

An informational newsletter for Idaho Medicaid Providers

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

December 2006

In this issue:

- 1 NPI. Get it. Share it. Use it.
- 2 New CMS 1500 Claim Form
- 3 NPI Frequently Asked Questions
- 5 DHW Adopts idaho.gov for Email Addresses
- 6 New Code for Billing Sign Language Services
- 6 Electronic Claim Voids and Replacements
- 6 Services in Excess of Remaining PA Units
- 7 Timely Filing
 Requirements:
 Clarification for
 Retroactive Eligibility
- 7 Important Notice Regarding PET Scans
- 8 Billing HCPCS J Codes for Hospital, Outpatient, and Professional Providers
- 9 For Faster Claims Processing, Avoid Billing Duplicate Claims
- 10 Documentation and Attachments
- 11 EDS Welcomes a New Team Member
- 11 Un-stick Your Paper Claims
- 11 More Tips for Billing Medicare Crossover Claims
- 12 December Office Closures

Information Releases:

Medicaid Information Release MA06-33

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

NPI. Get it. Share it. Use it.

Today, you need an Idaho Medicaid provider number to conduct business with the Idaho Medicaid program. On May 23, 2007, a National Provider Identifier (NPI) will become the primary provider identification number most providers will use. It is important to note that not all providers will be assigned an NPI, as some do not meet the federal definition of a healthcare provider. These providers are defined as "atypical". Providers who are not eligible for an NPI can still participate in the Idaho Medicaid program by using their current Idaho Medicaid provider number.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.

Healthcare providers, whether they are individuals or organizations, must obtain an NPI to identify themselves in HIPAA standard transactions accepted by Idaho Medicaid. Once assigned, the provider's NPI will not change, regardless of job or location changes.

The NPI will eliminate the need for healthcare providers to use different identification numbers to identify themselves in electronic transactions with multiple health plans.

A process to register NPI numbers with Idaho Medicaid is in development. Providers will be notified when Idaho Medicaid is ready to accept NPI registrations. Important NPI information will be included in future remittance advices (RAs), monthly MedicAide newsletters, and direct mail. Registering your NPI will not require re-enrollment in the Idaho Medicaid program. You must inform Idaho Medicaid of all NPI numbers you have obtained.

If you do not apply for an NPI and register it with Idaho Medicaid by May 23, 2007, you are at risk for not receiving payment for your submitted claims. So act today and apply for your NPI!

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

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

New CMS 1500 Claim Form

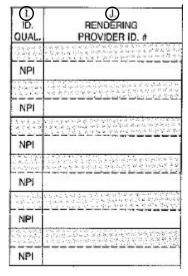
Idaho Medicaid is now able to accept claims on the new CMS 1500 (08/05). The National Uniform Claim Committee (NUCC) revised the HCFA/CMS 1500 Health Insurance Claim Form as a result of the federal rules in the Health Insurance Portability and Accountability Act (HIPAA). The CMS 1500 (08/05) claim form accommodates reporting of the new National Provider Identifier (NPI).

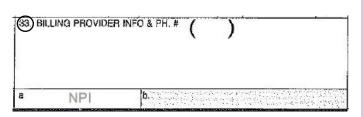
Idaho Medicaid will accept both the current and new versions of the 1500 claim form through May 22, 2007. As of May 23, 2007, only the new CMS 1500 (08/05) will be accepted. In addition, any re-billing of claims submitted on or after May 23, 2007 must be on the new CMS 1500 (08/05), even though earlier submissions may have been on the current CMS 1500.

It is strongly recommended that providers contact their clearinghouses/vendors prior to submitting a claim on the new form to ensure they are prepared to accept the new form.

A major difference between the new CMS 1500 (08/05) and the prior form is the split provider identifier fields (Fields 17, 24 I & J, and 33 on the form, as shown below.)

17) NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. 17b. NPI





The split fields will allow for entry of the NPI and the corresponding Idaho Medicaid provider number. It is important to note that the Idaho Medicaid provider number will continue to be required on all CMS 1500 claims after May 22, 2007. Idaho Medicaid encourages you to include your NPI, but the Idaho Medicaid provider number is required.

Billing instructions for the CMS 1500 (08/05) that are specific to Idaho Medicaid claim submissions have been developed and are posted on the Health and Welfare website (http://www.healthandwelfare.idaho.gov/site/3348/default.aspx) under Medicaid Providers.

More information can be found on the NUCC website at http://www.nucc.org, including a list of the changes for the 1500 form, Frequently Asked Questions (FAQs), contact information, and the NUCC 1500 Reference Instruction Manual.

DHW Phone Numbers Addresses Web Sites

DHW Websites

www.healthandwelfare.idaho.

Idaho Careline

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

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

Email: prvfraud@idhw.state.id.us

Healthy Connections

Regional Health Resources Coordinators

Region I - Coeur d'Alene (208) 666-6766 (800) 299-6766

Region II - Lewiston (208) 799-5088

(800) 799-5088

Region III - Caldwell (208) 455-7244 (800) 494-4133

Region IV - Boise (208) 334-0717 or (208) 334-0718 (800) 354-2574

Region V - Twin Falls

(208) 736-4793 (800) 897-4929

Region VI - Pocatello (208) 239-6270 (800) 284-7857

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

In Spanish (en Español) (800) 378-3385 (toll free) Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations:

DME Specialist Bureau of Medical Care P.O. Box 83720 Boise, ID 83720-0036 (866) 205-7403 (toll free) Fax (800) 352-6044 (Attn: DME Specialist)

Pharmacy P.O. Box 83720 Boise, ID 83720-0036 (866) 827-9967 (toll free) (208) 364-1829 Fax (208) 364-1864

Qualis Health (Telephonic & Retrospective Reviews) 10700 Meridian Ave. N. Suite 100 Seattle, WA 98133-9075 (800) 783-9207 Fax (800) 826-3836 or (206) 368-2765

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

Insurance Verification:

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

Transportation Prior Authorization:

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

Other Non-emergent and Out-of-State

(800) 296-0509, #1173 (208) 287-1173

Fax

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

Ambulance Review

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

Fax

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

NPI Frequently Asked Questions

1. What is NPI?

The National Provider Identifier (NPI) is part of the Health Insurance Portability and Accountability Act (HIPAA). NPI number or numbers will replace existing provider numbers and identify providers to health plans with a unique 10-digit provider identifier.

2. Why do we need the NPI?

It facilitates simpler electronic transmission of HIPAA standard transactions, provides a standard unique health identifier for health care providers, and enables an efficient coordination of benefits transactions.

3. Who can apply for and receive an NPI?

All individuals and organizations that meet the federal definition of a healthcare provider can apply for and receive an NPI.

4. Who should get an NPI?

Healthcare providers that send or receive HIPAA standard electronic transactions should get an NPI.

5. Who can't get an NPI?

Some Idaho Medicaid providers do not meet the definition of a health care provider but can still provide services. Idaho Medicaid has interpreted the NPI rule to designate the following provider types as "atypical":

- Non-Emergency Commercial Transportation
- Transportation Broker
- Individual Transportation Provider
- Agency Transportation Provider
- Personal Emergency Response Systems
- Home Modifications
- Chore Services
- Home Delivered Meals
- Self Determination Fiscal Employer Agent
- Supported Employment Services

6. Could other provider types be "atypical"?

Other provider types may be "atypical" depending on the information providers include on the NPI application. Idaho Medicaid recognizes the following provider types could be classified as either healthcare or "atypical":

- Personal Care Service (PCS) / Aged & Disabled (A&D) Agency
- 24 Hour PCS Home for Children (Foster Care)
- Adult Day Care
- Residential Assisted Living Facility (RALF)
- Behavior Consultation / Crisis Management
- Residential Habilitation Agency
- Certified Family Homes
- Respite Care

7. Can "atypical" providers still bill Idaho Medicaid?

Idaho Medicaid providers who are not eligible for an NPI can still participate in the Idaho Medicaid program by using their Idaho Medicaid provider number.

Continued on Page 4 (NPI FAQs)

Continued from Page 3 (NPI FAQs)

8. Can billing services and clearinghouses obtain an NPI?

Billing services and clearinghouses do not meet the definition of a health care provider and will not be eligible for an NPI.

9. Who is an individual provider?

A person or a sole proprietorship is considered an individual provider, and are eligible for a single NPI only.

10. Who is an organizational provider?

Examples of organizational providers are hospitals, clinics, group practices, nursing homes, etc. If you are an individual who is a healthcare provider and are incorporated, you may need to obtain an NPI for yourself and a separate NPI for your corporation or Limited Liability Company (LLC).

11. How can I get prepared to apply for an NPI?

Go to the following web page to determine what information you will need to provide to the National Plan and Provider Enumeration System (NPPES) to apply for an NPI: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions.

The Center for Medicare and Medicaid Services (CMS) developed the NPPES to assign the NPI to eligible healthcare providers. Fox Systems, Inc. is contracting with CMS to serve as the NPI enumerator.

12. How can I apply to get my NPI?

There are three ways you can get an NPI. You can:

- Apply online, visit: https://nppes.cms.hhs.gov. This is the fastest and most efficient
 way to get an NPI. Your NPI will be returned to you by email.
- Call (800) 465-3203 to request a paper application. Your NPI will be returned to you by mail.
- Authorize an employer or other trusted organization to obtain an NPI for you through bulk enumeration, or Electronic File Interchange (EFI). Your NPI will be returned to you by the organization you authorized to obtain your NPI.

Regardless of how you get your NPI, it is important that you keep the notification document you receive from NPPES informing you of your NPI. Learn more about the application process by clicking on National Provider Identifier (NPI) at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.

13. When should I apply to get my NPI?

Individual providers should apply now for their NPI. Organizational providers have other considerations to analyze when they apply for an NPI, but they also should apply now for their NPI(s).

14. When can I send my NPI to Idaho Medicaid?

A process to register NPI numbers with Idaho Medicaid is in development. Providers will be notified when Idaho Medicaid is ready to accept NPI registrations.

15. When will Idaho Medicaid begin using the NPI for healthcare transactions?

Based upon the Federal NPI requirements, Idaho Medicaid will require healthcare providers who have an NPI to use their NPI number for all electronic transactions beginning May 23, 2007.

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

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

EDS Phone Numbers
Addresses

MAVIS

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

EDS

Correspondence P.O. Box 23 Boise, ID 83707

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

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

PCS & ResHab Claims P.O. Box 83755 Boise, ID 83707

EDS Fax Numbers
Provider Enrollment
(208) 395-2198
Provider Services
(208) 395-2072

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

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 Trent 1720 Westgate Drive, # A Boise, ID 83704

jane.trent@eds.com (208) 334-0842 Fax (208) 334-0953

Region 5 **Penny Schell** 601 Poleline, Suite 3 Twin Falls, ID 83303 penny.schell@eds.com

(208) 736-2143 Fax (208) 678-1263

Region 6 **Janice Curtis** 1070 Hiline Road Pocatello, ID 83201

janice.curtis@eds.com (208) 239-6268 Fax (208) 239-6269

Region 7 Ellen Kiester 150 Shoup Avenue Idaho Falls, ID 83402 ellen.kiester@eds.com (208) 528-5728

Fax (208) 528-5756

MEDICAID INFORMATION RELEASE MA06-33

TO: All Providers

October 17, 2006

FROM: Leslie M. Clement, Administrator

SUBJECT: Changes to Reimbursement for Medicare Part B Psychiatric Crossover

Claims for Dual-Eligibles

Effective for dates of service beginning July 1, 2006, Idaho Medicaid will pay providers of psychiatric services (which are subject to Medicare's 37.5% reduction amount) the Medicaid allowable amount less any payment by Medicare and any other third-party payers.

If you need to adjust previously billed claims, please follow these instructions:

For Electronic Crossovers Claims:

When your claim is submitted via PES or other vendor software, previously paid crossovers claims can be voided and replaced electronically. The voided claim and the new claim will appear on the same Remittance Advice. Refer to your PES manual for instructions.

For Paper Crossover Claims:

Complete an Adjustment Request Form asking EDS to void the original claim ICN due to non-allowance of psych reduction amounts. Be sure to attach a new claim with the matching Medicare Explanation of Benefits.

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

LC/sp

DHW Adopts idaho.gov for Email Addresses

As of the New Year, Department of Health and Welfare (DHW) employees will have new email addresses that are consistent with other state agencies. Beginning January 2, 2007, all email addresses will end in @dhw.idaho.gov instead of @idhw.state.id.us. Usernames (everything before the @ sign) will remain the same. The Department of Health and Welfare has a plan to identify partners and consumers and get the word out to them on the change of email addresses. For example, a note will appear above the confidentiality notice on every email, and on various printed mailers. Automatic email generation systems will be updated as well. When this change takes place, emails sent to the old email addresses will be automatically forwarded for at least six months. After that point, senders to the old addresses will receive a non-delivery receipt.

New Code for Billing Sign Language Services

Effective December 1, 2006, providers billing for sign language interpretive services must use code T1013 (Sign Language Interpretive Services, per 15 minutes). This code pays \$12.50 per 15 minute unit. Note that this code is for sign language interpretation only. Oral interpretive services should continue to be billed using state-only code 8296A.

This notice supersedes information release MA03-54, Language Interpretation Reimbursement, as well as the information on page 2-4 of Section 2 (General Billing Information) of the Idaho Medicaid Provider Handbook.

If you have any questions please contact Eric Anderson, Senior Financial Specialist for the Medicaid Office of Reimbursement Policy, at (208) 364-1918.

Electronic Claim Voids and Replacements

Claim voids and replacements are the electronic equivalent of the paper adjustment process. The electronic process is quicker and more efficient than the paper process.

When a claim is paid incorrectly, submit an adjustment request to EDS. Incorrect payments may result from changes to information received after initial payment (e.g., third party resource payments or changes in nursing home participant liability amounts), provider billing errors, or claims processing errors. Adjustments can be done only on paid claims or paid claim details. These are claims that are listed in the "Paid Claims" section of the remittance advice (RA).

Providers can submit electronic void and replacements to EDS using the EDS billing software (PES) or their vendor software. For more information on submitting electronic adjustments, see the Idaho PES Handbook or vendor software instructions.

Services in Excess of Remaining PA Units

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

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

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

Timely Filing Requirements: Clarification for Retroactive Eligibility

The timely filing of Medicaid claims is guided by one basic rule: bill all claims within one (1) year of the date of service. 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 (6) months of the date of payment or date of the EOB for the Medicare claim.

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 (12) 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.

Except for Medicare crossover claims, all claims must be submitted within twelve (12) months of the date of service, including when the client receives retroactive eligibility. If a claim for payment under Medicare has been filed in a timely manner, Medicaid will consider claims for payment within six (6) months of the date of the Medicare payment or date of the EOB of the Medicare claim.

Previous exceptions to the timeliness requirement for retroactive eligibility no longer apply.

It is suggested that providers bill Medicaid for a client who is not currently Medicaid eligible but has applied for, or may possibly apply for Medicaid benefits. These claims can be billed using the client's Social Security Number (SSN). Medicaid will deny the claim because the client does not have an active eligibility status, but the provider will have established their placeholder for timeliness. The provider may then resubmit the claim to receive payment for covered services after the client is accepted into the Medicaid program.

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 has been 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.

Details about timely filing requirements were published in previous MedicAide newsletters. To see the complete text of Information Release MA04-59, see the January, February, or March 2005 MedicAide newsletter. The information release and newsletters are available at **www.healthandwelfare.idaho.gov**. Follow the links to Medicaid Provider Information and choose either Information Releases or Newsletters.

Important Notice

PET scans no longer require prior authorizations.

If you have any questions or need additional information, please call the Department of Health and Welfare at (208) 334-5747.

Billing HCPCS J Codes for Hospital, Outpatient, and Professional Providers

J Code billing seems to present problems for providers, leading to processing delays. The most common problem is that the National Drug Code (NDC) information is being billed incorrectly.

To avoid billing the incorrect NDC information, the claim data must be entered the same way the information is set up in the State's system. Verify the information through MAVIS, the State's website at **www.healthandwelfare.idaho.gov**, or by calling your EDS Provider Relations Consultant or Provider Services Representative.

Providers need to verify the following information:

- NDC information on the claim matches the product administered.
- All required fields on the NDC Detail Attachment Form, which are the NDC, Units, and Basis of Measurement.
 - Bill the Basis of Measurement on the NDC Detail Attachment form as GR (grams), ML (milliliters), or EA (each);
 note that UN should be reflected as EA.
 - Rarely will the units for the J code be the same as for the NDC, therefore the conversion step is necessary.
 - The number of units billed for the NDC has the correct conversion for the units billed on the J code.

Example of correct conversion:

- J9201 = Quantity 1 = 200mg.
- Units on claim for J9201 = Qty 10 x 200mg (which equals 2000mg).
- NDC 00002 7502 01, is dispensed as a vial, the strength is 1 gram(1000mg), and the unit of measure is EA. Therefore, 1 gram = 1 EA.
- Unit Description (Unit of Measure) is EA. Unit of Measure on the NDC attachment form should be 2 EA.
- This is derived by:
 - Dividing the 2000mg of the J Code dispensed by 1000mg (1gram) from the NDC description, which calculates to 2 grams.
 - Therefore, 2 grams = 2 EA.
 - The NDC Detail Attachment Form or the electronic billing screen should then reflect the NDC of the product dispensed, quantity 2, and unit of measure as EA.

Drug rebates from pharmaceutical manufacturers result in a significant cost savings to Idaho's Medicaid program. When claims are billed with incorrect NDC information, the drug manufacturers will not pay the State a rebate for drugs dispensed.

Provider billing practices play a huge part in the benefit to Medicaid from the drug rebate programs. The Centers for Medicare and Medicaid Services (CMS) supports the requirement for providers to correctly convert J codes to NCD units for proper billing and rebate retrieval. Your participation in this program is appreciated.

For Faster Claims Processing, Avoid Billing Duplicate Claims

Duplicate claims comprise the highest volume inventory for all claims that suspend for manual review. This means that a person must review the claim and make a decision for payment or denial. It can take approximately three weeks from the time the service is billed until the decision for payment or denial is reported. You can decrease the turnaround time from claim submission to payment by not submitting duplicate claims. If the total number of claims that suspend because they are duplicates could be reduced, then the average total turnaround time from claim submission to payment could be reduced. The information that follows describes billing practices that can decrease the time from claim submission to payment, and therefore increase the speed for which services are reimbursed.

General Tips for Avoiding Duplicate Claims

- Reconcile your Remittance Advice (RA) and post payments received each week, then claims are not rebilled (and suspended for review) that have already been paid.
- Wait for claims to appear in the Paid or Denied section of the weekly RA. If the claim is in the Pended section and another claim is submitted, it will be a duplicate claim and also suspend.
- A paid claim can only be corrected through an adjustment. Submit an Adjustment Request Form to correct any errors on paid claims.
- Do not resubmit entire claims with details where some lines have paid and some have denied. Just resubmit the
 denied lines with corrections. If the entire claim is resubmitted without deletion of the paid details the entire claim
 suspends for manual review which can take up to three weeks. In many cases, when just the denied lines are
 resubmitted, the claim does not suspend and payment can be made the week immediately following submission.

Professional Providers – Group Practices

- Many providers who offer services are enrolled as a group practice. These providers share a group provider number for billing purposes. If your claims are submitted and paid to the group number, the performing provider services are included in that payment. Sometimes a claim for the performing provider is resubmitted using the individual's provider number. These claims suspend because the claim has already been paid.
- To avoid having claims suspend as duplicates, bill for services with the group provider number and the rendering/ performing provider number, and do not rebill for services under the performing provider number. If the claim was originally billed with an incorrect group/performing provider number, that claim must be voided. Once complete, a new claim with correct information can be resubmitted.
- If you have any questions regarding billing using a group number, or how to submit an adjustment, please contact the EDS Provider Relations Consultant in your area or EDS Provider Services at (800) 685-3757.

Institutional Providers

The following tips apply to institutional providers such as hospitals, hospice, home health, and long term care:

- If you are billing for a Rev code that does not require a corresponding CPT code (for example 270, 420, 430, etc.),
 you must combine all services for that code on one line using multiple units. Breaking these charges into separate
 lines will cause them to be denied as duplicate billings. See the Provider Handbook for a list of Revenue codes
 that require CPT codes.
- ASC services are payable once per operating session. When billing procedure 41899 "UNLISTED PROC,
 DENTOALVEOLAR", this code can only be billed one time per claim. Billing multiple lines will cause denied lines
 and delays in your payment.
- If you submit the same batch of electronic claims multiple times in a day, immediately contact the EDS EDI
 department at (800) 685-3757 to prevent the claims from processing the second time. Processing the batch a
 second time will result in all the claims suspending as duplicate claims. This increases the inventory of suspended
 claims and slows processing time for all claims.
- When a specific detail on a claim is denied, your claim will process faster if you rebill only the DENIED detail
 whenever possible. Resubmitting the entire claim will cause delays in your payment. Another option is to use the
 most efficient process, which is to void the entire claim using an electronic void and claim replacement. This can
 be done regardless of whether the original claim was paper or electronic.

Documentation and Attachments

Ninety-nine percent of all Medicaid claims do not require any attachments, yet EDS receives claims with many unnecessary attachments. When no attachment is needed, electronic billing is the fastest and most efficient way of getting the claim processed. Average processing time for paper claims is a little over 5 days; average processing time for electronic claims is two hours.

The following chart includes the majority of instances when attachments are required. If a service is not on this chart, it likely 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. Since most hospital claims are prior authorized, there is no need to send attachments with these claims to EDS unless they are on the following chart.

Billing Situation	Required Attachment
Modifier 21, 22, and 23	Chart and/or Op report
Modifier 50 and 51 if Medicaid payment is over \$1,000	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.

Providers can save themselves copying costs, postage, and time by only sending attachments when they are specifically required. When documentation is required with a paper claim, please follow these guidelines:

- With multiple claims using the same attachment, make a copy of the attachment and include one copy with each claim.
- With an attachment printed on both sides of the page, make a copy of the back side and include both pages with the claim. Our scanning process only scans one side of a page.
- With an attachment on a small piece of paper, copy it or tape it to an 8½" x 11" piece of paper.
- When submitting several claims together, stack the claims with the required attachments one on top of the other;
 claim, attachment(s); claim, attachment(s). Do not use paper clips, staples, self-sticking notes, or glue.

See the Idaho Medicaid Provider Handbook for more complete information on attachments.

EDS Welcomes a New Team Member

In late October, EDS welcomed Lisa Trujillo-Dunn as their new Provider Services Manager. Lisa has over 10 years of experience in the government healthcare sector. With more than six years of experience with the State of California Department of Health Services and three years of experience with the EDS Healthy Families (SCHIP) and the Medi-Cal account in California, Lisa has a great deal of experience working with the Medicaid provider community.

For the Idaho Title XIX account, Lisa will oversee Provider Services, which includes Provider Enrollment, Regional Provider Relations Consultants (PRCs), Provider Correspondence, and Provider Service Representatives (PSRs). For provider billing questions, call the Medicaid Automated Voice Information System (MAVIS) at (800) 685-3757, or locally at (208) 383-4310. Remember, MAVIS is available 24 hours a day, seven days a week.

Un-stick Your Paper Claims

Thousands of paper claims are received every day, making an automatic envelope opener an indispensable office machine at EDS. This handy appliance works by shaking the batches of mail to settle the contents into the bottom of the envelopes. Then, the very top of each envelope is sliced off so the documents can be removed by hand as they are unfolded, unstapled, unclipped, repaired if torn, batched, and readied for scanning.

When sending paper claims, please be careful that the glue on the envelope flap does not stick directly onto the claim documents. When claims are stuck to the envelope, they can be torn when removed, or they may be sliced in the automatic envelope opener machine when the contents don't settle to the bottom and out of the way of the slicing blade.

Over-stuffed envelopes are also at risk for being stuck to the glue on the flap. Another risk is that the envelope can pull open and disclose protected health information (PHI) before it reaches its destination at EDS. Remember that HIPAA regulations governing the protection of health information strictly enforce how the information should be safeguarded against unauthorized disclosure. Please do not overstuff envelopes.

You can help us process your claims quickly by not sticking or stapling the claim to the envelope. In fact, all staples must be removed before scanning, so please do not use them at all. Claims should be sent flat in a large envelope with any required supporting documents behind each claim form.

To avoid the paper hassle altogether, remember that electronic billing is the fastest and most efficient way to get your claim processed when paper attachments are not necessary.

More Tips for Billing Medicare Crossover Claims

Remember that you can bill all Medicare Crossover claims electronically. It is no longer necessary to bill on paper with the Medicare Remittance Notice (MRN) attached. Information, such as what was applied to the Medicare payment and any adjustments that are on the Medicare Remittance Notice (MRN), can be entered in software (such as PES) that supports this submission. Electronic billing is faster and more efficient than billing on paper.

Additionally, please remember that if the claims are crossed over electronically from Medicare to Medicaid, it is not necessary to also submit those claims on paper. EDS has seen a substantial increase of duplicate billings for institutional crossover claims that have been sent electronically to Medicare and then are also automatically generated and submitted on paper. The result is a delay in payment. See the article titled "For Faster Claims Processing Avoid Billing Duplicate Claims" on Page 9 for more information regarding how duplicate billing delays payment and tips to avoid duplicate billing.

EDS P.O. Box 23 Boise, Idaho 83707

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December Office Closures

Monday, December 25, 2006, the Department of Health and Welfare and EDS offices will be closed for Christmas.

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

MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

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