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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 2005

December 15, 2004

MEDICAID INFORMATION RELEASE MA04-59

TO: All Participating Medicaid Providers

FROM: Randy May, Deputy Administrator

SUBJECT: CLARIFICATION OF TIMELY FILING REQUIREMENTS

Idaho Medicaid recently received communication from the Centers for Medicare & Medicaid Services (CMS) regarding Federal regulation 42 CFR 447.45(d)(1). This regulation states that Medicaid agencies must require providers to submit all claims no later than twelve months from the date of service.

Based on this communication, Idaho Medicaid is clarifying its policy regarding the timely filing of Idaho Medicaid claims. The following guidelines will become effective for claims received on or after Saturday, January 15, 2005:

- All claims must be submitted to Idaho Medicaid within twelve months (365 days) from the date of service. If a claim was originally submitted within twelve months of the date of service, a provider is no longer required to provide proof of subsequent continued billing activity in order to have those services considered for payment. Once a service has been billed within twelve months of the date of service, it is considered to have been billed timely. The Internal Control Number (ICN) of the original claim must be documented in the comments field on all electronic or paper resubmissions of the claim in order to prove the timeliness requirement was met. The ICN must indicate that the original claim was submitted within twelve months from the date of service. If the ICN of the original claim is not on the resubmitted claim, the claim will be denied, even if it was originally billed timely.
- If the client has a third party insurance carrier, the claim for services must be submitted to Idaho Medicaid within twelve months of the date of service regardless of the date of payment or date of the explanation of benefits (EOB) from the other insurance carrier. The only exception to this requirement is for Medicare crossover claims. If a claim for payment under Medicare has been filed in a timely manner, Medicaid will consider claims for payment within six months of the date of payment or date of the EOB of the Medicare claim.
- Claims for Idaho Medicaid clients receiving retro-eligibility must be submitted within twelve months of the date of service regardless of the date their eligibility was added.
- Idaho Medicaid providers with a retro-active eligibility date must submit claims within twelve months of the date of service regardless of their enrollment date.

(Continued on page 2)

(Continued from page 1)

 Claims for services requiring prior authorization (PA) from the Department or one of its agents must be submitted within twelve months of the date of service regardless of when the PA was issued.

Providers who fail to bill timely and have their claims denied for this reason cannot pursue collection actions against the client.

Adjustments to paid claims must be made within two years after the calendar quarter in which the payment was received. Adjustments can only be done on paid claims or paid details.

If you have any questions concerning the information contained in this release, please contact EDS Provider Services at (208) 383-4310 or 1-800-685-3757. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID HANDBOOK

This information replaces information to the following sections of your Idaho Medicaid Provider handbook: 2.1.2, 2.1.2.1, 2.1.2.2., and 2.6.1.

Physicians and Hospitals (Provider types: 001; 004: 005): Procedure code G0001, Routine venipuncture for collection of specimen(s), will **not** be valid after 12/31/2004. Effective 01/01/2005, use procedure code 36415.

DHW Phone Numbers

Addresses

Web Sites

DHW Websites

www.healthandwelfare.idaho.

Idaho Careline

211 (available in all areas) (800) 926-2588

Provider Fraud and Utilization Review

P. O. Box 83720

Boise, ID 83720-0036

(866) 635-7515 (toll free) (208) 334-0675

Fmail:

~medicaidfraud&sur@
idhw.state.id.us
(note: begins with ~)

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) 455-7163

(208) 455-7244 (Spanish)

(800) 494-4133

Region IV - Boise

(208) 334-4676

(800) 354-2574

Region V - Twin Falls

(208) 736-4793

(800) 897-4929

Region VI - Pocatello

(208) 239-6260

(800) 284-7857

Region VII - Idaho Falls

(208) 528-5766

(208) 528-5786

(800) 919-9945

Spanish Speaking (statewide) (800) 862-2147

Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations

DME Specialist
Bureau of Care Management
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax
(800) 352-6044
(att: DME Specialist)

PCG

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

Pharmacy

P.O. Box 83720 Boise, ID 83720-0036 (877) 200-5441 (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/

Transportation Prior Authorization Unit

idahomedicaid.htm

(800) 296-0509 (208) 334-4990 Fax (800) 296-0513 (208) 334-4979

Ambulance Review

(800) 362-7648 (208) 287-1155

Fax

(800) 359-2236 (208) 334-5242

1099 Tax Form Information

To avoid delays in receiving the 1099 form, please ensure that EDS has the proper mailing address on file by checking your most recent RA. If not, please use the Change of Provider Information Authorization Form (also available in your Idaho Medicaid Provider Handbook Forms Appendix). The provider must sign the form to authorize a change in the pay-to name or address or the tax ID number.

For any questions regarding the 1099 form, call MAVIS at 1-800-685-3757 ask for *AGENT*.

Provider Number:	Provider	Name:	
Date requested information is effective:			
Please change the information for the following name(s) or address(es):			ess(es):
Pay-to	Mail-t	0	Service Location(s)
Includes RA & check Inclu	udes correspo	ndence	Physical address change or add
Old Name		New Name	
		(attach a signe To name is cha	ed W-9 with effective date if Payanging)
Old Address:		New Address:	
Old Telephone Number:		New Telephon	e Number:
Old Tax ID Number:		New Tax ID No	umber:
		(attach a signe	ed W-9 with effective date)
Additional Comments			
Provider Signature:			
Date Signed:			

Mail to: EDS

Provider Enrollment P.O. Box 23 Boise, ID 83707 Fax to: EDS

att. Provider Enrollment (208) 395-2198

Submitted by DHW MAS Team

Billing DME Supplies

DME providers are reminded that when billing for supplies they should always use the date the supplies were dispensed as both the from and to dates of service. They should not date span.

Date spanning is used when the **from** date of service is different than the **to** date of service. It is generally used for rented items that are paid for by the day or month such as oxygen and wheelchairs.

DME supplies are **not** paid for by the day; they are paid for by the package and, therefore, date spanning is not used. Disposable items are billed using only the exact date they are dispensed, not the length of time they are used. If DME supplies are billed with a from and to date span, the claim may pend for overlapping services.

As an example:

"FastPay DME of Idaho" dispenses a box of lancets with a 30 day supply on Dec 21. Correctly billing this item, they enter 12/21/2004 in both the from and to date. Their claim is paid in the next processing cycle.

"SloPay DME of Idaho" also dispenses a box of lancets with a 30 day supply on Dec 21. Incorrectly billing this item, they use date spanning from Dec 21 to Jan 20. The client goes to the hospital on Dec 30. The claim from "SloPay" pends because they have spanned across the hospital stay even though they dispensed the supplies long before the client went into the hospital. Although the claim will eventually be paid, "SloPay" will have to wait for an adjudicator to research the error and override the edit.

To ensure prompt payment for DME supplies, always bill just for the date the supplies are dispensed.

Submitted by EDS Reference Team

Third Party Recovery (TPR) Policy – Provider Does Not "Accept Assignment" and Client Does Not Provide Payment or EOB from Other Insurance

Using the following instructions, claims can be processed for Third Party Recovery (TPR) denial explanation of benefit (EOB) reasons when the provider has not accepted assignment from the other insurance (OI) and cannot get the payment from the client.

Paper claims:

Include the payment to the client from the third party payer in the OI field and attach the third party EOB if received from the client.

If the client does not provide an EOB from the third party payer when the payment from the other insurance was sent to the client, enter the payment in the OI field. Also enter a comment in the comment field as to why no EOB was supplied (for example, 'contacted client three times; client would not supply EOB').

When the claim is billed without an EOB and no payment listed in the OI field, a comment is required in the comment field as to why no EOB was supplied and why there is no payment. These claims will be processed and referred to the Department's TPR contractor, Public Consulting Group (PCG), to follow up with the client.

Electronic claims:

Submit the claim with the Adjustment Reason Code (ARC) 100 ('Payment made to patient/insured/responsible party') in the reason code field and enter the payment or \$0.00 in the OI field. Claims billed with ARC code 100 are referred to PCG to follow up with the client.

EDS Phone Numbers Addresses

MAVIS

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

EDS

Correspondence PO Box 23 Boise, ID 83707

Provider Enrollment P.O. Box 23 Boise, Idaho 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

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

EDS is a registered mark and the EDS logo is a trademark of Electronic Data Systems Corporation.

EDS Phone Numbers Addresses

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 Hoover 1720 Westgate Drive, # A Boise, ID 83704

jane.hoover@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 Sheila Lux 1070 Hiline Road Pocatello, ID 83201

sheila.lux@eds.com (208) 239-6268 Fax (208) 239-6269

Region 7 Debra Babicz 150 Shoup Avenue Idaho Falls, ID 83402

debra.babicz@eds.com (208) 528-5728 Fax (208) 528-5756

Tips for Faster Processing of Claims

For the fastest possible processing of claims, send them electronically! With PES and other vendor software it is possible to send almost all claims electronically including crossovers and oxygen claims. Electronic claims can be approved to pay within hours of transmission.

If you want to get started in electronic claim submission, call MAVIS and ask for *TECHNICAL SUPPORT*. The number is (800) 685-3757. The EDI Technical Support team is available during normal business hours, 8:00 a.m. – 5:00 p.m. (Mountain Time).

If electronic billing is not an option for you, please follow these guidelines when submitting paper claims.

- Send all claims to P.O. Box 23, Boise, Idaho 83707
- Send all correspondence separately to the attention of a specific person and/or department. Do not include correspondence with claims. It will be scanned and included as claim documentation.

Everyday EDS receives approximately 5,000 pieces of mail. A machine opens all of the mail which is then sorted into correspondence and claims. All claims are fed into a scanner one page at a time to create an electronic image for processing. To speed the proper handling of your claims and correspondence and to avoid the loss of important information, please follow these guidelines:

- Do not fold claims; mail them flat in a large envelope.
- Do not staple or tape claims to the envelope. Do not tape or staple the claims and attachments together.
- Place any "attachments" behind the appropriate claim including EOBs. Make a copy of the EOB page for each claim to which it applies.
- Do not continue claims onto a second claim form. Each claim must have a total.
- Place all adjustment forms on top of any claims. It is not necessary to include a copy of the claim.
- Sort claims by type of claim form when sending several claim types in the same envelope.

"Re-submitting" Corrected Claims

When submitting a new claim to correct an old claim follow these steps:

- Wait for the old claim to appear on the Paid or Denied section of your weekly RA. Pended claims cannot be corrected.
- A **paid** claim can only be corrected through an adjustment. Submit an Adjustment Request Form to correct any errors on paid claims.
- A denied claim must be re-submitted as a new claim.
 - Use an electronic void and claim replacement if possible. This can be done regardless if the original claim was paper or electronic.
 - When submitting on a paper claim form, submit a new claim with the
 corrected information. If you are re-using an old claim with corrected
 information, use white correction tape to delete all detail lines that have
 already paid. If these details are not deleted, the claim will pend until an
 adjudicator can work it and deny the duplicate details. This can slow down
 the payment of your claim by up to a month.
- Writing "Corrected Claim" on an old claim does not correct it. Previously paid
 claims must be corrected through the adjustment process. Previously denied
 details must be re-submitted with the corrected information and any necessary
 justification such as "second visit to ER at 10:30 p.m." or "No TPL".

December 1, 2004

MEDICAID INFORMATION RELEASE MA04-37

TO: Providers of Mental Health Services

FROM: Leslie Clement, Acting Deputy Administrator

SUBJECT: TELEMEDICINE

This information release describes billing and service requirements for providing limited Medicaid mental health services through telemedicine technology. Medicaid will pay for telemedicine services that meet the requirements detailed in this release for **dates of service beginning August 1, 2003.** The following codes and modifier may only be used for telemedicine services provided by a physician or practitioner of the healing arts:

90862 (pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy)

90805 (psychotherapy, 20-30 minute session with medical evaluation and management services)

Claims must include modifier "GT".

Technology

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

Standards

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

- The referring practitioner is responsible to maintain standards of care within his identified scope of practice.
- The services must be medically necessary and follow generally accepted standards of care.
- Consultants providing care at a distance are required to maintain current Idaho licensure.
- Services are to be billed in accordance with applicable sections of the IDAPA.
- Claims must be made according to Department billing instructions.
- The same procedure codes and rates apply as for services delivered in person.
- Quality assurance/improvement activities relative to telemedicine delivered services need to be identified, documented, and monitored.
- Providers need to develop and document evaluation processes and participant outcomes related to the telemedicine program, visits, provider access, and participant satisfaction.
- All service providers are required to develop and maintain written documentation in the form of progress notes
 the same as is originated during an in-person visit or consultation with the exception that the mode of
 communication (i.e. teleconference) should be noted.
- Participant consent and other releases should be developed and maintained in the participant's permanent record.
- If an operator who is not an employee of the involved agency is needed to run the teleconferencing equipment or is present during the conference/consultation, he/she should sign a confidentially agreement. This statement should be filed with other documentation of the teleconference, such as a post-conference evaluation form.
- Idaho Medicaid will not reimburse for the use or upgrade of technology, for transmission charges, for charges of an attendant who instructs a patient in the use of the equipment or supervises/monitors a patient during the

(Continued on page 7)

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telemedicine encounter, or for consultations between professionals.

- Before an initial visit using telemedicine, the practitioner who delivers the service to a participant shall ensure that
 written information is provided to the participant in a form and manner which the participant can understand using
 reasonable accommodations when necessary.
- If the participant and/or legal guardian indicates at any point that she/he wants to stop using the technology, the service should cease immediately and an alternative appointment set up.

If you have any questions regarding this information, please contact Pat Guidry at 208-364-1844. Thank you for your continued participation in the Idaho Medicaid program.

IDAHO MEDICAID HANDBOOK

This information release adds information to the following sections of your Idaho Medicaid Provider Handbook dated June 1, 2004: Mental Health 3.1.2 and 3.1.7.

December 17, 2004

MEDICAID INFORMATION RELEASE #2004-53

TO: ALL GENERAL ACUTE HOSPITALS

FROM: Randy May, Deputy Administrator

SUBJECT: EXPEDITED MEDICAID ELIGIBILITY FOR CERTAIN NEWBORNS

The enclosed form "Notification of Birth: Anticipated Stays Greater Than 72 hours" was developed to assist hospitals in notifying the Department of Health and Welfare of births that may be covered by the Idaho Medicaid program. Use of this form will expedite Medicaid eligibility for certain newborns under the following circumstances:

- When a newborn has a length of stay greater than 72 hours;
- When a newborn that was discharged under 72 hours requires re-admission to the hospital, and the Medicaid Automated Voice Information System (MAVIS) does not reflect an open Medicaid eligibility status.

This form is also available on the Department's website at: www.healthandwelfare.idaho.gov. Go to "I want help with" and click on **Medicaid Provider Information**. Under "Other Resources" click on **Information Releases**, then under "Attachments" click on **2004-53**.

If you have questions regarding this information release, please contact Arlee Coppinger at 208-287-1177. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK

This Information Release replaces information in the following section of your Idaho Medicaid Provider Handbook dated June 1, 2004: Section 3.2.7.2 Hospital – Birth/Delivery Billing.

Enclosure (see page 8)

Notification of Birth: Anticipated Stays Greater Than 72 hours

Notification Date _____

Please fill out as completely as possible

Section 1—*To be completed by the hospital for anticipated stays greater than 72 hours*

Baby's Information	Mother's Information	
Full Name	Name	
Date of Birth	Date of Birth	
MID# (from EPICS)	MID#	
Gender	AKA	
City of Residence	County of Residence	
Hospital Information		
Hospital Name	Fax #	
Contact Person	Contact #	
E-mail Address		
Comments Section 2—To be completed by the Department		
EPICS Helpdesk—e-mail Epics@idhw.state.id.us Fax # 208	334-5817, attention Toni Witt	
Date Baby's MID# Provided to the Hospital SRS Worker (if known)		
Response section		

Instructions

Step 1—To be completed by the Hospital for anticipated stays greater than 72 hours

- 1. Electronically fill out <u>Section 1</u> as completely as possible. (Leave baby's MID# blank)
- 2. E-mail the form to EPICS Helpdesk <u>Epics@idhw.state.id.us</u> at the same time—In the same e-mail <u>cc</u> Sharon Wofford at woffords@idhw.state.id.us.
- 3. Use the words 'Notification of Birth' in the email subject line to provide for easy identification and quick turn around.
- 4. Babies hospitalized for 72 hours or less continue to follow your current procedure.

Step 2—*To be completed by the Department*

- 1. EPICS Helpdesk researches and processes the request.
- 2. <u>Section 2</u> is completed with the babies MID# inserted in <u>Section 1</u>.
- 3. EPICS e-mails the completed form back to the Hospital and cc's Sharon Wofford at woffords@idhw.state.id.us.

Note: forms received by EPICS Helpdesk during the last four working days of the month will take a little longer to cross into AIM due to EPICS processing cycles.

November 26, 2004

Medicaid Informational Letter 2004-57

TO: Physicians

FROM: Randy May, Deputy Administrator

SUBJECT: Bariatric Surgery, Panniculectomy/Abdominoplasty

Effective December 1, 2004, prior authorization for Bariatric Surgery (Gastric Bypass) and Panniculectomy/ Abdominoplasty will be conducted by Qualis Health. Eligibility and documentation requirements remain the same.

To submit prior authorization requests to Qualis Health, please call 800-783-9207, ext. 2. Required documentation may be mailed or faxed to:

Qualis Health 10700 Meridian Ave. N., Suite 100 PO Box 33400 Seattle, WA. 98133

Fax 800-826-3836

Attn.: Idaho Medicaid Contract

Questions regarding this letter may be directed to Arlee Coppinger, Contract Officer, at 208-287-1177.

November 26, 2004

Medicaid Informational Letter 2004-58

TO: Idaho Medicaid Hospital Discharge Planners

Idaho Infant Toddler Program

FROM: Randy May, Deputy Administrator

SUBJECT: Expansion of the UM/CM Neonate Program to All Hospitals

Since July 2004, Qualis Health has conducted a pilot program for the neonatal population with three Idaho Medicaid facilities. The Neonate Program integrates Utilization Management (UM) and Case Management (CM) services for the neonatal population of select Idaho Medicaid clients. One nurse case manager from Qualis Health performs both the UM and CM functions for those babies who meet specific clinical criteria.

Effective December 1, 2004, the Neonate UM/CM Program will be expanded to include all Idaho Medicaid hospital providers. You will be contacted by a Qualis Health Nurse Case Manager regarding babies in your facilities who meet criteria. The CM nurse will assist with discharge planning and in-home/community supports.

Questions regarding this letter may be directed to Arlee Coppinger, Contract Officer, at 208-287-1177.

December 3, 2004

MEDICAID INFORMATION RELEASE MA04-60

TO: Individual Transportation Providers and Service Coordinators

FROM: Randy May, Deputy Administrator

SUBJECT: Change in Medical Transportation Prior Authorization Requirements

FOR INDIVIDUAL TRANSPORTATION PROVIDERS BILLING S0215 (MEDICAL TRANSPORTATION):

Medicaid is initiating a six month pilot program to eliminate the requirement for prior authorization when Medicaid clients are transported less than 200 miles one-way, or 400 miles round trip, in the same day. This pilot program only applies to Individual Transportation Providers, and is effective for medical transportation provided between January 1 and June 30, 2005.

 Medical transportation over 200 miles one-way or 400 miles round trip in the same day will still require prior authorization. The process to request prior authorization has not changed. For information about obtaining prior authorization, please refer to the Medicaid Transportation Provider Manual, which is available online at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/s3_010_transportation.pdf Section 3.1.6.1, page 3-9.

MEDICAL TRANSPORTATION GUIDELINES:

- Travel must be necessary for a Medicaid client to get to or from a Medicaid-covered service.
- Client must not have any other available transportation, such as a client's personal vehicle, or a ride from family, friends, or charitable organizations.
- The mileage billed to Medicaid must be to the nearest available Medicaid provider to perform the needed services, and by the shortest practical route.
- Client must be in vehicle and transported for the entire distance billed.
- The provider must maintain the following documentation for a minimum of 5 years:
 - 1. Client name and Medicaid ID number for each trip.
 - 2. Date, time, geographical point, and odometer reading at point of client's pick-up and drop off.
 - 3. Total mileage each client was transported for each trip billed.
 - 4. Identification of the vehicle and driver transporting each client on each trip.

Please note: The Department will monitor this pilot program for over-utilization or abuse. Providers are subject to recoupments and additional actions by the Department as outlined in Idaho Administrative Code, Rules Governing the Medical Assistance Program, (IDAPA 16.03.09), Sections 200 through 223. These rules can be accessed online at: http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf.

All waiver <u>non-medical</u> transportation (Procedure Code A0080 with Modifiers U2, U3, or U8) will continue to require prior authorization from the client's Regional Medicaid Services office.

If you have questions about this information, please contact the Medicaid Transportation Unit locally at 334-4990 or toll-free 1-800-296-0509. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK:

This Information Release does **not** replace information in your Idaho Medicaid Provider Handbook.

RM/af

January 1, 2005

MEDICAID INFORMATION RELEASE MA05-01

TO: Nursing Facility Providers

FROM: Randy May, Deputy Administrator

SUBJECT: ELECTRONIC BILLING INSTRUCTIONS

Effective January 1, 2005, the requirements for billing long term care on the 837l transaction will change. A new edit will validate the units submitted on the detail and compare against the dates of service for that detail. This will facilitate claims processing and the audit settlement process.

EXAMPLE: To bill for a patient residing in a Long Term Care facility who is not discharged, enter the claim detail units and dates of service as follows:

The header dates of service are: from 01/01/2004 to 01/31/2004

The detail dates of service are:

	REVENUE CODE	FROM DOS	TO DOS	UNITS
Line 1	100	01/01/2004	01/20/2004	20
Line 2	183	01/21/2004	01/23/2004	3
Line 3	100	01/24/2004	01/31/2004	8

Those claims submitted on the paper form UB92 are not affected because there is not a **TO** date of service on that form.

Failure to follow these instructions will result in denial of claims.

If you have any questions regarding this information, please call EDS at 1-800-685-3757 or in the Boise area at 383-4310. Thank you for your continued participation in the Medicaid program.

RM/rlc

EDS P.O. Box 23 Boise, Idaho 83707

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





January Office Closure

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

Martin Luther King, Jr./ Idaho Human Rights Day Monday, January 17, 2005

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

MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

Co-Editors:
Becca Ruhl,
Division of Medicaid

Cynthia Brandt, Publications Coordinator, EDS

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

ruhlb@idhw.state.id.us

or

Becca Ruhl DHW MAS Unit PO Box 83720 Boise, ID 83720-0036

Fax: (208) 364-1911



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

February 2005

Documentation and Attachments

99% of all Medicaid claims do **not require any** attachments. The following chart includes most of the times when attachments are required. If a service is not on this chart, it probably does not require an attachment. When attachments are **not** needed, submit the claim electronically for faster processing.

For claims that require prior authorization, the documentation is sent to the authorizing body and **not** sent with the Medicaid claim. For hospital claims, there is no need to send attachments with these claims to EDS *unless they are on the* following chart.

Billing situation	Include this attachment
Modifier 21, 22, and 23	Chart and/or op report
Modifier 50 and 51 if Medicaid payment will be over \$1000.	Chart and/or op report
Modifier 62 (the claim and the co surgeon's claim should be billed within 30 days of each other)	Chart and/or op report
Any CPT code that ends in 99	Chart and/or op report
Sterilization or hysterectomy	Consent form
Abortion	Certificate of Medical Necessity
Private room	Certificate of Medical Necessity or physician's orders
Procedures that require manual pricing	If you are unsure about pricing, call MAVIS or check online at www2.state.id.us/dhw/medicaid/fee_schedule.htm
Procedures or services that require an invoice or receipt (see Provider Handbook)	Invoice or receipt. Example: hearing aids.
Claims billed for services that exceed Medicaid limitations may be denied for justification.	Justification for second service. When billing services requiring justification, use the appropriate comments field for the justification. This can be done electronically since no attachment is required.

Distributed by the Division of Medicaid Department of Health and Welfare State of Idaho See page 2 for Information Release MA05-03 regarding Client Name/Number Mismatches. "Effective March 1, 2005, claims submitted to Idaho Medicaid will be denied for edit 101 'Client name and/or number does not match client file' if the name submitted on the claim does not exactly match the name as it is contained within the claims processing system."

January 4, 2005

MEDICAID INFORMATION RELEASE MA05-03

TO: All Medicaid Providers

FROM: Randy May, Deputy Administrator

SUBJECT: CLIENT NAME/NUMBER MISMATCHES

Effective March 1, 2005, claims submitted to Idaho Medicaid will be denied for edit 101 "Client name and/or number does not match client file" if the name submitted on the claim does not exactly match the name as it is contained within the claims processing system.

A study was conducted to determine what would cause claims to set this edit. The top reasons are as follows:

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

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

An identification card is issued at the time a client becomes eligible for Medicaid benefits or whenever a name change is reported. The card number in the lower right hand side of the identification card is updated anytime a new card is issued for that client. When eligibility is being verified, the client's card number should also be verified to ensure that the card being presented is the client's most current card. If the card number on the identification card matches the card number reported by the eligibility verification system, then the name on the card will also match what is in the system. If the card number is lower than what is reported by the eligibility verification system, then the client's most current card should be requested from the client. Providers should request the card with picture identification and retain copies of this documentation for your records.

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

There is a possibility that the client's name may change between the time that eligibility is verified and the claim is submitted. Unfortunately there is no way to prevent these types of mismatches from occurring. The claim will be denied for edit 101 and providers will need to resubmit the claim with the updated name.

If you have any questions concerning the information contained in this release, please contact EDS Provider Services at (208) 383-4310 or 1-800-685-3757. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK

This Information Release replaces information in section 2 of your Idaho Medicaid Provider Handbook along with other necessary areas.

RM/bsr

Because of the importance of IR MA04-59, it is reprinted here in its entirety.

December 15, 2004

MEDICAID INFORMATION RELEASE MA04-59

TO: All Participating Medicaid Providers

FROM: Randy May, Deputy Administrator

SUBJECT: CLARIFICATION OF TIMELY FILING REQUIREMENTS

Idaho Medicaid recently received communication from the Centers for Medicare & Medicaid Services (CMS) regarding Federal regulation 42 CFR 447.45(d)(1). This regulation states that Medicaid agencies must require providers to submit all claims no later than twelve months from the date of service.

Based on this communication, Idaho Medicaid is clarifying its policy regarding the timely filing of Idaho Medicaid claims. The following guidelines will become effective for claims received on or after Saturday, January 15, 2005:

- All claims must be submitted to Idaho Medicaid within twelve months (365 days) from the date of service. If a claim was originally submitted within twelve months of the date of service, a provider is no longer required to provide proof of subsequent continued billing activity in order to have those services considered for payment. Once a service has been billed within twelve months of the date of service, it is considered to have been billed timely. The Internal Control Number (ICN) of the original claim must be documented in the comments field on all electronic or paper resubmissions of the claim in order to prove the timeliness requirement was met. The ICN must indicate that the original claim was submitted within twelve months from the date of service. If the ICN of the original claim is not on the resubmitted claim, the claim will be denied, even if it was originally billed timely.
- If the client has a third party insurance carrier, the claim for services must be submitted to Idaho Medicaid within twelve months of the date of service regardless of the date of payment or date of the explanation of benefits (EOB) from the other insurance carrier. The only exception to this requirement is for Medicare crossover claims. If a claim for payment under Medicare has been filed in a timely manner, Medicaid will consider claims for payment within six months of the date of payment or date of the EOB of the Medicare claim.
- Claims for Idaho Medicaid clients receiving retro-eligibility must be submitted within twelve months of the date of service regardless of the date their eligibility was added.
- Idaho Medicaid providers with a retro-active eligibility date must submit claims within twelve months of the date of service regardless of their enrollment date.
- Claims for services requiring prior authorization (PA) from the Department or one of its agents must be submitted
 within twelve months of the date of service regardless of when the PA was issued.

Providers who fail to bill timely and have their claims denied for this reason cannot pursue collection actions against the client.

Adjustments to paid claims must be made within two years after the calendar quarter in which the payment was received. Adjustments can only be done on paid claims or paid details.

If you have any questions concerning the information contained in this release, please contact EDS Provider Services at (208) 383-4310 or 1-800-685-3757. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID HANDBOOK

This information replaces information to the following sections of your Idaho Medicaid Provider handbook: 2.1.2, 2.1.2.1, 2.1.2.2., and 2.6.1.

December 23, 2004

MEDICAID INFORMATION RELEASE 2004-61

TO: Hospital Providers of Inpatient Mental Health Services

FROM: Leslie M. Clement, Deputy Administrator

SUBJECT: ADDITION OF LIMITED INPATIENT MENTAL HEALTH SERVICES FOR

CHIP-B PARTICIPANTS

The Children's Health Insurance Program B (CHIP-B) was implemented in July 1, 2004. CHIP-B provides a limited benefit package to qualified children and was implemented without an inpatient mental health benefit.

Effective immediately, a limited amount of inpatient mental health services are added to the CHIP-B benefit package. Medicaid/CHIP will now reimburse up to thirty (30) days of inpatient mental health services per calendar year provided to CHIP-B participants. This change is retroactive and applicable to services provided on or after July 1, 2004 to CHIP-B participants.

What you need to do: If you have provided inpatient mental health services to a CHIP-B participant since July 1, 2004, please request a retrospective review from Qualis Health to establish medical necessity for the inpatient stay. The medical necessity criteria are the same for CHIP-B as for regular Medicaid (see IDAPA 16.03.09.079). Once a prior authorization number is issued, you can bill Idaho Medicaid using the usual claim process. Penalties for late reviews will be waived if the services were provided prior to the date of this notice.

After January 1, 2005, all Medicaid provisions for inpatient mental health services, including penalties for late review, will apply.

For questions regarding the review process, please refer to the Idaho Medicaid Provider Manual, Section X. Psychiatric Review at www.qualishealth.org or call Qualis Health at 1-800-783-9207. If you have questions regarding benefits and billing, please contact EDS at 1-800-685-3757 or in the Boise area at 383-4310. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK:

This Information Release amends information in the following section of your Idaho Medicaid Provider Handbook: Appendix B: CHIP-B dated July 1, 2004.

LMC/rp

Additional Contact Information to Information Release 2004-61

For questions regarding the review process, please refer to the Idaho Medicaid Provider Manual, Section X. Psychiatric Review at www.qualishealth.org or call Qualis Health at 1-800-783-9207. If you have questions regarding benefits and billing, please contact EDS at 1-800-685-3757 or in the Boise area at 383-4310.

DHW Phone Numbers Addresses

Web Sites

DHW Websites

www.healthandwelfare.idaho.

Idaho Careline

211 (available throughout Idaho) (800) 926-2588

Provider Fraud and Utilization Review

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

(866) 635-7515 (toll free)

(208) 334-0675

Email:

~medicaidfraud&sur@
idhw.state.id.us
(note: begins with ~)

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) 455-7163

(208) 455-7244 (Spanish)

(800) 494-4133

Region IV - Boise

(208) 334-4676

(800) 354-2574

Region V - Twin Falls

(208) 736-4793

(800) 897-4929

Region VI - Pocatello

(208) 239-6260

(800) 284-7857

Region VII - Idaho Falls

(208) 528-5766

(208) 528-5786

(800) 919-9945

Spanish Speaking (statewide) (800) 862-2147

Prior Authorization Phone Numbers Addresses Web Sites

February 1, 2005

DME Prior Authorizations

DME Specialist
Bureau of Care Management
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax
(800) 352-6044
(att: DME Specialist)

PCG

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

Pharmacy

P.O. Box 83720 Boise, ID 83720-0036 (877) 200-5441 (toll free) (208) 364-1829 Fax (208) 364-1864

Qualis Health

(telephonic & retrospective reviews)
10700 Meridian Ave. N.
Suite 100
Seattle, WA 98133-9075
(800) 783-9207
Fax (800) 826-3836 or
(206) 368-2765
Qualis Health Website
www.qualishealth.org/
idahomedicaid.htm

Transportation Prior Authorization Unit

(800) 296-0509 (208) 334-4990 Fax (800) 296-0513 (208) 334-4979

Ambulance Review

(800) 362-7648 (208) 287-1155

Fax

(800) 359-2236 (208) 334-5242

MEDICAID INFORMATION RELEASE MA05-02

TO: Hospitals and Nuclear Medicine Providers FROM: Leslie Clement, Acting Deputy Administrator

SUBJECT: Billing Clarification and Information Concerning How To Properly Bill Idaho Medicaid For Radionuclide/Contrast Media

Hospitals and physicians usually use procedure code A4641 - Supply of radiopharma-ceutical diagnostic imaging agent, not otherwise classified, to bill radionuclide/contrast material. This code must be manually priced and an invoice is required. Often, the billing information does not match the invoice which makes it difficult or impossible to correctly price the claim.

In order to expedite this process, Medicaid has added more procedure codes with specific descriptions. When using these codes, providers must bill with the dosage as described below. When using these codes or A4641, the invoice must clearly state what is being billed. If it is necessary to write the dosage on the invoice, please do so. Billing A4641 with a unit of one (1) does not correspond with the invoice that reads per 200 uci or 50 mg.

HCPCS

Code	Description
A9500	technetium Tc 99m sestambi, per dose
A9502	technetium Tc 99m medronate, up tp 30 millicurie
A9503	technetium Tc 99 tetrofosmin, per unit dose
A9504	technetium Tc 99m apcitide
A9505	thallous chloride TL-201, per millicurie
A9507	indium in 111 capromab pendetide, per dose
A9508	iobenguane sulfate I-131, per 0.5 millicurie
A9510	technetium Tc 99m disofenin, per vial
A9511	technetium Tc 99m depreotide, per millicurie
A9512	technetium Tc 99m pertechnetate, per mci
A9513	technetium Tc 99m mebrofenin, per mci
A9514	technetium Tc 99m pyrophosphate, per mci
A9515	technetium Tc 99m pentetate, per mci
A9516	I-123 sodium iodide capsule, per 100 uci
A9517	I-131 sodium iodide capsule, per mci
A9519	technetium Tc 99m macroaggregated albumin, per mci
A9520	technetium Tc 99m sulfur colloid, per mci
A9521	technetium Tc 99m exametazine, per dose
A9522	indium-111 ibritumomab tiuxetan, per mci
A9523	yttrium 90 ibritumomab tiuxetan, per mci
A9524	iodinated I-131 serum albumin, 5 microcuries
A9525	low or iso-osmolar contrast material, 10 mg of iodne
A9526	ammonia N-13, per dose

(MA05-02 continued on page 6)

(IR MA05-02 contin	ued from page 5)
A9528 I-13	1 sodium iodide capsule, per millicurie
A9529 I-13	1 sodium iodide solution, per millicurie
A9530 I-13	1 sodium iodide solution, per millicurie
A9531 I-13	1 sodium iodide, per millicurie (up to 100 microcuries)
A9532 iodir	nated I-125, serum albumin, 5 microcuries
A9533 I-13	1 tositumomab, per millicurie
A9534 I-13	1 tositumomab, per millicurie
A9600 stror	ntium-89 chlride, per millicurie
A9605 sam	arium am 153 lexidronamm, 50 millicurie
A9699 NOC	
A9700 injed	ctable contrast material for use in echocardiography, per study
We annreciate	your continued participation in the Idaho Medicaid program. If you have

We appreciate your continued participation in the Idaho Medicaid program. If you have questions concerning billing for these services, please call EDS at 1-800-685-3757 or locally at 383-4310.

IDAHO MEDICAID PROVIDER HANDBOOK

This Information Release does **not** replace information in your Idaho Medicaid Provider Handbook.

EDS Phone Numbers Addresses

MAVIS

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

EDS

Correspondence PO Box 23 Boise, ID 83707

Provider Enrollment P.O. Box 23 Boise, Idaho 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

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

EDS is a registered mark and the EDS logo is a trademark of Electronic Data Systems Corporation.

EDS Phone Numbers Addresses

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 Hoover 1720 Westgate Drive, # A Boise, ID 83704

jane.hoover@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 Sheila Lux 1070 Hiline Road Pocatello, ID 83201

sheila.lux@eds.com (208) 239-6268 Fax (208) 239-6269

Region 7 Debra Babicz 150 Shoup Avenue Idaho Falls, ID 83402

debra.babicz@eds.com (208) 528-5728 Fax (208) 528-5756 February 1, 2005

MEDICAID INFORMATION RELEASE MA05-04

TO: Commercial Transportation Providers

FROM: Randy May, Deputy Administrator

SUBJECT: RESULTS OF MEDICAID'S COST DATA SURVEY

Medicaid rules for commercial transportation reimbursement require Medicaid to conduct a study at least every three years to evaluate the actual costs reasonably incurred by the typical commercial transportation provider. The Rules Governing Medical Assistance, Section 153, is available online at: http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

Medicaid has completed the most recent study which gave commercial transportation providers the opportunity to provide Medicaid with their operational and administrative cost data and ensure that Medicaid is not reimbursing providers below their costs. Medicaid extended the deadline for provider response twice to be sure providers were given additional time to submit their data to Medicaid.

Based on the data provided, Medicaid determined that the current per mile reimbursement is above the operational costs of the providers who responded to the survey. Therefore, the reimbursement rates for commercial transportation mileage will not increase at this time.

Please contact the Medicaid Transportation Unit at 208-287-1153 if you have questions concerning this Information Release.

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

IDAHO MEDICAID PROVIDER HANDBOOK:

This information release does **not** replace information in your Idaho Medicaid Provider Handbook.

RM/af

EDS P.O. Box 23 Boise, Idaho 83707

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BOISE, ID
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February Office Closure

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

Presidents Day Monday, February 21, 2005

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

MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

Co-Editors: Kathy Gillingham, Division of Medicaid

Cynthia Brandt, Publications Coordinator, EDS

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

GillingK@idhw.state.id.us

or

Kathy Gillingham DHW MAS Unit PO Box 83720 Boise, ID 83720-0036

Fax: (208) 364-1911



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- 6 Informational Letter 2005-06 High Risk Pregnancy Case Management
- 7 2005-07 Idaho Medicaid Disproportionate Share Hospital (DSH) Survey

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

March 2005

Basic Rule for Timely Filing

The timely filing of Medicaid claims is guided by one basic rule: bill all claims within one year of the date of service.

This is in keeping with the recent clarification by the Centers for Medicare & Medicaid Services (CMS) of Federal regulation 42 CFR 447.45(d)(1). This regulation states that Medicaid agencies must require providers to submit all claims no later than twelve months from the date of service. As a result of this clarification, the Idaho Medicaid program clarified its guidelines regarding timely filling for claims received on or after January 15, 2005.

Bill all claims within one year of the date of service

Regardless of the circumstances, all claims must be submitted within twelve (12) months of the date of service, including when:

- payment is made by other insurance
- the client receives retro-eligibility
- the provider receives retro-active enrollment in Idaho Medicaid program
- the claim is for services requiring prior authorization (PA)

The **only** exception is for Medicare crossover claims which may be billed within six months of the date of payment or EOB from Medicare.

It is suggested that providers bill for a client who has applied for but not yet received Medicaid eligibility. Medicaid will deny the claim because the client does not have an active status, but the provider will have established their placeholder for timeliness. The provider

may then resubmit the claim after the client is accepted into the Medicaid program to receive payment for covered services. However, if the provider has received payment from a client, they are not required to submit a claim to Medicaid and reimburse the client if and when the client becomes eligible.

It is also suggested that providers bill Medicaid for a client who has primary insurance. While the claim will be denied because of the other insurance, the provider will have again established their placeholder for timeliness. Should the other insurance later adjust the claim, the provider may then resubmit the claim to Medicaid.

When resubmitting a claim, the internal control number (ICN) of the original claim must be documented in the comments field on all electronic or paper resubmissions in order to prove the timeliness requirement was met. If the ICN of the original claim is not on the resubmitted claim, the claim will be denied, even if it was originally billed timely.

Reminder: providers who fail to bill timely and have their claims denied for this reason **cannot** pursue collection actions against the client.

To see the complete text of Information Release MA04-59, see the January or February 2005 *MedicAide* newsletter. The information release and newsletters are available at www.healthandwelfare.idaho.gov. Follow the links to *Medicaid Provider Information* and either *Information Releases* or *Newsletters*.

Submitted by EDS Provider Services

Small Provider Billing Unit Seeking Recruits

Awesome job.

I really got a lot from your training.

I look forward to submitting another claim .

an SPBU graduate

The Small Provider Billing Unit (SPBU) is looking for providers who bill fewer than 100 Medicaid claims a month, don't use a billing service, and want to save time and money by billing more efficiently. The SPBU is recruiting now for their training program. Some of the benefits of joining the SPBU are:

- Comprehensive training in Idaho Medicaid billing procedures
- One-on-one training with an SPBU representative
- Three-phase program lasting up to one year
- Participation in the program is free

As a member of the SPBU program, you will learn how to take advantage of all of the resources on the Idaho Medicaid Provider Resources CD. In addition, you will learn how to read an RA, request prior authorization, complete an electronic or paper claim form, verify client eligibility and Healthy Connections, and use the Idaho Medicaid Provider Handbook to answer other questions.

After completing the SPBU program, providers who began with error rates in the 20-30% range reduce their errors to as little as 2 or 3 percent of total claims billed. One provider said of her success, ""This is a great program! The representatives always get back to me with answers to my questions. Their responsiveness and friendliness was very refreshing. They were able to solve 99% of the problems so that billing was not interrupted. I have recommended this program to several other small providers."

If you are interested in joining the SPBU program or would like to learn more, call the Medicaid Automated Voice Information Service (MAVIS) at (800) 685-3757, ask for AGENT. You will be connected with a Provider Services Representative who will take your name, provider number, and phone number. A member of the SPBU will then contact you and get you started in the program.

Submitted by EDS SPBU

Terminated NDCs Billed On Outpatient **Claims**

The Medicaid drug rebate program requires a drug manufacturer to enter into an agreement with the State of Idaho to receive federal funding for outpatient drugs dispensed to Medicaid clients. A condition of this agreement is that any drug dispensed in an outpatient setting must be billed with a valid NDC. NDCs that have been terminated by a drug manufacturer are not valid codes.

A valid NDC becomes a terminated NDC when the efficacy expiration date of the last lot produced elapses on a product the labeler has discontinued or changed. Labelers allow time for the product efficacy to expire before terminating the NDC. Once the NDC has been terminated by the labeler. Medicaid will no longer pay for that product without a product label showing the disputed NDC and a valid expiration date.

If Medicaid incorrectly pays a claim billed with a terminated NDC, Medicaid does not receive the appropriate rebate from the manufacturers because the NDC is terminated. Medicaid will recoup any such payments made to providers. Providers who bill with a terminated NDC must re-bill with the correct NDC for the drug at the time it was dis-

To avoid this problem, providers should update their billing system regularly to ensure that they have only current NDCs in their system and that terminated NDCs are deleted.

Submitted by EDS Drug Rebate Unit

DHW Phone Numbers

Addresses

Web Sites

DHW Websites

www.healthandwelfare.idaho.

Idaho Careline

211 (available throughout Idaho) (800) 926-2588

Provider Fraud and Utilization Review

P. O. Box 83720

Boise, ID 83720-0036

(866) 635-7515 (toll free)

(208) 334-0675

~medicaidfraud&sur@ idhw.state.id.us (note: begins with ~)

Healthy Connections

Regional Health Resources Coordinators

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Region II - Lewiston

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(800) 799-5088

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(208) 455-7244 (Spanish)

(800) 494-4133

Region IV - Boise

(208) 334-4676

(800) 354-2574

Region V - Twin Falls

(208) 736-4793

(800) 897-4929

Region VI - Pocatello

(208) 239-6260

(800) 284-7857

Region VII - Idaho Falls

(208) 528-5766

(208) 528-5786

(800) 919-9945

Spanish Speaking (statewide) (800) 862-2147

Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations

DME Specialist
Bureau of Care Management
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax
(800) 352-6044
(att: DME Specialist)

PCG

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

Pharmacy

P.O. Box 83720 Boise, ID 83720-0036 (877) 200-5441 (toll free) (208) 364-1829 Fax (208) 364-1864

Qualis Health

(telephonic & retrospective reviews) 10700 Meridian Ave. N. Suite 100 Seattle, WA 98133-9075 (800) 783-9207 Fax (800) 826-3836 or (206) 368-2765

Qualis Health Website www.qualishealth.org/ idahomedicaid.htm

Transportation Prior Authorization Unit

(800) 296-0509 (208) 334-4990

Fax

(800) 296-0513 (208) 334-4979

Ambulance Review

(800) 362-7648 (208) 287-1155

Fax

(800) 359-2236

(208) 334-5242

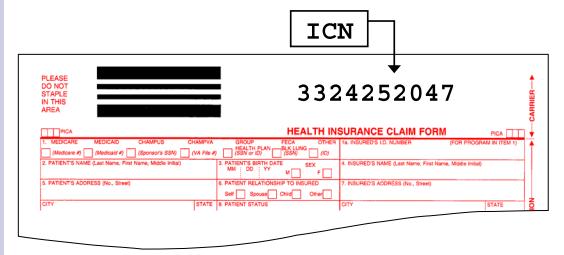
Paper Claims

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 them.
- 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, pharmacy, and the dental claim forms 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.

When a claim is received by EDS it is sorted and prepared for scanning. A part of the scanning process is to add an internal control number (ICN) to the claim and any attachments. This number is printed at the top of the claim form. If there is any other printing in that space, the ICN number is garbled and the claim cannot be tracked.



Submitted by EDS Provider Services

March Regional Provider Workshops

EDS Provider Relations Consultants will continue to offer a series of provider workshops in 2005. Each consultant conducts a two-hour workshop every two months in her region. The next workshop is scheduled for Tuesday, March 8, 2005, from 2 to 4 p.m. Topics include general Medicaid billing, provider resources, and PES software. Please pre-register with your local provider relations consultant. You can find Consultant contact information in this newsletter on page 5.

February 1, 2005

MEDICAID INFORMATION RELEASE 2005-05

TO: Prescribing Providers, Pharmacists, Pharmacies, Hospitals, and Long-

Term Care Facilities

FROM: Randy May, Deputy Administrator

SUBJECT: NEW PRIOR AUTHORIZATION CRITERIA FOR ANGIOTENSIN II

RECEPTOR ANTAGONISTS AND BETA ADRENERGIC BLOCKER

DRUG CLASSES

Idaho Medicaid is implementing an Enhanced Prior Authorization Program for select therapeutic classes including the identification of preferred agents. The Enhanced Prior Authorization Program (EPAP) is designed to provide Medicaid participants the most effective drug at the right price. **Beginning March 1, 2005**, Angiotensin II Receptor Antagonists and Beta Adrenergic Blocker agents will be the next drug classes to have new prior authorization requirements:

Drug/Drug Class:	ANGIOTENSIN II RECEPTOR ANTAGONISTS AND BETA ADRENERGIC BLOCKERS
Implementation Date:	Effective for dates of service on or after March 1, 2005

Drug Class	Preferred Agent(s)	Non-preferred Agent
Angiotensin II Receptor Blockers	Avapro [®] Cozaar [®] Micardis [®]	Atacand [®] Benicar [®] Diovan [®]
Beta Blockers	Atenolol Acebutolol Betaxolol Bisoprolol Labetalol Metoprolol tartrate Nadolol Pindolol Propranolol Innopran XL® Timolol Toprol XL® Coreg® (Heart Failure ONLY)	Blocadren® Cartrol® Corgard® Inderal® Inderal LA® Kerlone® Levatol® Lopressor® Normodyne® Sectral® Tenormin® Trandate® Visken® Zebeta®

[^] Use of non-preferred agents must meet prior authorization requirements

To assist our providers with providing the right care at the right time with the right price, the Department is presenting the relative cost ranking of the preferred agents net of all rebates in these classes. The Department requests that all Medicaid providers consider this ranking as a **secondary** factor when determining the most appropriate drug therapy for their patients.

(Continued on page 5)

EDS Phone NumbersAddresses

MAVIS

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

EDS

Correspondence PO Box 23 Boise, ID 83707

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

Medicaid Claims PO Box 23 Boise, ID 83707

PCS & ResHab Claims PO Box 83755 Boise, ID 83707

EDS Fax Numbers

(208) 395-2072

Provider Enrollment (208) 395-2198 Provider Services

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

EDS Phone Numbers Addresses

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 Hoover 1720 Westgate Drive, # A Boise, ID 83704

jane.hoover@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 Vacant 1070 Hiline Road Pocatello, ID 83201

Temporary contact: call MAVIS at (800) 685-3757, ask for AGENT

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

ellen.kiester@eds.com (208) 528-5728 Fax (208) 528-5756

Lowest to Highest Relative Cost (Cost to Medicaid after rebates)	
Angiotensin II Receptor	Blockers
Micardis®	100%
Avapro®	140%
Cozar®	150%
Beta Blockers	
Metoprolol Tartrate	100%
Atenolol	110%
Propranolol HCL	210%
Acebutolol	590%
Labetalol HCL	730%
Timlolo, Toprol XL®	740%
Innopran XL®	750%
Bisoprolol	1,000%
Nadolol	1,040%
Betaxolol	1,080%
Pindolol	1,460%
Coreg®	2,540%

Point-of-service pharmacy claims will be routed through an automated computer system to apply PA criteria specifically designed to assure effective drug utilization. Through this process, therapy will automatically and transparently be approved for those patients who meet the system approval criteria. For those patients who do not meet the system approval criteria, it will be necessary for you to contact the Medicaid Drug Prior Authorization help desk at (208) 364-1829 or fax a PA request form to (208) 364-1864 to initiate a review and potentially authorize claims. To assist in managing patients affected by these changes, Medicaid will be sending in a separate mailing a list to prescribing providers of their patients who are currently receiving therapy and whose claims for these drugs will be affected.

The Enhanced PA Program and drug class specific PA criteria are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. The determination of medications to be considered preferred within a drug class is based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes in comparison with other therapeutically interchangeable alternative drugs and secondarily on cost.

(Continued on page 6)

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(Continued from page 5)

Additional therapeutic drug classes will be added in the coming months to the Enhanced Prior Authorization (EPAP) program. Please watch for further information releases on the Medicaid Pharmacy website at www.healthandwelfare.idaho.gov.

A current listing of all the preferred agents by drug class and prior authorization criteria is also available online at www.healthandwelfare.idaho.gov.

As always, your support is critical to the success of this Medicaid Pharmacy initiative. It is our goal to partner with you in the provision of quality, cost-effective health care to your patients. Questions regarding the Prior Authorization program may be referred to Medicaid Pharmacy at (208) 364-1829.

IDAHO MEDICAID PROVIDER HANDBOOK:

This Information Release does **not** replace information in your Idaho Medicaid Provider Handbook.

January 20, 2005

Medicaid Informational Letter 2005-06

TO: Physicians

FROM: Randy May, Deputy Administrator

SUBJECT: High Risk Pregnancy Case Management

High risk pregnancy case management services are now available to support you in caring for Idaho Medicaid patients. Pregnant women, who are at risk for premature labor or congenital issues of the fetus, may be referred to a Qualis Health Nurse Case Manager, who will telephonically assist with the coordination of in-home and community support services. To make a referral:

- Contact Qualis Health at 1-800-783-9207 and request case management services.
- A nurse case manager will send a packet of information to the patient with information about the voluntary, no-cost service.
- If the patient wishes to participate, she will return the signed form to Qualis Health.

If you have questions please contact Arlee Coppinger at 208 287-1177.

January 28, 2005

MEDICAID INFORMATION RELEASE 2005-07

TO: ALL HOSPITAL ADMINISTRATORS

FROM: LESLIE M. CLEMENT, Acting Deputy Administrator

SUBJECT: IDAHO MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) SURVEY

On September 30, 2005, Idaho Medicaid will distribute a DSH payment to all eligible hospitals for federal fiscal year 2005. In order to be considered for a DSH payment, the hospital must:

Provide all data requested on the attached survey. All data entered on the survey should be for the fiscal year indicated on the survey form.

Verify that the information in the shaded areas on the survey is correct, as provided by Myers and Stauffer LC. If you disagree with any of this information, please attach documentation supporting the correct information.

Return the survey by May 31, 2005 to:

Myers and Stauffer LC Attn: Karen McKittrick 8555 W. Hackamore Dr., Suite 100 Boise, ID 83709-1693

Please Note: If the survey is *received after May 31, 2005*, the hospital will *not* be considered for a DSH payment.

If you have any questions concerning the survey, please contact Karen McKittrick at (208) 378-1400 or (800) 336-7721. Thank you for your participation in Idaho Medicaid.

LMC/SP/klm

Attachment

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EDS P.O. Box 23 Boise, Idaho 83707

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MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

Co-Editors: Kathy Gillingham, Division of Medicaid Cynthia Brandt, Publications Coordinator, EDS

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

GillingK@idhw.state.id.us

or

Kathy Gillingham DHW MAS Unit PO Box 83720 Boise, ID 83720-0036

Fax: (208) 364-1911





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

April 2005

In this issue:

- Idaho Health Care Conference 2005
- Payment Error Rate Measure
- New PRCs in Regions 6 & 7
- Contacting a PRC
- Client Medicaid **Identification Number**
- Tips for Faster **Processing of Claims**
- Idaho Medicaid Provider Resources CD
- Notice for Service **Coordination Agencies**

Information Releases

- MA05-08 Change In Billing Procedures For PE Clients
- **7** Additional information to Medicaid Information Release MA04-55

Medicaid providers are invited to attend the annual Idaho Healthcare Conference in May. The conference will be held in six locations and have a tropical theme. Registration is free for all Idaho health care providers. Multiple sessions will allow participants to attend classes by all presenters.

This annual meeting is sponsored by the Department of Health and Welfare/Medicaid, EDS, the Idaho State Insurance Fund, Blue Cross of Idaho, CIGNA Medicare, Regence BlueShield of Idaho, and TriWest Healthcare Alliance.

Vendor fairs are offered to participants at all of the Healthcare Conference locations. This is a valuable opportunity to talk directly with vendors about their products. Participants are encouraged to visit with the exhibitors during breaks and at lunch.

All events are from 8:00 a.m. to 4:15 p.m. Registration starts at 8:00 a.m. and classes begin at 8:30 a.m. Locations are listed below:

Boise

Wednesday, May 4 Boise Centre On-The-Grove 850 Front Street, Boise ID

Clarkston, WA

Tuesday, May 10 Quality Inn 700 Port Drive, Clarkston, WA

Post Falls

Wednesday, May 11 Templins Resort 414 E. First Ave., Post Falls, ID

Idaho Falls

Tuesday, May 24 Shilo Inn 780 Lindsay Blvd., Idaho Falls, ID

Pocatello

Wednesday, May 25 Pond Student Building, #14 Idaho State University 1065 S. 8th St., Pocatello, ID

Burley

Thursday, May 26 **Burley Convention Center** 800 N. Overland Ave., Burley, ID

See page 2 for a complete listing of classes offered by the Idaho Medicaid program.

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

Medic/Aide April 2005



Medicaid/EDS Class Offerings

HEALTHY CONNECTIONS - 101

This class will explain enrollment, referrals (including 3-way), exemptions, and billing issues.

HEALTHY CONNECTIONS - Advanced Discussion

This is an open discussion on how to deal with difficult patients, how Healthy Connections can help you, and billing the Medicaid client. Time will be allotted for a Q&A session.

PROVIDER RESOURCES

This session will cover the resources available to providers: Idaho Medicaid Provider Resources CD, PES, *MedicAide* Newsletter, Idaho Department of Health and Welfare Website, Small Provider Billing Unit (SPBU), Provider Service Representative (PSR), Provider Relations Consultant (PRC), MAVIS, and POS devices.

LIFE OF A CLAIM

This class will explore the life cycle of a claim upon its arrival at EDS until it appears on your Idaho Medicaid Remittance Advice (RA).

TOP 10 MOST PREVENTABLE DENIALS

In this session we will review the top 10 claim denial reasons. Instruction will include billing tips that demonstrate how to avoid these denials - ultimately saving you time and money.



DHW Phone Numbers

Addresses

Web Sites

DHW Websites

www.healthandwelfare.idaho.

Idaho Careline

211 (available throughout Idaho) (800) 926-2588

Provider Fraud and Utilization Review

P. O. Box 83720

Boise, ID 83720-0036

(866) 635-7515 (toll free) (208) 334-0675

Email:

~medicaidfraud&sur@
idhw.state.id.us
(note: begins with ~)

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) 455-7163

(208) 455-7244 (Spanish)

(800) 494-4133

Region IV - Boise

(208) 334-4676

(800) 354-2574

Region V - Twin Falls

(208) 736-4793

(800) 897-4929

Region VI - Pocatello

(208) 239-6260

(800) 284-7857

Region VII - Idaho Falls

(208) 528-5766

(208) 528-5786

(800) 919-9945

Spanish Speaking (statewide) (800) 862-2147

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Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations

DME Specialist Bureau of Care Management PO Box 83720 Boise, ID 83720-0036 (866) 205-7403 (toll free) (800) 352-6044 (att: DME Specialist)

PCG

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

Pharmacy

P.O. Box 83720 Boise, ID 83720-0036 (877) 200-5441 (toll free) (208) 364-1829 Fax (208) 364-1864

Qualis Health

(telephonic & retrospective reviews) 10700 Meridian Ave. N. Suite 100 Seattle, WA 98133-9075 (800) 783-9207 Fax (800) 826-3836 or (206) 368-2765

Qualis Health Website www.qualishealth.org/ idahomedicaid.htm

Transportation Prior Authorization Unit

(800) 296-0509 (208) 334-4990

(800) 296-0513

(208) 334-4979

Ambulance Review

(800) 362-7648 (208) 287-1155

Fax

(800) 359-2236

(208) 334-5242

Payment Error Rate Measurement - Project Summary

The Payment Error Rate Measurement (PERM) pilot project is an effort to estimate the accuracy of medical payments made by Medicaid and the State Children's Health Insurance Program (SCHIP). The Improper Payments Information Act of 2002 (Public Law 107-300) directed all federal programs including the Centers for Medicare and Medicaid Services (CMS), whose responsibility it is to oversee the state Medicaid programs, to review all of its programs and activities annually. They are to identify those programs that may be susceptible to significant improper payments, estimate the annual amount of improper payments, and submit those findings to Congress each year.

For the past three-years, CMS piloted the Payment Accuracy Measurement Demonstration Project (PAM). CMS has extended the pilot for a fourth year to refine the process, and changed the name from PAM to PERM. This model has been designed to estimate payment error rates (the ratio of the dollar value of inaccurate payments to the dollar value of total payments). The focus of this project is to develop a single methodology that can produce both state-specific and national level Medicaid payment accuracy estimates to comply with the requirements of the Improper Payments Information Act. It is expected that after this fourth year of the pilot, the PERM project will be implemented on a national basis, and all states will be required to participate.

The model can be summed up as follows: each state will draw a statistically valid, random sample of claims and capitation payments from the universe of recently-paid Medicaid and SCHIP claims and capitation payments. The state will then review and audit the sampled claims/capitation payments to determine the validity of the payments made. The audit will include an examination of the accuracy of the claims processing system or capitation payment rosters, the medical necessity of the service for which payment was claimed, and the eligibility of the beneficiary who received the service. The dollar amount of any errors identified (overpayments and underpayments) will be tracked and used to calculate the final payment error rate.

The assistance of providers is requested for this project. The sample size for this initiative is modest and most providers will not be sampled, but a small number will be asked to submit medical records to the state Medicaid or SCHIP agency for review. It is unlikely that the number of records requested from any single provider would be more than one or two. Hence, the burden on any single provider should be limited. Providers are strongly encouraged to respond with requested documentation in a timely manner. Your cooperation will ensure the state's program is fully credited for claims accurately paid. If documentation for the requested claim is not provided, the amount of the claim will be considered an error, resulting in a higher error rate.

Because this research project is conducted to improve the accuracy of Medicaid payments, records submitted to your Medicaid agency for review do not need to be deidentified to comply with the privacy provisions in the Health Insurance Portability and Accountability Act (HIPAA). This is outlined in federal regulations regarding the utilization of Medicaid services, by Section 1902 (a) (27) of the Social Security Act and Federal Regulation 42 CFR 431.107. State Medicaid and SCHIP programs are authorized to access patient medical records for purposes directly related to the administration of those programs. As a provider, you are required to retain and make records available as requested by the Medicaid/SCHIP agency within a reasonable length of time. No special beneficiary permission is necessary for the release of records.

New Provider Relations Consultants in Regions 6 and 7

EDS is happy to announce that two new Provider Relations Consultants have joined the EDS team. Janice Curtis and Ellen Kiester each bring many years of health care experience in eastern Idaho.

Janice replaces Sheila Lux Region 6 and Ellen replaces Debra Babicz in Region 7. Please join us in wishing good luck to Sheila and Debra, and welcoming Janice and Ellen!

Contact information for both of them is on page 5 of this newsletter.

EDS PRCs help keep providers up-to-date on billing changes resulting from program and policy changes implemented by the Division of Medicaid. PRCs accomplish this by:

- Conducting provider workshops
- Visiting a provider's site to conduct training
- Assisting providers with electronic claims submission

Initial communication with consultants may be directed through a provider service representative to determine which PRC can best support a provider's particular needs.

MAVIS, PSR, or PRC? Whom do I call?	 Routine questions about eligibility, limitations, codes, etc., can all be addressed by MAVIS. Toll-free: I-800-685-3757, in Boise calling area: 383-4310 Questions that cannot be answered by MAVIS can be routed to a Provider Service Representative (PSR). Questions that cannot be answered by a PSR will be referred to a regional Provider Relations Consultant.
What do I need before I call?	 The Internal Control Number (ICN) of the claim Your Medicaid provider number The client's Medicaid identification number (MID) Dates of service The date of the RA The EOB code from the RA telling why the claim pended or denied
When should I call a PRC directly?	 If you have multiple denials on a claim If your keep having claims deny for the same reason If you are having trouble finding an answer for a claim question.

EDS Phone Numbers Addresses

MAVIS

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

EDS

Correspondence PO Box 23 Boise, ID 83707

Provider Enrollment P.O. Box 23 Boise, Idaho 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

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

EDS Phone Numbers Addresses

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 Hoover 1720 Westgate Drive, # A Boise, ID 83704

jane.hoover@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

Client Medicaid Identification Number

Effective April 1, 2005, the edit validating the Medicaid Identification (MID) client number submitted on a claim will be set to automatically deny paper claims for all claim types when the client number is invalid or not on file. This includes all PWC presumptive eligibility clients. The number 9999999 will no longer be accepted as a valid number. (See Information Release MA05-08 on page 7 of this newsletter for more information on PE clients.) The only exception is for crossover claims.

A MID is assigned to each client enrolled in the Idaho Medicaid program. It is 7 digits in length and is required on every claim submitted to EDS whether it is via electronic claim submission, POS, or on paper. The correct field on a paper claim is different for each of the claim forms currently in use and must contain the 7-digit MID number:

CMS 1500: field 1a

• UB-92: field 60

• Dental: field 13 (1999 & 2000 form)

Pharmacy: field 3

All paper CMS 1500 claims are electronically scanned. The only permanent record of these claims is the scanned copy. Now, more than ever, it is important for paper claims to be easy to read. Paper claims that cannot be scanned are returned to the provider.

See the following article, *Tips for Faster Processing of Claims*, for more information on how to submit claims to Idaho Medicaid.

Tips for Faster Processing of Claims

For the fastest possible processing of claims, send them electronically! With PES and other vendor software it is possible to send almost all claims electronically including crossovers and oxygen claims. Electronic claims can be approved to pay within hours of transmission.

If electronic billing is not an option for you, please follow these guidelines when submitting paper claims.

- Send PCS and Rehab claims to P.O. Box 83755, Boise, Idaho 83707. Send all other claims to P.O. Box 23, Boise, ID 83707.
- Send all correspondence (that is not a claim) separately to the attention of a specific person and/or department. Do not include correspondence with claims.
 It will be scanned and included as claim documentation.

Everyday EDS receives approximately 5,000 pieces of mail. A machine opens all of the mail which is then sorted into correspondence and claims. All claims are fed into a scanner one page at a time to create an electronic image for processing. To speed the proper handling of your claims and correspondence and to avoid the loss of important information, please follow these guidelines:

- Do not fold claims; mail them flat in a large envelope.
- Do not staple or tape claims to the envelope. Do not tape or staple the claims and attachments together.
- Place any "attachments" behind the appropriate claim including EOBs. Make a copy of the EOB page for each claim to which it applies.
- Do not continue claims onto a second claim form. Each claim page must have a total.
- Place all adjustment forms on top of any claims. It is not necessary to include a copy of the claim.
- Sort claims by type of claim form when sending several claim types in the same envelope.

Idaho Medicaid Provider Resources CD

All active providers receive the *Idaho Medicaid Provider Resources* CD in the mail. The next CD is due out in mid-April. It contains a variety of provider resources including:

Provider Electronic Solutions (PES): the PES software can be used to verify Idaho Medicaid eligibility and to submit electronic claims in HIPAA-compliant transactions. To submit electronic claims, you must have an Electronic Claims Submission (ECS) Agreement on file with EDS. If you have not completed an agreement, insert the CD in the computer drive, select *PES* from the main menu on the CD, and select *ECS Agreement*. Print, complete, and mail this form to EDS. The CD also includes the *PES Handbook* and quick installation instructions.

General Provider Resources: Qualis Health Provider Manual (April 2005), Medicaid and You (a client brochure), Forms, and Acrobat Reader[®].

POS Device Resources: the POS Device User Guide and Installation Guide for the Idaho Medicaid POS device.

Idaho Medicaid Provider Handbook: the *Idaho Medicaid Provider Handbook.* The handbook is the primary resource for information about the Idaho Medicaid program. The electronic handbook is used regularly by the EDS provider service representatives to answer provider questions.

New Features: a new feature on the April CD is the inclusion of the Idaho Medicaid Fee Schedule and Qualis Select Pre-Authorization List as separate files for easy access.

Ease of Use

Providers have discovered that the electronic versions of the handbooks and reference files gives them more flexibility in using the materials. The electronic version allows users to:

- copy the resource to one or more computers or LAN for easy access
- use the search function to locate specific information
- complete standard forms online before printing and mailing them
- copy and paste sections of handbooks to their own office manuals
- print specific sections of handbooks as needed
- read about program requirements and procedures for all provider types and specialties

Notice for Service Coordination Agencies

All Service Coordination (Case Management) Agencies must comply with the requirements of IDAPA 16.03.17 that went into effect 3-20-04.

April 1, 2005

MEDICAID INFORMATION RELEASE MA05-08

TO: PWC (Pregnant Women and Children) Clinic Providers

FROM: Leslie Clement, Acting Deputy Administrator

SUBJECT: CHANGE IN BILLING PROCEDURES FOR PRESUMPTIVE ELIGIBILITY (PE) CLIENTS WHO ARE

PREGNANT

Medicaid is changing the process for submitting claims for Presumptive Eligibility (PE) clients in order to decrease claim processing time and assure claim payment accuracy.

Eligibility for pregnancy services under the PE program is determined as follows:

- Client and provider complete program questions and determine if client is eligible for the PE program.
- Client's local field office receives the application for services from the provider, processes it, and issues a Medicaid number for client's PE eligibility period.
- Client's Presumptive Eligibility period ends after a maximum coverage period of 45 days or sooner if the candidate is eligible for PWC (Pregnant Women and Children) or another Medicaid program.

Claims received by EDS on or after 4/1/2005 with a 9999999 in the client ID number field will be automatically denied. Please follow these steps to submit your claims:

- Verify client's eligibility using MAVIS or electronic software. See your provider manual, Section 1., General Provider and Client Information, for instructions on verifying eligibility. This section may be accessed online at: http://www.healthandwelfare.idaho.gov/ Rainbow/Documents/medical/s1 gen info.pdf
- Submit your claim with the client's Medicaid ID number, (not 9999999).

If you have any questions regarding these billing requirements, please contact EDS at 383-4310 (in Boise) or 1-800-685-3757. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK:

This Information Release **replaces** information found in Section 1., 1.4.1.1 – Program Procedures for pregnant women (PWC) PE which states "*Providers who serve PE clients mark these claims with "9999999" in the insured's ID number field".*

LC/af

Additional information to Medicaid Information Release MA04-55 **CLARIFICATION OF MEDICAID REIMBURSEMENT POLICY FOR BILLING THE COMPONENTS OF THE GLOBAL SURGICAL PROCEDURE CODES: PRE-OPERATIVE, INTRA-OPERATIVE AND POST-OPERATIVE**

Providers were instructed in IR MA04-55 to bill for postoperative services with a modifier 55 and the **same surgical CPT code** billed on the original surgical claim.

Please be aware: if that surgical procedure required a prior authorization (PA) number, then all postoperative services related to that same surgery will require the **same PA number** be entered on the claim. If the PA is missing or is incorrect, the claim will deny for prior authorization.

If you have questions regarding benefits and billing, please contact EDS at 1-800-685-3757, or for those in the Boise area, 383-4310.

EDS P.O. Box 23 Boise, Idaho 83707

PRSRT STD
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PERMIT NO. 1





Check your mail!

In April all active providers will receive the new Idaho Medicaid Provider Resources CD. It contains the updated Idaho Medicaid Provider Handbook, the Provider Electronic Solutions (PES) software with upgrades, and the POS device user's guide.

Providers using the CD format of the handbook will be able to copy the handbook files to their desktop computer (s) for use, print paper copies of all the materials they want, and complete forms online to be printed and mailed.

Providers can use the PES software to check client eligibility and service limitations online as well as submit claims.

Providers who are unable to use the CD may request a paper copy of the provider handbook for their provider specialty.

MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

Co-Editors:
Kathy Gillingham,
Division of Medicaid
Cynthia Brandt,
Publications Coordinator,
EDS

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

GillingK@idhw.state.id.us

or

Kathy Gillingham DHW MAS Unit PO Box 83720 Boise, ID 83720-0036

Fax: (208) 364-1911

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