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State of Idaho

MedicAide

An informational newsletter for Idaho Medicaid Providers

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

August 2008

The NPI is Here. The NPI is Now. Are You Using It?

Center for Medicaid and Medicare Services (CMS) Release June 11, 2008

In an effort to ensure that the data submitted to the National Plan and Provider Enumeration System (NPPES) for organization health care providers is accurate, CMS initiated an NPPES-IRS data match to ensure that the legal business name (LBN) and employer identification number (EIN) in NPPES are consistent with IRS data.

This week, CMS will mail out letters to organization health care providers that have an EIN/LBN combination in NPPES that are different from the information maintained by the IRS. These letters request that the health care providers review and update their LBN and/or EIN in NPPES.

If health care providers can not furnish data that are consistent with the IRS, CMS will deactivate the National Provider Identifier (NPI) in NPPES. CMS will continue to match the health care provider data in NPPES against IRS data to ensure the accuracy of NPPES data.

How Is Your Cash Flow? Are Submitted Claims Missing From Your Weekly Paper Remittance Advice (RA)?

Tracking each of your claims from submission to final adjudication is the only way to ensure no disruption in your cash flow. The following information is designed to help providers reduce or eliminate NPI claim errors and payment interruptions.

Why should you reconcile your weekly paper RA against the electronic claims you submitted?

Electronic claims submitted with an **NPI only** that cannot be linked to a unique Idaho Medicaid provider number will not be found on your paper RA. When a unique Medicaid provider number is not found using the submitted NPI, the provider information needed to process the claim and notify the provider of the claim failure can't be found. This is called a black-hole claim.

How can you reconcile your paper RA against the claims that you submitted?

1. Track your claim submissions through the acceptance reports from your clearinghouse, or if you use provider electronic solutions software, from the acceptance report you request after your claims submission.
2. Match the claims submitted to paid, denied, and pended claims on your paper RA.

Note: Pended claims are only shown on the paper RA if you requested that option at enrollment.

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If you find missing claims during your claim reconciliation or your RA indicates a claim denial for Explanation of Benefit codes 049, 050, 051, 052, 053, 054, 055, or 056, follow the steps listed on the Idaho Medicaid NPI Web page. You can find the Web page at: <https://npi.dhw.idaho.gov> by clicking on the *NPI Registration Instructions* link on the left side of the page. If, after implementing the changes suggested on the Web page you are still unable to successfully submit claims, please email the details of your situation to: NPIHD@dhw.idaho.gov. An NPI specialist will work with you to resolve the claim problems.

Still not sure what an NPI is and how you can get it, share it, and use it? More information on the NPI can be found on the CMS Web site, CMS NPI page at: <http://www.cms.hhs.gov/NationalProvidentStand>. Providers can apply for a new or additional NPI online at: <https://nppes.cms.hhs.gov/>, or call the NPI enumerator at: (800) 465-3203, to request a paper application.

Healthy Connections (HC) Referral Numbers on Electronic Claims

Beginning May 27, 2008, HC referral numbers must be sent in the 2300 loop of the 837 electronic claim transactions. Some providers have been unable to submit claims to Idaho Medicaid because the HC referral number was not moved to the 2300 loop in their electronic claim data.

For complete information about submitting HC referral numbers in electronic claims, please review the updated vendor specifications documents posted on the NPI application Web page at: <https://npi.dhw.idaho.gov>. Click the *NPI Registration Instructions* link on the left side of the page; you will be taken to the Idaho Medicaid NPI Web page. The link for the *Vendor Specifications* documents is on the right side of the page near the bottom of the list.

Providers Who Submit Crossover Claims

Are you getting the 051 Explanation of Benefit (EOB) code on crossover transactions? If you submit crossover claims to Medicare with a NPI that is linked to multiple Idaho Medicaid provider numbers, you may have seen this denial code. This problem is most common for providers who submit both durable medical equipment (DME) and pharmacy claims under the same NPI with Medicare, but it can affect any provider who submits claims to Medicare with a NPI that is linked to multiple Idaho Medicaid numbers.

Idaho Medicaid recommends you submit the appropriate taxonomy code on the pharmacy and DME crossover claims you submit. However, it has come to our attention that the taxonomy code sent at the billing level (Loop 2000A) of the claim may not be passed along by your clearinghouse or by the Medicare Coordination of Benefits (COBC) contractor.

If you are unable to submit the appropriate taxonomy code, or your clearinghouse or the Medicare COBC will not transmit the billing level taxonomy code on your crossover claims, you also have the following options:

- Apply for an additional NPI for each provider type. (e.g. One NPI for pharmacy crossover claims and a different NPI for DME crossover claims.)
- Resubmit the claim to Idaho Medicaid using provider enrollment software.
- Resubmit the claim to Idaho Medicaid on paper.

In some cases, reclassifying existing Idaho Medicaid provider numbers or adding new ones may eliminate the situation. To explore this possibility, please email the details of your situation to: NPIHD@dhw.idaho.gov.

Providers must decide which option is best for them. For questions about these denials or assistance with taxonomy codes and where they are placed in the claim data, please call your provider relations consultant (PRC). Phone numbers for PRCs are listed in the sidebar on page 5.

DHW Contact Information

◆ **DHW Web site**
www.healthandwelfare.idaho.gov

◆ **Idaho Careline**
2-1-1
Toll free: (800) 926-2588

◆ **Medicaid Fraud and Program Integrity Unit**
PO Box 83720
Boise, ID 83720-0036
Fax: (208) 334-2026
prvfraud@dhw.idaho.gov

Healthy Connections Regional Health Resources Coordinators

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

◆ **Region II - Lewiston**
(208) 799-5088
(800) 799-5088

◆ **Region III - Caldwell**
(208) 642-7006
(800) 494-4133

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

◆ **Region V - Twin Falls**
(208) 736-4793
(800) 897-4929

◆ **Region VI - Pocatello**
(208) 235-2927
(800) 284-7857

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

◆ **In Spanish (en Español)**
(800) 378-3385

Prior Authorization Contact Information

◆ **DME Specialist, Medical Care**
PO Box 83720
Boise, ID 83720-0036
Phone: (866) 205-7403
Fax: (800) 352-6044
(Attn: DME Specialist)

◆ **Pharmacy**
PO Box 83720
Boise, ID 83720-0036
Phone: (866) 827-9967
(208) 364-1829
Fax: (208) 364-1864

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

www.qualishealth.org/idaho
medicaid.htm

Transportation

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

◆ **Other Non-emergent and Out-of-State**
Phone: (800) 296-0509, #1173
(208) 287-1173
Fax: (800) 296-0513
(208) 334-4979

◆ **Ambulance Review**
Phone: (800) 362-7648
(208) 287-1157
Fax: (800) 359-2236
(208) 334-5242

Insurance Verification

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

All Providers:

Are You Getting the 009 Explanation of Benefits (EOB) Code on Transactions?

Some providers are getting a 009 EOB denial code (Attending provider is missing/not on file) at the detail level of their claims. Here is some important information to help providers correct and resubmit their claims.

1. Verify the NPI submitted in the detail line is registered with Idaho Medicaid.
2. If the NPI is not registered and linked to an Idaho Medicaid provider number, arrange with the provider to get their NPI registered with Idaho Medicaid. The NPI registration is not valid until the next day.
3. Resubmit the claim once the registered NPI has been on file with Idaho Medicaid for at least 24 hours.

NPIs must be registered online at: <https://npi.dhw.idaho.gov/>. Your local public relations consultant (PRC) can help you with the registration process. Phone numbers for the PRCs are listed in the sidebar on page 5.

You can also email your questions to: NPIHD@dhw.idaho.gov. An NPI specialist will work with you to resolve the claim problems.

Paper Claims:

Do Not Require National Provider Identifier (NPI)

Your NPI is for electronic claims processing. However, paper claims require a valid Idaho provider identification number for processing. You can put your NPI on the paper claim, but it is not required. Paper claims are processed using only your provider identification number.

Please make sure your provider identification number is in the correct field of the paper claim form and is legible for scanning. Remember, a computer will read the claim data so legibility and alignment within the field is very important.

The paper CMS-1500 claim form requires a qualifier: **1D** (one-D), to be placed in front of your 9-digit Idaho Medicaid provider identification number in field **33b** (for example: **1D012345678**). It should be legible and aligned within the field. **Claims submitted with only an NPI in field 33 cannot be processed and will be returned to you.**

The **1D** qualifier should be entered into field **24I** when a rendering provider's Idaho Medicaid provider identification number is listed in the pink shaded area of field **24J**. When a rendering provider's identification number is required, the **1D** qualifier and the 9-digit Idaho Medicaid provider identification number is required. The NPI number is not used to process paper claim forms. **Claims submitted with only an NPI in field 24J will be denied.**

You will find specific instructions for filling out claim forms at the end of Section 3 in your *Medicaid Provider Handbook*.

Paper claims **require** a valid Medicaid provider number for processing. Paper claims submitted with an NPI number only in field **33** cannot be processed and will be returned to providers for correction. CMS-1500 claim forms require the **1D (one-D)** qualifier preceding the Idaho Medicaid provider number in field **33b**. The **1D** qualifier should be entered into field **24I** when a rendering provider's Idaho Medicaid provider identification number is listed in the pink shaded area of field **24J**. Claims submitted with **only** an NPI in field **24J** will be denied. Detailed instructions for paper claims are listed at the end of Section 3 in your *Medicaid Provider Handbook*.

Medicaid Information Release #MA08-15

To: Providers of 24-Hour Homes for Children
From: Leslie M. Clement, Administrator
 Division of Medicaid
Subject: Medicaid Provider Numbers for 24-Hour Homes for Children

Effective immediately, each 24-hour home for children will have one Medicaid provider number regardless of the number of service providers in the home. Only one 24-hour home for children provider number can be used to bill for personal care services for participants.

Providers of 24-hour homes for children who currently have multiple Medicaid provider numbers for personal care services must notify Regional Medicaid Services (RMS) in writing, to let them know which provider number they will keep. One Medicaid provider number for each 24-hour home for children must be selected by August 15, 2008. If a number is not selected, all Medicaid provider numbers associated with the 24-hour home for children will be inactivated.

If you have questions regarding this information, please contact the Alternative Care Coordinator in the Division of Medicaid's Bureau of Long-Term Care at: (208) 287-1156.

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

MEDICAID INFORMATION RELEASE #MA08-16

To: Home Health Providers
From: Leslie M. Clement, Administrator
Subject: Home Health Medicaid Caps

This information release summarizes Medicaid cap limits for all home health agency cost settlements, with effective dates of service from July 1, 2008 through June 30, 2009. The table listed below summarizes the Medicaid caps. (See *IDAPA 16.03.09.720 – IDAPA 16.03.09.725* for more information.)

	Revenue Code	Medicaid Cap Limits	Medicaid Cap Limits
		7/1/07-6/30/08	7/1/08-6/30/09
Skilled Nursing	551	\$209.88	\$217.90
Physical Therapy	421	\$134.61	\$139.32
Occupational Therapy	431	\$136.65	\$146.94
Speech Therapy	441	\$165.69 (6/1/08-6/30/08)	\$191.95
Home Health Aide	571	\$127.81	\$91.99

If you have any questions pertaining to the information found in this information release, please contact the Principal Financial Specialist, Office of Reimbursement, Division of Medicaid at: (208) 364-1817. Thank you for your continued participation in the Idaho Medicaid Program.

LMC/sp

EDS Contact Information

- ◆ **MAVIS**
Phone: (800) 685-3757
(208) 383-4310
- ◆ **EDS Correspondence**
PO Box 23
Boise, ID 83707
- ◆ **Medicaid Claims**
PO Box 23
Boise, ID 83707
- ◆ **PCS & ResHab Claims**
PO Box 83755
Boise, ID 83707
- EDS Fax Numbers**
- ◆ **Provider Enrollment**
(208) 395-2198
- ◆ **Provider Services**
(208) 395-2072
- ◆ **Participant Assistance Line**
Toll free: (888) 239-8463

**Provider Relations
Consultant Contact
Information**

◆ **Region 1**
Prudie Teal
1120 Ironwood Dr., Suite 102
Coeur d'Alene, ID 83814
Phone: (208) 666-6859
(866) 899-2512
Fax: (208) 666-6856
EDSPRC-Region1@eds.com

◆ **Region 2**
Darlene Wilkinson
1118 F Street
PO Drawer B
Lewiston, ID 83501
Phone: (208) 799-4350
Fax: (208) 799-5167
EDSPRC-Region2@eds.com

◆ **Region 3**
Mary Jeffries
3402 Franklin
Caldwell, ID 83605
Phone: (208) 455-7162
Fax: (208) 454-7625
EDSPRC-Region3@eds.com

◆ **Region 4**
Angela Applegate
1720 Westgate Drive, # A
Boise, ID 83704
Phone: (208) 334-0842
Fax: (208) 334-0953
EDSPRC-Region4@eds.com

◆ **Region 5**
TBD
601 Poleline, Suite 3
Twin Falls, ID 83303
Phone: (208) 736-2143
Fax: (208) 678-1263
EDSPRC-Region5@eds.com

◆ **Region 6**
Abbey Durfee
1070 Hilline Road
Pocatello, ID 83201
Phone: (208) 239-6268
Fax: (208) 239-6269
EDSPRC-Region6@eds.com

◆ **Region 7**
Ellen Kiester
150 Shoup Avenue
Idaho Falls, ID 83402
Phone: (208) 528-5728
Fax: (208) 528-5756
EDSPRC-Region7@eds.com

June 30, 2008

MEDICAID INFORMATION RELEASE MA08-17

To: Providers of School-Based Services, Developmental Disabilities Agencies, Mental Health Clinics, and Psychosocial Rehabilitation Agencies
From: Leslie M. Clement, Administrator
Subject: Changes to Medicaid Coverage and Reimbursement

Starting with date of service June 1, 2008, speech therapy, occupational therapy, and physical therapy evaluations must be billed at no more than one unit for each evaluation and will be reimbursed at the following rates:

Service	CPT or HCPCS Code	Description	New Rate
Speech and Language Evaluation	92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status – one unit for each evaluation	\$131.28
Physical Therapy Evaluation	97001	Physical Therapy Evaluation – one unit for each evaluation	\$64.68
Occupational Therapy Evaluation	97003	Occupational Therapy Evaluation – one unit for each evaluation	\$68.87

If you have any questions regarding this information, please contact the Office of Reimbursement in the Division of Medicaid at: (208) 364-1994.

You can access this Information Release and additional rate changes on the Department of Health and Welfare's Web site at: <http://www.healthandwelfare.idaho.gov>.

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

Idaho Medicaid Provider Handbook

This information release replaces information to the following sections of your *Medicaid Provider Handbook* dated July 2008: "Rehabilitative and Health Related Services Guidelines: 3.2.12.1, Evaluation Services".

Medicaid Management Information System Transition

Idaho Medicaid will be transitioning to a new system at the end of 2009. Many new features will be available to you. One exciting new feature is the Web portal.

The portal will allow you to:

- Submit claims using the Web.
- Submit and retrieve Healthy Connections referrals.
- Submit prior authorization requests.
- Check on the status of current prior authorizations for your members.
- Download your Remittance Advice directly from the portal.
- Inquire about submitted claims.

This is just a preview of the new system features. Each month, we will provide you with additional information on what the new system will do for you. Keep watching the newsletter for more information on the transition to the new system. If you need additional information please contact Cindy Day at: dayc@dhw.idaho.gov.

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

EDS provider relations consultants (PRCs) continue to offer a series of provider workshops. Each consultant conducts a two hour regional workshop every two months to help providers in their region.

The topics include:

- Learn more about National Provider Identifier (NPI)
- General Medicaid Billing
- Provider Resources
- Using PES Software
- CMS-1500

The next workshop is scheduled for all regions Tuesday, September 9 from 2 to 4 p.m. These training sessions are provided at no cost to providers, but space is limited so please pre-register with your local PRC. Phone numbers for the PRCs are listed in the sidebar on page 5.

Vision Providers: Two Index Lens Codes will be Covered

Starting July 1, 2008, two Index lens codes will be covered. Prior authorization is required from the Medical Care Unit. Please indicate if you are requesting glass or plastic index lenses.

HCPCS Code	Description	Idaho Medicaid Criteria
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens	Covered when the participant has a 4.00 diopter reading or higher
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens	Covered when the participant has a 10.00 diopter reading or higher

“Roll Down Effect”:

Medicaid Claims that have Other Insurance Payments

When Medicaid claims that have other insurance payments are processed, Medicaid applies those other insurance payments by “rolling down” the payment.

For example, if Blue Cross insurance paid \$5.00 for a particular claim detail line, it is assumed that \$5.00 will be processed for that specific line item. This is not true. The way EDS processes other insurance payments, whether the payment comes from Medicare or any other insurance, is by what is called the “roll down effect.”

Medicaid deducts any insurance payments from the **total** Medicaid allowed amount for the entire claim. This is not figured on each detail, line-per-line as the insurance company allowed. The insurance payment is deducted from the first payable Medicaid service detail line and carried down to the next consecutive detail line until all the insurance payment is used. This is Medicaid policy. Hopefully, this will provide a clear explanation of how Medicaid processes other insurance payments.

If you have questions, please call MAVIS at: (800) 685-3757. If you would like to speak with a provider service representative when you call, ask for an agent.

Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

Due to a recent change in the criteria for modifier 58, the Idaho Department of Health and Welfare (IDHW) has determined that procedures billed with this modifier are to be paid at 100 percent of the rate on file instead of the previous payment of 80 percent of the rate on file. This change went into effect on 01/01/2008. Providers that submitted claims on or after 01/01/2008 can submit adjustment requests for 100 percent of the rate on file for the associated procedure code.

Note: Providers often want to know why and how the modifier is used for hospital outpatient reporting. The reference to the postoperative period in the definition of modifier 58 does not have strict relevance in hospital outpatient reporting. However, the individual circumstance depicted by modifier 58 has tracking relevance to Medicaid.

Because hospital outpatient reporting represents services performed within a given 24-hour period, or a range of dates, the original intent and use of modifier 58 is not altered for hospital outpatient reporting. The use of modifier 58 indicates that the reported procedure is related to the original procedure, intended to be performed sometime in the future as a staged procedure, and may represent:

- A procedure performed by the original surgeon or provider.
- A follow-up surgery more extensive than the original procedure.
- A therapy following a diagnostic surgical procedure.
- The time frame for the performance of the staged procedure. This may occur during the postoperative period (i.e., global surgical period) associated with the original surgery.

Using modifier 58 enables Medicaid to appropriately pay for the procedure and other associated postoperative services performed within or subsequent to the procedure's assigned global surgical period.

The intent and use of modifier 58 precludes its use to report the treatment of a problem that requires a return to the operating room. For more information on global billing, refer to IR MA04-55 (POLICY FOR BILLING THE COMPONENTS OF THE GLOBAL SU).

Are You Prepared for the Payment Error Rate (PERM) Audit? The state of Idaho will be participating in the PERM audit starting in October 2008

What is PERM?

PERM measures improper claim payments in Medicaid and the State Children's Health Insurance Program (SCHIP) and produces state and national-level error rates for each program. The error rates are based on reviews of Medicaid and SCHIP fee-for-service claims made in the federal fiscal year (FY) under review.

Why is PERM required?

PERM was developed by the Centers for Medicare and Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA). The IPIA requires the heads of federal agencies, including the Department of Health and Human Services to:

- Annually review programs it administers and identify programs that may be susceptible to significant improper payments.

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- Estimate the amount of improper payments.
- Submit those estimates to Congress.
- Submit a report on actions the agency is taking to reduce the improper payments.

How will the PERM audit take place?

Three federal contractors will conduct a review of the Medicaid and SCHIP fee-for-service claims and managed care claims. Responsibilities are broken out in the following manner:

- Statistical Contractor (SC) – Responsible for selection of claims sample and conducting the calculation of the claim error rates.
- Documentation/Database Contractor (DDC) – Responsible for the collecting medical policies, medical records, and tracking.
- Review Contractor (RC) – Responsible for conducting the medical reviews and claim adjudication reviews.

What is the responsibility of the Idaho Medicaid provider?

The RC will conduct reviews of selected Medicaid and SCHIP claims to determine if the claims were paid correctly. If a claim is selected in the sample for a service that you, the provider, rendered to either a Medicaid or SCHIP participant, the DDC will contact you directly for a copy of your medical records to support the medical review of the claim.

After receiving the request for medical records, the provider must submit the information within 60 days. The DDC and/or state staff will follow up with the provider at regular intervals to ensure that requested information is submitted before the due date.

Remember, keep your provider address and contact information current in the Medicaid Management Information System so the record requests are received timely. Send new address and contact information to EDS, attention provider enrollment. Past studies have shown that the most frequent errors found during the medical review are due to insufficient documentation or no documentation at all. The Department of Health and Welfare, Division of Medicaid, therefore requests that providers submit their medical documentation before the 60-day timeline. Lack of documentation is an easily preventable error!

Any documentation requested from providers that is not received by the DDC is considered an error against a state's Medicaid or SCHIP Program. The DDC timeline will not be extended and the state will be required to reimburse CMS the federal financial participation for that claim. This could result in the state recovering that amount from the provider.

What about the Health Insurance Portability and Accountability Act (HIPAA) regulations?

Providers should submit documentation using the methods described by the DDC. Understandably, providers are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided and furnish CMS with information regarding any payments claimed by the provider for those services.

The collection and review of protected health information (PHI) contained in individual-level medical records for payment review purposes is permissible by both HIPAA and the implementing regulations at *45 Code of Federal Regulations, parts 160 and 164*.

We will have more information to share with the Medicaid provider community in future Medic/Aide newsletters. We encourage you to read the commentary, as we will have regular provider updates to help you prepare for your upcoming role in the PERM audit.

More information is available on the CMS Web site at: <http://www.cms.hhs.gov/PERM/>.

Attention All Providers ...

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

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

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

Billing For All Psychotherapy Service Providers

Effective September 1, 2008, the family psychotherapy service code listed below should be billed with modifier UA-Professional Mental Health, if performed by a physician.

90846 – Family psychotherapy (without the patient present)

Submitting Paper Medicare Crossover Claims

Each paper Medicare crossover claim must be submitted with a Medicare Remittance Notice (MRN) attached. The MRN must clearly state what was applied to the Medicare payment and any adjustments made to the claim. MRN forms that don't have any wording on them to identify that the insurance carrier is Medicare are being submitted.



If the MRN doesn't clearly identify that it is a Medicare document, please write *Medicare Crossover* on the top right margin of the claim, or the MRN, to ensure that your claim is batched as a Medicare crossover and processed correctly. This information is located in the *Medicaid Provider Handbook, Section 2.5, Crossover Claims*. Claims that aren't clearly identified on the top of the claim form, or the MRN, might be denied or incorrectly processed.

You can bill Medicare crossover claims electronically with the *Provider Electronic Solution (PES)* software. Electronic billing is faster and more efficient than billing on paper. To request PES software and training at no cost, call the EDI Helpdesk in the Boise area at: (208) 383-4310, or toll-free at: (800) 685-3757 and say *technical support*. The EDI Helpdesk is available from 8 a.m. to 6 p.m. MT.

Billing Instructions For Physician Codes

Reimbursement rates for physician services were changed retroactively effective July 1, 2008. Idaho Medicaid will perform mass adjustments to claims with dates of service after July 1, 2008. However, mass adjustments will pay at the higher rate only if the claim was originally billed with your usual and customary charge.

If any of your claims were not paid at the new rate on file because your original billed amount was less than the new rate on file, you need to void the original claim and resubmit it at the higher amount.

Top Reason Paper Claims are Returned Without Processing

When paper claims arrive at EDS, the document control team looks at each claim to validate that it contains the basic information needed for processing. The single most common reason claims are returned to the provider without processing is the provider identification number or qualifier 1D (one-D) is missing from field 33b on the CMS-1500 form.

Each paper claim must have the Idaho Medicaid provider identification number on the claim for it to be processed, and to ensure that any payment is sent to the correct provider. This is not the National Provider Identifier (NPI) number that is used for electronic claims processing.

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

Billing Provider Information Fields

33. BILLING PROVIDER INFO & PH# ()	
a.	b. 1D123456789

Tips for Mailing Paper Claims More Efficiently

Paper claims arrive at EDS at a rate of about 18,000 a week. They are opened with a machine that slices the edge from the envelope. Mailroom workers manually extract the claims and attachments from the envelopes and prepare them for electronic scanning.

For the most efficient handling, please follow these instructions:

- When sending claims with attachments, place the attachments behind the corresponding claim form and stack them so that there is a claim and its attachments, then another claim and its attachments, etc. placed in a pile.
- Do not use staples or paper clips, they must be removed for scanning.
- Do not fold the claim form. Folded claims can be torn or mutilated in the mail opening process.
- Use a large flat envelope (9" X 12" or larger) to send claims.
- Do not overstuff the envelope.
- If correspondence is included with the claims, place it on the top of the claims and write *Correspondence Enclosed* on the envelope, so it will be handled appropriately.
- Send claims to the following address:

EDS
PO Box 23
Boise, ID 83707

Provider's Billing Options: Private Pay Patients Who Later Become Medicaid Participants

The purpose of this article is to clarify the provider's billing options. Several questions have come up regarding to what extent providers can continue to bill patients who, at the time the service was provided were private pay, but later were determined eligible for Medicaid for this same time period. The following guidelines are being provided to help determine when billing Medicaid participants is appropriate.

Situation	Provider Option(s)
A patient presents for Medicaid covered service and is not Medicaid eligible. Provider agrees to provide service and patient agrees to pay privately. Patient never becomes Medicaid eligible.	Provider is encouraged to have the patient sign an agreement to pay privately. Provider is encouraged to bill Medicaid if there is any possibility of the patient eventually receiving Medicaid eligibility. Billing before eligibility is determined guarantees the claim will always be timely for future submissions. Provider can bill patient privately.
Same as above, except that patient eventually becomes Medicaid eligible for the period in which the above service was provided. Provider is never informed of Medicaid eligibility (by participant or otherwise).	Provider can bill participant privately.
Same as above, except that provider becomes aware of Medicaid eligibility (either through the participant or other means). Provider has not yet billed Medicaid.	Provider can continue to bill participant, or can bill Medicaid, but cannot do both. If the provider chooses to bill Medicaid, the provider must accept Medicaid payment as payment in full and is subject to the one year claim timely filing requirement (see <i>Information Release MA04-59</i>). Once the provider submits a Medicaid claim, the participant can no longer be billed. Providers are encouraged to always bill Medicaid within one year from the date of service if they think their patient will eventually become Medicaid eligible.
Same as above, except that provider becomes aware of Medicaid eligibility (either through the participant or other means). Provider billed Medicaid within the one year timely filing requirement.	Provider can no longer bill the participant and can rebill Medicaid. Must accept Medicaid payment as payment in full.

Note: The participant may be liable for the cost of any service that is beyond the scope of Medicaid coverage. When this is the case, the provider must inform the participant before performing the service and is encouraged to have the participant agree in writing to accept responsibility for payment of services not covered by Medicaid.

If the participant has made payments for services that eventually would have been covered by Medicaid and the provider then chooses to bill Medicaid, Medicaid will consider the billing to be fraudulent unless the provider first returns all payments made by the participant for the service.

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