicAide Newsletter will go green and be online unless providers call to request a paper copy. To receive the newsletter by mail, call Provider Services at 1 (866) 686-4272. These changes also contribute to overall cost reductions to the Idaho Medicaid program.

Why Access Idaho Medicaid Online?

Spending Time Here May Save You Time Later

If you haven't done so already, check out the Idaho Medicaid portal at www.idmedicaid.com for announcements, contact information, Information Releases, the Provider Handbook, User Guides, training information, and more. Click on a link on the left navigation menu to go directly to the information you need. You can become a Trading Partner to securely submit claims online, access your claim status, and review your remittance advices.

This Web site is for our providers and is continually evolving to help you get the information you need when you need it.

Timely Filing

All claim types must be submitted to Idaho Medicaid within 365 days of the date of service. Two exceptions are:

1. Paid Medicare claims, which must be submitted within six months of the date of the Medicare payment reported on the Medicare EOB, also known as the Medicare Remittance Notice (MRN).
2. Participants who are retroactively approved for Medicaid more than 365 days after the date of service.

Claims which are submitted within the timely filing period do not need to be paid to be considered timely. They can be paid, pended, or denied as long as they are in the processing system within 365 days of the start date of service. However, if they will be resubmitted after the timely filing period has expired, it is very important to keep documentation to help support timely filing of the original claim. A summary of timely filing submission rules and acceptable documentation are provided below:

Denial Resubmissions. An original claim must be submitted within 365 days of the date of service. If more than 365 days have elapsed since the date of service, and the claim was not submitted originally within 365 days of the start date, the system will pend the claim for review. If appropriate documentation is not attached the claim (copy of RA with the denial, copy of retro eligibility notice, etc), the claim will be denied. If any portion of the original claim was paid, the claim must be adjusted rather than resubmitted. Include documentation for timely filing, such as a remittance advice (RA) showing the original denial.

Denied claims may be resubmitted on paper or through your Trading Partner Account online at www.idmedicaid.com, but must be for the same services submitted on the original claim. If new services need to be billed they must be submitted in a separate claim with appropriate documentation to avoid being denied for timely filing.

We recommend using your online Trading Partner Account to resubmit the denied claim so the link between the original timely submission and the adjusted claim are retained for timely filing. In this case no other documentation is required. The online claim will retain the same claim control number as the original claim with a two digit extension that begins with an "A". For example, if this is the first resubmission, it would be "A1".

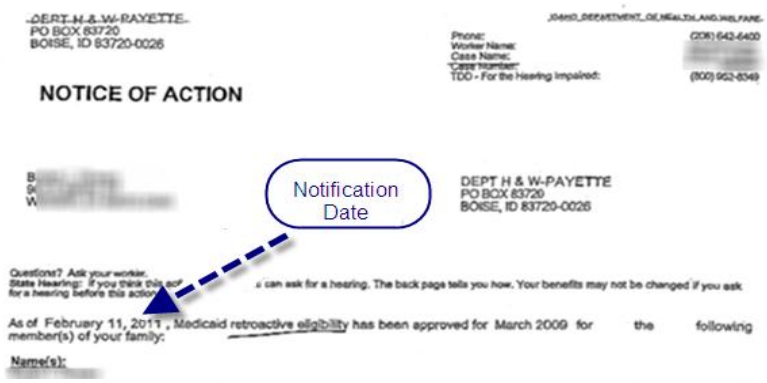
Paid Claim Adjustments. Adjustments to paid claims must be made within two years after the payment was issued on the original claim. Adjustments can be made only on paid claims, even if one or more lines were denied.

Adjusted claims may be resubmitted on paper or online, but must be for the same services submitted on the original claim. If new services need to be billed they must be submitted in a separate claim with appropriate documentation to avoid being denied for timely filing. If requesting an adjustment on paper, include the original ICN/claim number and the claim frequency code in box 22 on the CMS 1500 and box 64 on the UB04.

We recommend using your online Trading Partner Account to resubmit the paid claim so the link between the original timely submission and the adjusted claim are retained for timely filing. In this case, no other documentation is required. The online claim will retain the same internal claim control number (ICN) as the original claim with a two digit extension that begins with an "A". For example, if this is the first resubmission, it would be "A1".

Date of Submission. To determine if a claim is within 365 days from the date of service, use the Julian date from the original claim number (the 3rd, 4th, and 5th characters from the left in the ICN) against the date of service. Refer to the Glossary in the Provider Handbook under *ICN* for more information on the MMIS claim number format. To determine the submission date for an HP/EDS claim, use the Julian date of the original claim number or ICN (the 5th, 6th and 7th characters).

Participant Eligibility. Claims for Idaho Medicaid participants who receive retroactive eligibility must be submitted within 365 days from the date the retroactive eligibility approval letter was issued to the participant. The retroactive eligibility approval letter, also called the *Notice of Action*, should be attached to the claim for verification. See below:



If the initial claim is submitted electronically in a timely manner without a participant Medicaid identification number (MID), or with an invalid MID, the claim transaction will be rejected and an EDI transaction rejection report will be generated. This must be retained as documentation of timely filing. If the claim is submitted on paper, the provider will be mailed a Return to Provider (RTP) letter, which must be kept for documentation to support timely filing.

Once a provider has acquired the participant's MID, the claim must be submitted with supporting documentation, such as a copy of the participant's retroactive eligibility letter/Notice of Action, the EDI transaction rejection notice or the RTP letter.

Third Party Insurance. If the participant has third-party insurance other than Medicare, the claim must be submitted to Idaho Medicaid within 365 days of the date of service *regardless* of whether the other insurance has paid or denied. Claims denied by Medicare and other third-party carriers for timely filing will also be denied by Idaho Medicaid.

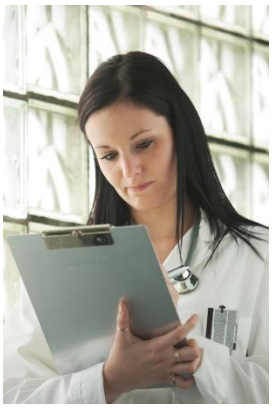
Medicare Claims with Valid Denials. Medicare claims with valid denials are processed as straight Medicaid claims (not Medicare primary claims) and are subject to the Medicaid 365 day timely filing requirement. The Medicare Remittance Notice (MRN) should be included with the claim whether submitted on paper or online.

Prior Authorization. Claims requiring Prior Authorization (PA) must be submitted within 365 days of the date of service *regardless* of the date the PA was issued.

Additional Services on a Resubmitted Claim. If a claim is resubmitted more than 365 days after the date of service, but includes services that did not appear on the original claim, those additional services will be denied. Additional services that need processing and payment should be submitted on a separate claim with required documentation if submission is more than 365 days from the date of service.

HP/EDS Claims. For claims filed initially with HP/EDS in a timely manner, Idaho Medicaid will consider claims for payment if proof of submission is documented. HP/EDS claims that have been denied should also be resubmitted with proof of timely filing since these claims are not stored in the Molina system. Submit your paper verification document with the paper claim, or upload a copy of the verification with your portal submission or electronic claim. Acceptable documentation includes an RTP letter, electronic rejection report, a remittance advice, or a letter from EDS saying that they are no longer processing claims.

Provider Retroactive Eligibility. Claims must be submitted within 365 days of the date of service regardless of the provider's enrollment date.



Psychological/Neuropsychological Testing Update

Effective January 1, 2011, Medicaid has established new policies governing psychological and neuropsychological testing. Please refer to the January MedicAide newsletter for reasons and details about these policy changes. Medicaid has received several inquiries regarding the policy change and the process for obtaining authorizations for testing when authorization is needed. This article aims to clarify aspects of the authorization process which some providers have found confusing.

All policy remains the same except service limits. The new policy requires that service limits are driven by the medical necessity of the service rather than the service limits being determined by how many other evaluation and diagnostic services have already been rendered. There is no change in definitions, coverage, or the staff qualified to render the services.

Psychologists do not have to fill out or sign the authorization request form. Psychologists have the option of filling out the form themselves or delegating the task to another staff member. The staff member can fill out the form using information obtained from the psychologist, however all requests must include individualized information and the

specific reason(s) for testing as opposed to a generalized statement such as "testing to clarify diagnosis and direct treatment".

Services do not have to be delayed due to the authorization process. The authorization can be obtained prior to rendering any testing services, after testing services have already been initiated, or within 60 days of the completion of the testing services.

Professionals besides psychologists may perform testing services. Existing Medicaid policy, based on Idaho statute, requires the person performing general psychological testing to be: 1) a licensed psychologist; 2) a service extender registered with the Idaho Bureau of Occupational Licensing; or, 3) licensed professionals as described in Idaho statute 54-2303 and IDAPA 16.03.09.709.03. No students, interns or trainees are qualified to deliver Medicaid-reimbursed psychological testing services. For neuropsychological testing, requirements at IDAPA 16.03.09.709.03 state that agency staff may deliver this service if they are: 1) a licensed psychologist (or physician); or, 2) a service extender with specific competencies in neuropsychological testing. No other professionals, students, interns or trainees are qualified to deliver Medicaid-reimbursed neuropsychological testing services.

Only licensed psychologists and physicians can render testing services billed under codes 96101 and 96118. These codes are not available to be rendered by persons holding a doctorate level degree who are not licensed, any service extenders whatsoever, nor any other professional rendering testing services. Licensed psychologists and physicians may also render services that are billed under these codes when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician and computer-administered tests.

Service extenders and other qualified professionals must only render testing services billed under those technician codes (or computer administered codes) they are qualified for. These codes are specifically designated for qualified professionals who render testing services and who are not licensed psychologists or physicians. **NOTE:** Please refer to the matrix below to identify correct billing codes.

Professional rendering direct services	96101	96102	96103	96118	96119	96120
Licensed Psychologist or Physician	Yes	No	Yes	Yes	No	Yes
Service Extender	No	Yes	Yes	No	Yes	Yes
Other Qualified Professionals	No	Yes	Yes	No	No	No

Codes 96101/96118 should not be billed for interpretation or report of tests administered via technician or computer. If a licensed psychologist or physician is only interpreting and reporting the information of a psychological test without integrating data from other sources, the time spent on interpreting and reporting is already included in the payment under the technician (96102/96119) or computer code (96103/96120) and cannot be billed separately.

Whether the battery of tests is general or neurological is determined by the question that needs to be answered by the testing results, not the specific tests that are administered. The appropriate codes to use when rendering general psychological testing or neuropsychological testing services depends on the focus of the testing services. Generally speaking, for testing to be considered neuropsychological in focus, the goal should be to determine the extent of cognitive impairment due to a known or suspected medical/neurological disorder or brain injury or aimed at differentiating between a psychiatric condition and a medical/neurological condition. Coding is not based on the tests that are conducted; it is based on the reason for testing.

Some interview tools and functional assessment tools such as the CAFAS/PECFAS are not considered psychological tests and cannot be billed as such. IDAPA 16.03.09.707.14 specifically instructs that psychological testing "does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purpose of determining participant's mental status, diagnoses or functional impairments."

Not all psychological and neuropsychological services are reimbursed by Medicaid. Providers rendering testing services are responsible for accurately matching the delivered service with the appropriate CPT code in order to ensure their claims are appropriately reimbursable. The only CPT codes reimbursed by Medicaid are; 96101, 96102, 96103, 96118, 96119, and 96120. While it is within the purview of providers to deliver whatever testing services they deem clinically appropriate, they must only bill Medicaid for those specific services associated with the codes identified herein.

Adults who receive DDA services and for whom additional psychological services are needed should be referred to a mental health clinic so that additional services can be authorized. IDAPA 16.03.10.653.03 states the service limit for psychological testing provided by a DDA is four (4) hours. Adult DDA participants who need more than four (4) hours of psychological testing may be able to obtain the services but not through a DDA. Since the need for additional testing services implies a need for mental health services the adult participant should be referred to a mental health clinic for the additional psychological testing. The only exception would be for a child participant through the EPSDT program. DDA providers who have determined a child participant needs more than four (4) hours of psychological testing should proceed with their usual process for making EPSDT requests for services.

Explaining testing results to the participant is reimbursable. Time spent by licensed psychologists and physicians explaining the outcomes of the testing can be billed. If the conversation focuses on how the results impact treatment, then appropriate psychotherapy codes should be billed. If the session focuses exclusively on providing the participant with an interpretation of the results, then it is billed as 96101 or 96118.

Authorizations require a date range, not a single date in time. On authorization requests providers should indicate the date range they expect to use in the administration of tests, interpretation of results, preparation of the report, and delivery of results. The billing system has not been able to accommodate this in the past and providers are accustomed to billing with a single date. This is not accurate and is no longer necessary as of January 1, 2011. On the occasion that a provider intends to provide <u>all</u> testing services (administration, interpretation, report writing and explanation of results) on one day, then a single date can be authorized. All claims should accurately reflect the date the services were rendered.

The definition of a unit is one hour or one test. Most Medicaid services that are billed in units refer to fifteen (15) minutes of services but this does not apply to psychological or neuropsychological testing. One unit is one hour or one test, depending on the CPT code used.

The forms for requesting authorization of psychological and neuropsychological testing have been updated. These forms are optional but using them will expedite authorizations. Please refer to the following link for the updated forms: http://healthandwelfare.idaho.gov/Providers/MedicaidProviders/tabid/214/default.aspx Agencies that have previously submitted claims incorrectly and have been reimbursed for those claims should contact Molina and make the necessary adjustments to their billing. If you have any questions on this topic, please contact the Office of Mental Health and Substance Abuse at 208-334-0767 or 1-866-681-7062.

Medicaid Program Integrity

Determining How to Bill for 15-Minute Timed Codes

During recent audits, the Medicaid Program Integrity Unit identified inappropriate practices involving the calculation of units for timed codes. Providers billed separate units for each session rather than using the total minutes of service provided in a day to determine units.

For example, a worker provided eight minutes of a service in one session. The worker let several minutes lapse and provided another eight minutes of service in a second session. The provider billed a total of two units when the worker provided only 16 minutes of service. This practice resulted in the provider being reimbursed for more units of service than were actually provided.

Several CPT and HCPCS codes used for evaluations, therapy modalities and procedures specify that one unit equals 15 minutes. Providers may bill a single 15-minute unit for treatment that is greater than or equal to eight minutes. Two units should be billed when the interaction with the participant is greater than or equal to 23 minutes but is less than 38 minutes. This pattern remains the same when calculating the time spent providing the service.

The Idaho Medicaid Provider Handbook states, "Providers should not bill for services performed for less than eight minutes. This time should be documented though may not be billed for that day unless additional service time occurs on that same day for the same participant."

The Department will recoup payments made to providers based on this inappropriate practice of calculating timed codes.

For additional guidance please consult CMS Program Memorandum Transmittal AB-00-14.

Provider Training Opportunities in June

The **Eligibility, Benefits, and Building a Patient Roster** training session is open to all Medicaid providers in June. It will be delivered by Provider Relations Consultants on the following dates at the following locations:

Location	Date	Time	Location (DHW Office)
Region 1	**6/17/2011**	9 -11 A.M. PDT	Coeur d'Alene DHW Office Conference room #102 1120 Ironwood Dr. Coeur d'Alene, ID
Region 2	**6/9/2011**	9 -11 A.M. PDT	Lewiston DHW Office Basement Training Room 1118 F Street Lewiston, ID
Region 3	**6/14/2011**	9 -11 A.M. MDT	Caldwell DHW Office West Sawtooth Conference Room 3402 Franklin Rd. Caldwell, ID
Region 4	**6/7/2011**	9 -11 A.M. MDT	Boise DHW Office Suite B Conference Room 1720 Westgate Dr. Boise, ID
Region 5	**6/14/2011**	9 -11 A.M. MDT	Twin Falls DHW Office (**NEW**) Conference Room 803 Harrison Street Twin Falls, ID 83301
Region 6	**6/30/2011**	9 -11 A.M. MDT	Pocatello DHW Office 2nd Floor Conference Room, Ste#230 1070 Hiline Road Pocatello, ID
Region 7	**6/14/2011**	9 -11 A.M. MDT	Idaho Falls DHW Office 1st floor computer lab 150 Shoup Ave. Idaho Falls, ID

This new session is designed to add depth to the eligibility sessions given in May, as well as instruct providers on how to build and access a patient roster.

Please check the **Idaho Medicaid Training Center** calendar for upcoming dates by logging into your Medicaid Training Center user profile and registering for the session in your region. Additionally, walk-ins are always welcomed!

All onsite classroom sessions are available for registration through the Idaho Medicaid Training Center. Go to www.idmedicaid.com, and click on **Training** in the menu on the left side of the screen. Click on the **Idaho Medicaid Training Center** information link to access the registration form.

System Updates and Announcements

IHCC

The Idaho Health Care Conference has concluded for 2011. Approximately 1600 providers attended sessions throughout Idaho. You can find Molina's conference presentations on billing tips, prior authorizations and navigating the portal at www.idmedicaid.com under Training on the left navigation panel.

Include Service Location on Claims

Some claims ***require*** the 12 or 14-digit (a dash counts as a digit) Service Location number to process and pay correctly. Please refer to the billing instructions section of the Provider Handbook for assistance with proper billing.

Updated User Guides

A series of Trading Partner User Guides have been updated with new information. To access this important information, please visit the main page of www.idmedicaid.com and click on User Guides on the left navigation panel.

Updated Numeric Fee Schedule

Providers can see the newly updated 2011 numeric fee schedule online at www.idmedicaid.com. To view the most current numeric fee schedule, click on Medicaid Fee Schedules. The numeric fee schedule is applicable to most providers. Additional custom fee schedules are updated as needed.

Maintenance Forms Available

There are now hardcopy options for providers who are unable to submit maintenance requests electronically. Paper forms are required for Healthy Connections providers. Provider maintenance forms are available online at www.idmedicaid.com. Completed forms can then be faxed or mailed to Molina Medicaid Solutions. See page 19 for address information.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT – Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 5, 2011

MEDICAID INFORMATION RELEASE MA11-08

To: Certified Family Home (CFH) Providers

From: Leslie M. Clement, Administrator

Subject: Implementation of New Fees Related to CFHs

House Bill 260 tasked the department to "Implement changes to the certified family homes pursuant to Idaho Code Chapter 31, Title 39, to:

(i) Create approval criteria and process for approving new certified family homes;
(ii) Recertify current certified family homes; and
(iii) Develop applicant and licensing fees to cover certifying and recertifying costs;"

Effective July 1, 2011, the department is implementing an ongoing, monthly CFH assessment fee of $25 per CFH to cover recertification costs. The department will invoice and collect this fee on a quarterly basis. The department can institute a revocation action when the provider doesn't pay the $25 monthly recertification fee (IDAPA 16.03.19.913.02.n).

Effective July 1, 2011, the department will also implement a new one-time CFH application fee of $150 to cover orientation of potential CFH providers, required training, consultation, and initial onsite surveys of new CFHs (IDAPA 16.03.19.109.01. and IDAPA 16.03.19.109.02).

Payments for the application fees must be made before attending CFH orientation training. All payments must be made to the department's Revenue Unit located at 803 Harrison, PO Box 5579, Twin Falls, ID 83303.

Questions should be directed to the statewide Certified Family Home Program Manager at (208) 239-6260.

LMC/rs

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RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
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Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 26, 2011

MEDICAID INFORMATION RELEASE MA11-09

To: All Medicaid Developmental Disability Agencies (DDA) Adult Service Providers, and Developmental Disability (DD) Adult Targeted Service Coordination Providers

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions – Developmental Therapy Blended Rates

Effective July 1, 2011, in compliance with House Bill 260, Section 9, the department will implement blended rates for adult developmental therapy (DT).

The rate for Home and Community-Based DT procedure codes and Center-Based DT procedure codes will be automatically modified for claim dates of service beginning on July 1, 2011, to reflect the blended rate. No addendums will be required.

The department is releasing more detailed communication and instruction to providers regarding DT claims submitted for Dates of Service (DOS) beginning July 1, 2011, and annual plans submitted beginning July 1, 2011. Please refer to the Medicaid page on the Department of Health and Welfare's Website for this information.

Adult DD Procedure Codes

Benefit	Procedure Codes	New Rate for DOS Beginning 7/1/2011
Individual	97537	$3.34/unit
Group	97537-HQ	
Individual	H2032	$3.02/unit
Group	H2032-HQ	

If you have questions about the reimbursement changes for DT benefits, please email the policy subject matter expert in the Bureau of Developmental Disabilities at DDProviderQuestions@dhw.idaho.gov, or call (208) 947-3364.

Thank you for participating in the Idaho Medicaid Program.

LMC/rs

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LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
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Boise, Idaho 83720-0009
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FAX: (208) 364-1811

May 24, 2011

MEDICAID INFORMATION RELEASE #MA11-10

To: All Medicaid Providers of Chiropractic Services

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions –Chiropractic Services

Effective for dates of service on and after July 1, 2011, and in compliance with House Bill 260, Section 9, participants will be limited to six visits per calendar year for treatment involving manipulation of the spine to correct a subluxation condition. No other conditions are covered under this benefit.

If you have questions about the changes in limitations for chiropractic services, please contact the policy subject matter expert for chiropractic services in the Division of Medicaid at (208) 364-1897.

Thank you for participating in the Idaho Medicaid Program.

LMC/rs

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RICHARD M. ARMSTRONG – Director

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DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 24, 2011

MEDICAID INFORMATION RELEASE #MA11-11

To: All Medicaid Providers of Vision Services

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions –Vision Services

Effective for dates of service on and after July 1, 2011, in compliance with House Bill 260, Section 9, Idaho Medicaid will no longer cover vision services for adults unless they require evaluation and treatment for a chronic disease such as diabetes. There are no changes for vision services for participants who are under the age of 21.

If you have questions about the changes in limitations for vision services, please contact the policy subject matter expert for vision services in the Division of Medicaid at (208) 364-1897.

Thank you for participating in the Idaho Medicaid Program.

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Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 24, 2011

MEDICAID INFORMATION RELEASE #MA11-12

To: All Medicaid Providers of Podiatrist Services

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions – Podiatric Services

Effective for dates of service on and after July 1, 2011, and in compliance with House Bill 260, Section 9, Idaho Medicaid will reimburse podiatrists for preventive care or for treatment of acute foot conditions only if the participant has a chronic condition with vascular restrictions such as diabetes.

If you have additional questions about the changes in limitations for podiatric services, please contact the policy subject matter expert for podiatric services in the Division of Medicaid at (208) 364-1897.

Thank you for participating in the Idaho Medicaid Program.

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RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 24, 2011

Medicaid Information Release #MA11-13

To: Medicaid Dental, Anesthesia, Hospital, Ambulatory Surgical Center (ASC), and Case Management providers

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Changes to Medicaid Dental Program

On July 1, 2011, Medicaid will implement the following changes to its dental program:

- New dental benefit limitations for adults age 21 and older.
  - In compliance with recent changes to state Medicaid law in House Bill 260, dental benefits for adults ages 21 and older will be limited to emergency dental treatment only, effective with dates of service on or after July 1, 2011. Coverage will be limited to the list of services in the table below.
  - Children and pregnant women of any age aren't impacted by this change. They will continue to have access to the same dental benefits currently available to them through Idaho Smiles.

- A new group of eligible adults will be covered by Idaho Smiles.
  - Effective for dates of service on or after July 1, 2011, claims for adults on Medicare Part A and Part B who are over the age 21 and who **are not** on the Medicare Medicaid Coordinated (MMCP/Medicare Advantage) Plan will now be covered under the Idaho Smiles dental insurance plan. This group has been receiving dental benefits directly through Medicaid.
  - Claims for all participants with Medicaid dental coverage *with dates of service on or after July 1, 2011,* must be submitted to DentaQuest, the Idaho Smiles claims administrator.
  - Any dental claims and adjustments *with dates of service before July 1, 2011,* that were covered by Molina Health should still be sent to Molina.
  - Claims for MMCP/Medicare Advantage eligible adults should continue to be submitted to the insurance plan listed on their MMCP/Medicare Advantage card.

Medicaid will notify the affected participants of this change. DentaQuest will also distribute a "Welcome" packet and identification card to new Idaho Smiles members.

If you have questions, please contact Idaho Smiles Customer Service at (800) 936-0978. Thank you for participating in the Idaho Medicaid Program.

Billable Non-Pregnant Adult Dental Codes Effective July 1, 2011

Code	Description
D0140	Limited oral evaluation - problem focused
D0220	Intraoral periapical film
D0230	Additional intraoral periapical films
D0330	Panoramic film
D7140	Extraction
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth soft tissue
D7230	Removal of impacted tooth partially bony
D7240	Removal of impacted tooth completely bony
D7241	Removal of impacted tooth w/complications
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7285	Biopsy of hard oral tissue
D7286	Biopsy of soft oral tissue
D7450	Excision of malignant tumor <1.25 cm
D7451	Excision of malignant tumor >1.25 cm
D7510	Incision and drainage of abcess
D7511	Incision and drainage of abcess, complicated
D9110	Minor palliative tx of dental pain
D9220	Deep sedation/anesthesia first 30 min
D9221	Regional block anesthesia
D9230	Analgesia, anxiolysis, nitrous oxide
D9241	IV conscious sedation first 30 min
D9242	IV conscious sedation ea addl 15 min
D9248	Non IV conscious sedation
D9420	Hospital call
D9610	Therapeutic parenteral drug single administration
D9630	Other drugs and/or medicaments by report

LMC/rs

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 24, 2011

MEDICAID INFORMATION RELEASE #MA11-14

To: Psychosocial Rehabilitation Services (PSR) Agency Providers

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions –PSR Service Limitations for Adults

Effective July 1, 2011, in compliance with House Bill 260, Section 9, the department will implement a reduction in service limits for adults receiving PSR services. PSR service limits will be reduced from five hours per week to four hours per week for eligible participants age 21 years and older. No additional hours are available for ongoing PSR services.

Service limits for eligible child participants up to age 21 years will continue to be five hours per week. PSR Crisis Intervention Services remain available up to a total of 10 hours per week through a prior authorization process conducted in the Office of Mental Health and Substance Abuse. Please refer to IDAPA 16.03.10.124 for a more detailed description of PSR service limitations.

If you have questions about the change in PSR service limits please contact the Office of Mental Health and Substance Abuse at MentalHealthRules@dhw.idaho.gov or by phone at (208) 334-0767 or (866) 681-7062.

Thank you for participating in the Idaho Medicaid Program.

LMC/rs

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May 25, 2011

MEDICAID INFORMATION RELEASE MA11-15

To: All Medicaid Providers of Audiology Services

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions – Audiology Services

Effective July 1, 2011, in compliance with House Bill 260, Section 9, Medicaid will not cover screening, preventive, or corrective audiology services for adults. Additionally, Medicaid will not cover hearing aids or any ancillary hearing aid services for adults.

Medicaid will continue to cover diagnostic audiology services necessary to obtain a differential diagnosis or to determine the site of a lesion. Audiology services for participants under the age of 21 will not change.

If you have questions about the changes in audiology services, please contact the policy subject matter expert for audiology services in the Division of Medicaid at (208) 364-1897.

Thank you for participating in the Idaho Medicaid Program.

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May 26, 2011

MEDICAID INFORMATION RELEASE MA11-16

To: Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) Providers

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions - Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)

Effective July 1, 2011, in compliance with House Bill 260, section 24, ICF/IDs are required to pay an assessment annually. This assessment will maintain adequate state trustee and benefit funds to the extent that a general fund short fall exists or as limited by the maximum assessment set forth in Idaho Intermediate Care Facility Assessment Act in Idaho Code 56-1601. The assessment funds will also be used to match federal funding for the Federal Upper Payment Limit (FUPL).

If you have questions about these changes, please contact the Senior Financial Specialist in the Office of Reimbursement, Division of Medicaid at (208) 364-1994.

Thank you for participating in the Idaho Medicaid Program.

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DIVISION OF MEDICAID
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Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 25, 2011

MEDICAID INFORMATION RELEASE MA11-17

To: Nursing Facility Providers

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions – Nursing Facilities

Effective July 1, 2011, in compliance with House Bill 260, section 19, nursing facilities are required to pay an assessment annually. The assessment will not exceed the maximum amount allowed under federal law. This assessment will maintain adequate state trustee and benefit funds to the extent that a general fund short fall exists or as limited by the maximum assessment set forth in Idaho Skilled Nursing Facility Assessment Act in Idaho Code 56-1501.

If you have questions about this change, please contact the Senior Financial Specialist in the Office of Reimbursement, Division of Medicaid at (208) 364-1994.

Thank you for participating in the Idaho Medicaid Program.

LMC/rs

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LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 31, 2011

MEDICAID INFORMATION RELEASE MA11-18

To: All Hospital Providers

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions - Hospital Reimbursement

Effective for dates of service on or after July 1, 2011, payments to hospitals for outpatient occupational therapy, physical therapy and speech therapy will be paid by procedure codes rather than revenue code billing.

A change is being implemented for Idaho non-state government owned hospitals (NSGOs). The NSGOs will need to participate in the annual hospital assessment set forth in the Idaho Hospital Assessment Act in Idaho Code 56-1401.

If you have questions about this change, please contact the Principal Financial Specialist in the Office of Reimbursement, Division of Medicaid at (208) 364-1817.

Thank you for participating in the Idaho Medicaid Program.

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DIVISION OF MEDICAID
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PHONE: (208) 334-5747
FAX: (208) 364-1811

May 26, 2011

MEDICAID INFORMATION RELEASE MA11-19

To: All Non-Institutional Providers

From: Leslie M. Clement, Administrator

Subject: House Bill 260 Budget Reductions - Provider Payments

Effective July 1, 2011, in compliance with House Bill 260, section 16, Medicaid payments made to non-institutional providers will not exceed 100% of the current Medicare rate for primary care procedure codes as defined by the Centers for Medicare and Medicaid Services, otherwise the reimbursement rate will be at 90% of the current Medicare rate. Where there is no Medicare rate on file, the payment rate to Medicaid providers will be based on current Medicaid pricing.

If you have questions about this change, please contact the Senior Financial Specialist in the Office of Reimbursement, Division of Medicaid at (208) 364-1994.

Thank you for participating in the Idaho Medicaid Program.

LMC/rs

DHW Contact Information

DHW Web site	www.healthandwelfare.idaho.gov
Idaho CareLine	2-1-1 1 (800) 926-2588
Medicaid Program Integrity Unit	P.O. Box 83720 Boise, ID 83720-0036 prvfraud@dhw.idaho.gov Fax: 1 (208) 334-2026
Healthy Connections Regional Health Resource Coordinators	
Region I **Coeur d'Alene**	1 (208) 666-6766 1 (800) 299-6766
Region II **Lewiston**	1 (208) 799-5088 1 (800) 799-5088
Region III **Caldwell**	1 (208) 455-7244 1 (208) 642-7006 1 (800) 494-4133
Region IV **Boise**	1 (208) 334-0717 1 (208) 334-0718 1 (800) 354-2574
Region V **Twin Falls**	1 (208) 736-4793 1 (800) 897-4929
Region VI **Pocatello**	1 (208) 235-2927 1 (800) 284-7857
Region VII **Idaho Falls**	1 (208) 528-5786 1 (800) 919-9945
In Spanish **(en Español)**	1 (800) 378-3385

Insurance Verification

HMS PO Box 2894 Boise, ID 83701	1 (800) 873-5875 1 (208) 375-1132 Fax: 1 (208) 375-1134

Prior Authorization Contact Information

Please use these numbers to submit prior authorization requests to Medicaid or to communicate with Medicaid staff regarding details of prior authorization requests. For questions regarding claims with an existing prior authorization, please call Provider Services at 1 (866) 686-4272.

DME Specialist, Medical Care P.O. Box 83720 Boise, ID 83720-0036	1 (866) 205-7403 Fax: 1 (877) 314-8782 (Attn: DME Specialist)
Pharmacy PO Box 83720 Boise, ID 83720-0036	1 (866) 827-9967 Fax: 1 (800) 327-5541
Therapy and Surgery PA Requests PO Box 83720 Boise, ID 83720-0036	1 (208) 287-1148 Fax: 1 (877) 314-8779
Qualis Health (Telephonic & Retrospective Reviews) 10700 Meridian Ave. N. Suite 100 Seattle, WA 98133-9075 http://www.qualishealth.org/cm/idaho-medicaid	1 (800) 783-9207 Fax: 1 (800) 826-3836 1 (206) 368-2765
Preventive Health Assistance PHA Unit PO Box 83720 Boise, ID 83720-0009	1 (877) 364-1843 1 (208) 364-1843 Fax: 1 (877) 845-3956
Office of Mental Health and Substance Abuse (OMHSA) PO Box 83720 Boise, ID 83720-0036	1 (208) 334-0767 1 (866) 681-7062 Fax: 1 (888) 560-1784

Transportation

Effective September 1, 2010, Idaho Medicaid contracted with American Medical Response (AMR) for all non-emergency medical transportation services. Please go to www.idahonemt.net or call 1 (877) 503-1267 for more information.

Ambulance Review	1 (800) 362-7648 1 (208) 287-1157 Fax: 1 (877) 314-8781

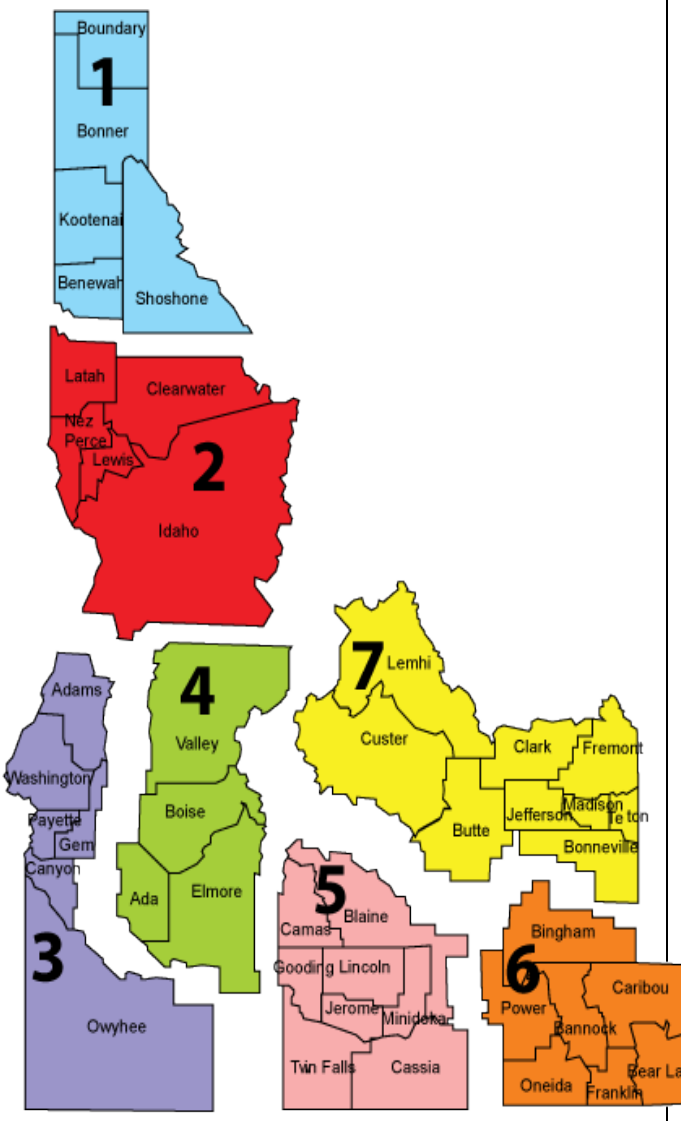
Molina Provider and Participant Services Contact Information

Provider Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4272 1 (208) 373-1424
Provider Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4272 1 (208) 373-1424
E-mail	idproviderservices@molinahealthcare.com idproviderenrollment@molinahealthcare.com
Mail	P.O. Box 70082 Boise, ID 83707
Participant Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4752 1 (208) 373-1432
Participant Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4752 1 (208) 373-1424
E-mail	idparticipantservices@molinahealthcare.com
Mail – Participant Correspondence	P.O. Box 70081 Boise, ID 83707
Medicaid Claims	
Utilization Management/Case Management	P.O. Box 70083 Boise, ID 83707
CMS 1500 Professional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional	P.O. Box 70085 Boise, ID 83707
UB-04 Institutional Crossover/CMS 1500/Third Party Recovery (TPR)	P.O. Box 70086 Boise, ID 83707
Financial/ADA 2006 Dental	P.O. Box 70087 Boise, ID 83707

Molina Provider Services Fax Numbers

Provider Enrollment	1 (877) 517-2041
Provider and Participant Services	1 (877) 661-0974

Provider Relations Consultant (PRC) Information

Region 1 and the state of Washington Deanna LaCombe 1120 Ironwood Drive Suite 102 Coeur d'Alene, ID 83814 1 (208) 559-4793 Region.1@MolinaHealthCare.Com	**Idaho Regional Map** 
Region 2 and the state of Montana Kristi Irby 1118 F Street P.O. Box Drawer B Lewiston, ID 83501 1 (208) 991-7138 Region.2@MolinaHealthCare.Com	
Region 3 and the state of Oregon Rainy Natal 3402 Franklin Caldwell, ID 83605 1 (208) 860-4682 Region.3@MolinaHealthCare.Com	
Region 4 and all other states Julie Colleran 1720 Westgate Drive, Suite A Boise, ID 83704 1 (208) 994-2476 Region.4@MolinaHealthCare.Com	
Region 5 and the state of Nevada Brenda Rasmussen 803 Harrison St. Twin Falls, ID 83301 1 (208) 484-6323 Region.5@MolinaHealthCare.Com	
Region 6 and the state of Utah Kelsey Gudmunson 1070 Hiline Road Pocatello, ID 83201 1 (208) 870-3997 Region.6@MolinaHealthCare.Com	
Region 7 and the state of Wyoming Kristi Harris 150 Shoup Avenue Idaho Falls, ID 83402 1 (208) 991-7149 Region.7@MolinaHealthCare.Com	

Molina Medicaid Solutions
PO Box 70082
Boise, Idaho 83707

IDAHO DEPARTMENT OF HEALTH & WELFARE

Digital Edition

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***MedicAide* is the monthly informational newsletter for Idaho Medicaid providers.**
Editor: Chris Roberts, Division of Medicaid

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

Chris Roberts
Robertc2@dhw.idaho.gov
DHW – Medicaid System Support Team
PO Box 83720
Boise, ID 83720-0009
Fax: (208) 332-7974