MedicAide

An informational newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid July 2010

In This Issue

Information Releases

Provider Handbooks Updated

The Provider Handbooks are updated and available on the www.idmedicaid.com Web site. Click on the **Provider Handbook** link in the left navigation pane.

Updates were made to the following sections:

- **General Information**
- **General Billing Instructions**
- **Claim Form Instructions**
  - CMS 1500/Professional
  - UB04/Institutional
  - Dental

Most of the changes were to clarify the content, so please review the Section Modifications at the beginning of the documents. To go directly to the Provider Handbook, click here.

The handbook is set up in the following structure.

Document	Description
Directory	Contains contacts, addresses, telephone, and fax numbers used in the handbook.
Provider Type and Specialty Crosswalk	Contains the old provider types and specialties cross-walked to the new provider types and specialties.
General Provider and Member Information	Contains basic information for all provider types
General Billing Instructions	Contains basic billing instructions for all provider types
CMS-1500 Instructions	Contains field-by-field instructions for completing the CMS-1500 form, plus procedure codes, diagnosis codes, place of service codes, and other specialty specific requirements.
UB04 Instructions	Contains field-by-field instructions for completing the UB04 form, plus revenue codes, diagnosis codes, units of service, and other specific requirements.
ADA Dental Instructions	Contains field-by-field instructions for completing the ADA Dental form and other specific requirements.
Provider Type Guidelines Adult Residential Care Agency – Institutional Agency – Professional Allopathic and Osteopathic Physicians Ambulatory Health Care Facility Behavioral Health and Social Service Providers Chiropractic Providers Dental Providers Dietary and Nutritional Service Providers Eye and Vision Services Providers Group of Providers Hospital Laboratory Long Term Care Facility	Contains specific policy information for each provider specialty.

Document	Description
Managed Care Organization Non-Emergent Transportation Providers Nursing and Custodial Care Facility Nursing Services Providers Other Service Providers Physician Assistants & Advanced Practice Nursing Providers Podiatric Medicine and Surgery Service Providers Respiratory, Developmental, Rehab & Restorative Services Speech, Language and Hearing Service Providers Suppliers Technologists, Technicians and Other Tech Service Providers Transportation Services	
Remittance Advice (RA) Analysis	Contains a detailed explanation of the RA
Glossary	Contains acronyms and definitions of words used in the provider handbook

School-Based Services

Overlapping Services

Recent audits of school-based services have revealed instances where Idaho Medicaid was billed for psychosocial rehabilitation (PSR) services, intensive behavioral interventions (IBI) or developmental therapy (DT) at the same time the participant was receiving occupational, physical, or speech-language pathology (SLP) (Therapy Services).

Reimbursement for PSR, IBI, or DT services provided during the time the participant is receiving Therapy Services is not allowed. The PSR, IBI, DT therapist is not delivering a billable service to the participant at the same time the Therapy Services professional / paraprofessional is working with the participant.

As stated in the Medicaid Provider Agreement under the section “Accurate Billing”, “the provider must assure that a duplicate claim under another program or provider type is not submitted.”

The Department will recoup payments made for PSR, IBI, or DT services delivered at the same time participants are receiving OT, PT, or SLP services.

Documentation Requirements

Audits of school-based services have also revealed instances where school districts are not maintaining records in accordance with rules and their provider agreements. IDAPA

16.05.07.101.02 states providers must grant to the Department and its agents immediate access to records for review and copying during normal business hours.

In their Medicaid provider agreements, school districts agree to generate and maintain all records as are necessary to comply with documentation requirements. Such records must be maintained for at least six (6) years after the date of service and must be made available immediately upon request of the Department.

Schools that send records off-site to a billing agency or other location and are unable to comply with requests for immediate access are in violation of IDAPA rule and their provider agreements. Records must be available for immediate access by the Department.

Eastern Idaho Mental Health Clinic Treatment Director Sentenced for Health Care Fraud

On May 17, 2010, B. Lynn Winmill, Chief United States District Judge, sentenced Vanessa Cattanea, 36, of Charleston, West Virginia, to 20 months in prison for multiple counts of health care fraud. Cattanea was also ordered to serve 3 years of supervised release and to pay $1,054,260 in restitution to Medicaid following her release from prison. Co-defendant, Ronald Bret Hamilton, 49, of Pocatello, passed away in March 2010.

Cattanea and Hamilton were convicted in December 2009 by a federal jury in Pocatello, Idaho, on multiple counts of health care fraud. The jury found Hamilton guilty on 55 of 72 counts and Cattanea guilty on 76 of 84 counts.

During the 9-day trial, the jury heard evidence that Hamilton was the owner and Cattanea the treatment director for Teton Family Services, a mental health clinic that offered partial care and other mental health clinic services for children. Teton Family Services operated clinics in Pocatello, Blackfoot, and American Falls.

The evidence showed that Hamilton and Cattanea knowingly and fraudulently billed Medicaid for trips to out of clinic locations such as roller skating rinks, bowling alleys, swimming pools, amusement parks, zoos, campgrounds, Yellowstone National Park, Bear Lake, and locations in Utah. Medicaid does not reimburse providers for mental health clinic services provided outside the clinic. Teton Family Services also billed for services provided by unlicensed/unqualified staff.

The two agencies investigating the case were the US Department of Health and Human Services Office of Inspector General and Idaho Health and Welfare's Medicaid Program Integrity (MPI) Unit.

The MPI Unit is dedicated to pursuing fraud and abuse in the Medicaid program. Providers who bill Medicaid for non-covered services (including services by unqualified staff) or providers who alter, falsify, or destroy records will be referred for possible prosecution.

Timely Filing Documentation

All claim types must be submitted to Idaho Medicaid within 12 months (365 days) from the date of service regardless of the member's eligibility status. There is one exception: which is Medicare crossover claims. To determine if a claim is within 12 months (365 days) from the date of service, use the Julian date of the original claim number. The claim number is also known as the ICN number. See the article titled Claim Number Format on page 10 or refer to the Glossary in the Provider Handbook for more information.

For Medicare claims filed in a timely manner, Medicaid will consider claims for payment if filed within six months of the date of payment or date of the EOMB of the Medicare claim. Attach a copy of the Medicare Remittance Notice (MRN) and submit the claim on paper or electronically if your software supports the transaction. Claims denied by Medicare for timely filing will in turn be denied by Medicaid, as not being timely.

Claims for Idaho Medicaid members who receive retro-eligibility must be submitted within 12 months (365 days) of the date of service regardless of the date their eligibility was added. If the initial claim is submitted electronically without a Member ID or with an invalid Member ID, the claim will be rejected and an EDI transaction rejection code will be generated. If the claim is submitted on paper, the provider will receive a return to provider (RTP) letter.

> ****NOTE**: It is very important to keep this documentation to help support timely filing of the original claim. Once the provider has acquired the Member's ID, they must submit the claim with supporting documentation such as a copy of the member's approval notice, EDI transaction rejection code, or return to provider letter. These claims will then be reviewed for payment.

If the member has a third party insurance carrier, the claim for services must be submitted to Idaho Medicaid within 12 months (365 days) 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 is for Medicare crossover claims. If a Medicare claim is received, Medicaid will consider the claim for payment if it is within six months of the date of the Medicare payment on the Medicare EOMB. For more information see section 2.5 Crossover Claims, for crossover billing.

Idaho Medicaid providers with a retro-active enrollment date must submit claims within 12 months of the date of service regardless of their enrollment date.

Claims for services requiring a prior authorization (PA) from Idaho Medicaid or one of its agents must be submitted within 12 months (365 days) of the date of service regardless of when the PA was issued.

For claims filed initially with HP/EDS in a timely manner, Idaho Medicaid will consider claims for payment if proof of submission is documented. Such proof could be a RTP letter, electronic rejection report or a remittance advice. Submit your paper verification with the paper claim or upload a copy of the verification with your electronic claim.

Adjustments to paid claims must be made within two years after the payment was issued on the original claim. Adjustments can only be made on paid claims or paid claim details. Denied claims or claim details must be resubmitted as a new claim.

Claim Type Description	Submission Rule
Original Claims	Claim must be submitted within 12 months (365 days) of the date of service.
Medicare Crossover Claims; Paid	Claim must be submitted within 6 months of the date of payment or date of the EOB of the Medicare claim. (Attach MRN.) Medicare claims with valid denials are processed as straight claims – not Medicare Crossovers and are subject to the Medicaid 12 month requirement.
Member Retroactive Eligibility	Claim must be submitted within 12 months (365 days) of the date of service regardless of the date the participant's eligibility was added.
Other Insurance	Claim must be submitted within 12 months (365 days) of the date of service regardless of the date of payment or date of the EOB.
Provider Retroactive Eligibility	Claim must be submitted within 12 months (365 days) of the date of service regardless of the enrollment date.
Claims Requiring PA	Claim must be submitted within 12 months (365 days) of the date of service regardless of when the PA was issued.
Claims filed timely with HP/EDS	Idaho Medicaid will consider claims for payment if proof of submission is documented. Such proof could be a RTP letter, electronic rejection report or a remittance advice.
Adjustments to Paid Claims	Claim must be submitted within 2 years after the payment was received.
Denials	Claims should be resubmitted within 12 months (365 days) of the date of service. If more than a year has lapsed since the date of service, indicate original ICN in the remarks field on claim.

Pre-Appeals and Appeals

(June update to Provider Handbook, General Billing Information)

A pre-appeal process is available to providers who want someone to physically review their claim and not have a systematic adjustment or replacement of a claim. To initiate a pre-appeal follow the procedure outlined below.

Fill out the **Claims Review Request** form with the necessary information:

- Original claim ID requiring review
- Provider information
- Member information
- Comments – any explanation needed to help in review
- Attachments – any attachments they feel will help support their request as well as any required documentation not previously submitted (such as timely filing, medical necessity, notes, or reports)

Mail pre-appeal to:

Molina Correspondence Team
P. O. Box 70082
Boise, ID 83707

Molina will review the claim and send a written explanation of the final determination.

To appeal Molina's review or request a review of the reimbursement amount of a particular service, send a written request for appeal to IDHW.

Include the following information with the appeal:

- Copy of Molina review notice
- Copy of claim and all attachments or new claim for possible resubmission
- Copy of RA

Medicaid will review the claim and respond in writing with the final determination.

Mail appeals to:

Administrative Procedures Section
Idaho Department of Health and Welfare
450 West State Street 10th floor
P.O. Box 83720
Boise, ID 83720-0036
Fax: (208) 334-6558

Claim Adjustment Requests

For detailed instructions on submitting claim adjustment requests, please refer to the Provider Handbook, General Billing Instructions, Adjustments. You can find the Handbook at www.idmedicaid.com and click on the Provider Handbook link.

Paper Pharmacy Claims

Paper pharmacy claims, that are not crossovers or J codes billed with an NDC, should be mailed to:

First Health Services Corporation
Idaho Paper Claims Processing Unit
P.O. Box C-85042
Richmond, VA 23261-5042

Do Your Patients Need to Lose or Gain Weight?

The Preventive Health Assistance (PHA) benefit may be able to help pay for a weight management program. PHA provides assistance to Medicaid patients who meet the Centers for Disease Control definition of being obese or underweight.

To qualify for this benefit, Medicaid patients must:

- be over the age of 5
- have a Body Mass Index (BMI) in the obese or underweight range, **and**
- want to improve health through weight management.

If you have a patient you think may qualify, please refer them to the PHA Unit at **1 (877) 364-1843,** or give them a PHA brochure.

If you would like to request a supply of PHA brochures or if you would like more information on PHA benefits, please call the PHA Unit at **1 (877) 364-1843**.

Individual and Group Psychotherapy

(June update to Provider Handbook, CMS 1500 Instructions, D.1.2 Individual and Group Psychotherapy)

The UA Modifier is required when services are provided by a physician.

Mental Health Case Management

(June update to Provider Handbook, CMS 1500 Instructions, B.1.22 Mental Health Case Management)

Crisis service coordination services needed beyond the 3 hour limit with ongoing service coordination hours must be prior authorized by Medicaid. The member must meet the criteria described in Section 3.4.2 Crisis Assistance for Adults with Severe and Persistent Mental Illness.

Extension of Interim Healthy Connections Referral Procedures

Healthy Connections (HC) information continues to be transitioned into the new MMIS system through the month of July. As a result, you may not be able to verify a member's HC Primary Care Provider (PCP) or if a referral has been issued.

For HC members that need to access and receive care in July 2010, referrals will not be required.

Attention PCPs: For referrals you issue with a date span that exceeds July 31, 2010, please document the details of the referral to be entered in the system at a later date. Once your members appear on your online Primary Care Roster, you must start issuing referrals through Health PAS-Online.

For questions, contact the Healthy Connections Consolidated Unit at 1 (888) 528-5861.

Checking Claim Status

Instead of sending claim tracers/inquires, you can check the status of your claim in three ways:

1. Go to https://www.idmedicaid.com, log into your trading partner account, and select Claim Status.
2. Send an electronic claim inquiry transaction (276/277 transaction).
3. Call MACS at 1 (866) 686-4272 and select option 3.

Health PAS-OnLine is Available 24/7

Health PAS-OnLine is the name of the new provider portal at www.idmedicaid.com. It is available 24 hours a day, seven days a week for your convenience.

You are encouraged to use the Health PAS-OnLine Web site for your initial enrollment and ongoing provider account maintenance needs. Before you begin an update to your provider account, review the Provider Maintenance Quick Reference guide to ensure you choose the correct maintenance option. When maintaining your provider account information, make all of your updates at the same time and record the assigned case number. A new case number is generated each time you submit an update to your information in Provider Maintenance.

Additionally, the online system is designed to streamline processes and reduce the time it takes to file and adjudicate claims. Answers to your billing code questions can be found in the Provider Handbook, located on the Web site. Fee schedules are also located on the site via a link to the State's website. Visit www.idmedicaid.com and eliminate wait times!

Where to Send Paper Claims

To ensure accurate processing and faster payment, please mail your claims and supporting documents to Molina at the specific P.O. Box that corresponds to the type of claim. Mail claim forms as follows:

Claims

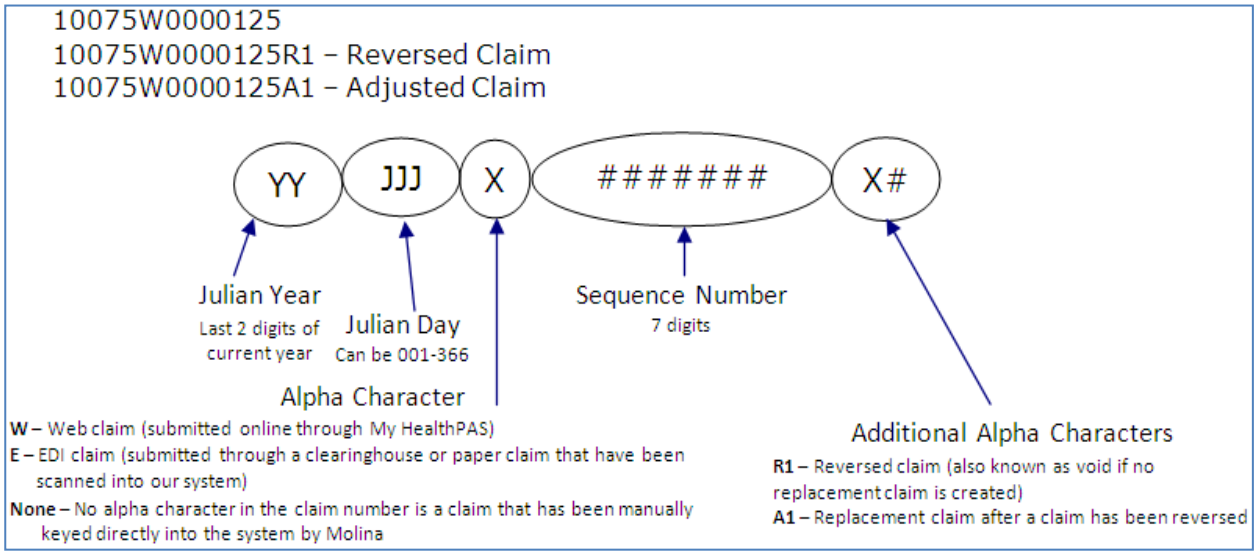
CMS 1500	UB-04	UB-04 Crossover / CMS 1500 Crossover / Third Party Recovery (TPR)	Dental ADA 2006
Molina Medicaid Solutions PO Box 70084 Boise, ID 83707	Molina Medicaid Solutions PO Box 70085 Boise, ID 83707	Molina Medicaid Solutions PO Box 70086 Boise, ID 83707	Molina Medicaid Solutions PO Box 70087 Boise, ID 83707

Non-Claim Correspondence

Member	Provider	Utilization Management / Case Management
Molina Medicaid Solutions PO Box 70081 Boise, ID 83707	Molina Medicaid Solutions PO Box 70082 Boise, ID 83707	Molina Medicaid Solutions PO Box 70083 Boise, ID 83707

Claim Number Format

Claim numbers generated in the new MMIS system will be a 12 or 13-digit alpha numeric number which includes a two-digit year, three-digit Julian date, a single alpha character and seven numbers. A sample is shown in the image below.



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June 10, 2010

MEDICAID INFORMATION RELEASE MA10-07

To: All Medical Providers

From: Leslie M. Clement, Administrator

Subject: Changes to Medicaid's Reimbursement of CPT Codes

Effective for claims with dates of service on or after **July 1, 2010**, Idaho Medicaid will no longer reimburse the following Current Procedural Terminology (CPT) codes:

Office or Other Outpatient Consultations and Inpatient Consultations

99241	99245	99253
99242	99251	99254
99243	99252	99255
99244		

You will need to use the appropriate CPT Evaluation and Management code for the services rendered. Admitting physicians must bill with an AI modifier. Consulting providers must put "Consult" in box 19 on the CMS HCFA 1500 form. If billing electronically, consultants must type "Consult" in the comment field. Failure to bill these procedures appropriately will result in delay or denial of payment for your claims.

The Centers for Medicare and Medicaid Services (CMS) made this policy change official in Transmittal 1875, Change Request 6740, issued December 14, 2009, effective January 1, 2010. You can find Transmittal 1875 on CMS's Web site at www.cms.gov.

You can access this information release and additional rate changes for these codes on the Idaho Department of Health and Welfare's Web site at www.healthandwelfare.idaho.gov.

If you have any questions regarding this information, please contact the Senior Financial Specialist in the Division of Medicaid's Office of Reimbursement at (208) 287-1162.

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

LMC/rs

FAQs: Claims

No.	Question	Answer
1.	**As a transportation provider, how do I bill for mileage?**	Use your trading partner account to enter a professional claim or send in a CMS 1500 with code for mileage and number of miles.
2.	**How do I request a void or replacement/adjustment to a claim?**	You can submit an electronic adjustment using the Health PAS- OnLine Web site or your vendor software. When submitting electronic adjustments, use claim frequency 8 to void a claim, or claim frequency 7 to replace a claim. You can submit a paper adjustment by submitting a completed claim form indicating the original claim number and appropriate claim frequency code. If submitting the adjustment on a CMS 1500 place the appropriate frequency code in box 22 along with the original claim number. A frequency code of 8 indicates you wish to void the original claim. A frequency of 7 indicates you wish to replace the original claim. If submitting the adjustment on a UB-04 claim form, the last digit of the bill type is the frequency code. In Box 4, the bill type must show a 7 or 8 in the frequency position and the original claim number in box 64. See the *Claim Form Instructions* for detailed information. If submitting the adjustment ADA Dental 2006-place a 7 or 8 in box 35 followed by the original claim ID of the claim to be adjusted. For claims submitted through the web site in Form Entry, there is an option for reverse.
3.	**Do we need to include a TPR Carrier ID number on a paper or direct data entry (DDE) claim form?**	No, the TPR Carrier ID number is used for EDI claim submission only.
4.	**What service code should I be billing?**	Many of the codes providers previously billed have not changed. However, to ensure appropriate billing you should refer to the Provider Handbook, Claim Form Instructions appendices for specific coding guidelines for your type and specialty.
5.	**Should I use modifiers with my codes?**	Some CPT codes no longer require modifiers. To ensure you are using modifier appropriately refer to the Provider Handbook Claim Form Instructions appendices for specific coding guidelines for your type and specialty.

No.	Question	Answer
6.	**Why won't the diagnosis code search work?**	In the new system, decimals are required in all diagnosis codes (e.g. V60.4). Try the search with the code including the decimal.
7.	**Are there significant changes to the way we submit EDI healthcare claims today?**	Yes. Changes to the information and placement of that information in the electronic transactions are annotated in the HIPAA X12 companion guides located on the web portal at www.idmedicaid.com under the Companion Guides link. Please visit that location and save a copy for your review. Significant changes include requiring a service location to be submitted on healthcare claims where a service is provided at a location other than the providers billing location, member Medicaid ID should be submitted exactly as it appears on the member's eligibility card, and taxonomy code submission will no longer be required.
8.	**If a rate change is made mid-month, will I have to split the bill to two claims?**	No, you should submit one claim and split the claim detail lines to show the appropriate dates of service for each rate.
9.	**When share of cost (SOC) is changed, how do the claims get adjusted?**	Once you are notified of the change, you must resubmit your claim. If you resubmit on paper you need to include the frequency code 7; indicating a replacement claim. If you resubmit through the web site using the direct data entry (DDE) option you can choose the reverse and resubmit option.
10.	**Are PA numbers required on the claim?**	No, the PA number is not required on the claim itself. The system will look up any PA in the system when one is required to adjudicate the claim. Providers are still required to obtain a PA for services rendered based on Idaho Medicaid rules.
11.	**Where should I send claims?**	Please refer to **Where to Send Paper Claims** in this newsletter on page 9. You can also find this information at www.idmedicaid.com under the Frequently Asked Questions link.
12.	**What if I make a mistake on a paper claim form?**	If you make a mistake on a paper claim form you must complete a new claim form. Claim forms with White Out, correction tape, line out, or any alteration to the claim is not allowed and will be rejected.
13.	**What kind of form do I bill on?**	The services you perform will determine what kind of claim form you will bill on. The **CMS 1500 Professional Form** is used by professional / mid-levels, transportation, waiver service, providers billing CPT or HCPCS codes.

No.	Question	Answer
		The **UB-04 Institutional Form** is used by hospitals, LTC, hospice, and other institutional providers billing revenue codes and corresponding CPT/HCPCS codes when applicable. The **2006 Dental ADA form** is used by all dental provider types and specialties using ADA codes. If you are an Oral Surgeon billing for a medical surgery, please use the CMS 1500 form. For further information on what forms to use go to www.idmedicaid.com. Select the Provider Handbook link, open the *Provider Handbook* folder, open the *Provider Type Guidelines* folder, and search for your specific provider type.
14.	**Do we use the same paper form we used for EDS?**	The new MMIS requires the red and white CMS 1500 and UB04 paper claim forms and will only accept the 2006 Dental ADA paper claim form. Forms must be filled out using black or blue ink and have no highlighting on them. Instructions about completing these claim forms can be found in the Provider Handbook at www.idmedicaid.com.
15.	**What will the claim number look like in the new system?**	The claim number will change with the new MMIS system. It is system generated, formatted as a two digit year, three digit Julian date, and seven numbers with alpha characters. For more detail on the claim numbers, please refer to **Claim Number Format** article found in this newsletter on page 10.
16.	**What does adjudicate mean?**	Adjudication is the process used to review and determine if a claim is complete, payable, and the correct amount of the payment.
17.	**If HP/EDS denied my claim, how do I re-bill it?**	For claims filed initially with HP/EDS in a timely manner, Medicaid will consider claims for payment if proof of submission is to HP/EDS is documented. Such proof could be a Return to Provider (RTP) letter, or a remittance advice. You can submit the original ICN number; however the necessary documentation must also be attached. Include your paper verification with a paper claim or upload a copy of the verification with your electronic claim.
18.	**What number should I use for billing?**	Your NPI, or if you do not have an NPI your Medicaid provider number preceded with an "M" or an "A" as shown on your provider enrollment approval letter.
19.	**Will I have to re-bill all of my claims when there is a rate change?**	No, once we are notified of the quarterly rate change or of a cycle rate change, all affected claims will be found and reprocessed with the new rate.

No.	Question	Answer
20.	**What do I do if I've been notified of a share of cost (SOC) change in the past, during the time when HP/EDS was processing claims?**	Resubmit your claim with the frequency code 7, indicating a replacement claim. We will be adjusting and reconsidering claims that were originally processed through HP/EDS.
21.	**Are referral numbers required on the claims?**	No, they are not. Healthy Connections numbers are no longer used on the claim. **Please note**: Healthy Connections (HC) information continues to be transitioned into the new MMIS system through the month of July. As a result, you may not be able to verify a member's HC Primary Care Provider (PCP) or if a referral has been issued. For HC members that need to access and receive care in July 2010, referrals will not be required. Attention PCPs: For referrals you issue with a date span that exceeds July 31, 2010, please document the details of the referral to be entered in the system at a later date. Once your members appear on your online Primary Care Roster, you must start issuing referrals through Health PAS-OnLine. For questions, contact the Healthy Connections Consolidated Unit at 1 (888) 528-5861.
22.	**What do the different claim statuses mean after I adjudicate a claim on the Web site?**	You may see the following status on a claim: **WARN**: This status is informational only, used for reporting purposes and reminding you of possible changes to policy in a specific situation (i.e. possible duplicate, possible auto accident, possible workmen's comp, etc.) NO ACTION needs to be taken. **PEND**: This status indicates that something needs to be reviewed on this claim or service line by a Claims Resolution Specialist. NO ACTION is required by the provider. Claims with a PEND status are worked by the Claims department and okayed once resolved. **DENY**: This status indicates the claim or service line is being denied. There will be a remit message populated explaining why. **PAY**: This status is indicating the service line is okay to pay.

FAQs: Healthy Connections

No.	Question	Answer
1.	**What is a primary care provider? (PCP)**	A PCP is an individual physician or mid-level who, under agreement with the Healthy Connections Program, manages and provides primary care services for Idaho Medicaid members.
2.	**If I am an individual PCP that is also designated as a PCCM, what information should I consider when completing Provider Record Update?**	• Capitation payment will be made directly to your billing NPI. • Members will be enrolled directly to your individual PCCM and that name will appear on HC notices. • PCCM name will appear in HC Directory on Health PAS-OnLine. • Referrals to be initiated by individual PCP at Health PAS-OnLine. • A rendering provider is required on submitted claims.
3.	**If I am a PCCM Group with a single service location, what information should I consider when completing Provider Record Update?**	• Rendering PCPs must be affiliated to PCCM group in provider record • Capitation payment will be made directly to PCCM group billing NPI • Members will be enrolled to the PCP/PCCM group and that name will appear on HC notices • Each rendering PCP/PCCM group name will appear in HC Directory at Health PAS-OnLine • HC member roster to be mailed monthly or available at Health PAS-OnLine • Referrals to be initiated by HC PCPs within PCCM at Health PAS-OnLine • Services rendered for an enrolled member by any PCP within the group do not require a referral. A referral is required for services rendered by a non HC PCP within your own group. • A rendering provider is required on submitted claims.
4.	**If I am a PCCM Group with multiple service locations and/or provider specialties enrolled under one billing NPI, what information should I consider when completing Provider Record Update?**	• All service locations and/or specialty groups where members will be enrolled must be created as a separate service location in provider record. • Capitation payment will be made directly to PCCM group billing NPI. • Rendering PCPs must be affiliated to each service location or specialty group where they provide care. • Members will be enrolled to a service location or specialty group and that service location will appear on HC notices; for example the PCCM name would appear as ABC Medical State Street or ABC Medical OB/GYN • Each rendering PCP/PCCM service location/specialty group name will appear in HC Directory at Health-PAS-Online • HC member rosters are created for each service location/specialty group and will be mailed monthly or available at Health PAS-OnLine • Referrals can be initiated by HC PCPs within PCCM at any service location/specialty group at Health PAS-OnLine

No.	Question	Answer
		• Services rendered for an enrolled member by any HC PCP within the group do not require a referral. A referral is required for services rendered by a non HC PCP provider within your own group • A rendering provider is required on submitted claims
5.	**If I am a PCCM Group with multiple service locations and/or provider specialties enrolled under separate billing NPIs, what additional information should I consider when completing Provider Record Update?**	• Capitation payments will be made directly to each separate PCCM billing NPI. • For provider entities with PCCMs enrolled with separate NPIs, a referral may be required if members access care at PCCM other than enrolled. To prevent this referral requirement the call coverage option to affiliate all PCCMs must be selected in provider record. • HC member rosters are created for each service location/specialty group for each separate billing NPI and will be mailed monthly or available at Health PAS-OnLine. • When completing Trading Partner agreement to access secure provider portal at Health PAS-OnLine, all separate NPIs must be connected under one agreement. This will allow any PCPs affiliated to provider entity to initiate a referral for members enrolled at any PCCMs affiliated to provider entity.
6.	**If I am a Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) or Indian Health Services (IHS) with one location, what information should I consider when completing Provider Record Update?**	• RHC/FQHC/IHC providers are not required to enroll or affiliate rendering providers in provider record. Enrolling rendering providers in provider record is encouraged for PCP names to appear on Provider Directory at Health PAS-OnLine. • Capitation payment will be made directly to PCCM group billing NPI. • Members will be enrolled to the PCCM group and that name will appear on HC notices. • PCCM group name will appear in HC Directory at Health PAS-OnLine. • HC member roster to be mailed monthly or available at Health PAS-OnLine. • Referrals to be initiated by PCCM clinic at Health PAS-OnLine • A rendering provider is not required on submitted claims. • FOR INTERNAL USE: Due to encounter billing type, Molina provider enrollment will create specific Healthy Connections Service Location for RHC/FQHC/IHS Provider type with single location.

No.	Question	Answer
7.	**If I am an RHC/FQHC or IHS with multiple service locations, what information should I consider when completing Provider Record Update?**	• RHC/FQHC/IHS providers are not required to enroll or affiliate rendering providers in provider record. Enrolling rendering providers in provider record is encouraged for PCP names to appear on Provider Directory at Health PAS-OnLine. • Capitation payment will be made directly to PCCM group billing NPI • All service locations where members will be enrolled must be created in provider record. • Members will be enrolled to a service location and that service location will appear on HC notices; for example the service location would appear as FQHC/Any town, Idaho or RHC/Happy town, Idaho on HC notices. • Each PCCM service location name will appear in HC Directory at Health PAS-OnLine. • HC member rosters are created for each service location and will be mailed monthly or available at Health PAS-OnLine. • Referrals can be initiated for any PCCM service location at Health PAS-OnLine. • A rendering provider is not required on submitted claims.
8.	**What is a PCCM Multi-Disciplinary Organization?**	This is a large organization that owns multiple entities (example – hospitals, clinics) and completes provider record with one NPI.
9.	**If I'm a PCCM Multi-Disciplinary Organization enrolled under one NPI, what information should I consider when completing Provider Record Update?**	• All service locations and/ or specialty groups where members will be enrolled must be created in provider record; for example the PCCM name would appear as ABC Medical State Street or ABC Medical OB/GYN on HC notices. • Capitation payment will be made directly to PCCM group billing NPI. • Rendering PCPs must be affiliated to each service location or specialty group where they provide care. • Members will be enrolled to a service location or specialty group and that service location will appear on HC notices. • Each rendering PCP/PCCM service location/specialty group name will appear in HC Directory at Health PAS-OnLine. • HC member rosters are created for each service location/specialty group and will be mailed monthly or available at Health PAS-OnLine. • Referrals can be initiated by HC PCPs within PCCM at any service location/specialty group at Health PAS-OnLine. • Services rendered for an enrolled member by any HC PCP within the group do not require a referral. A referral is required for services rendered by a non HC PCP provider within your own group. • A rendering provider is required on submitted claims.

No.	Question	Answer
10.	**If I'm a PCCM Multi-Disciplinary Group and I own both RHC/FQHC AND non RHC/FQHC clinics, what additional information should I consider, other than items listed in PCCM Multi-Disciplinary Organization, when completing Provider Record Update?**	For RHC/FQHC/IHS service locations • Not required to enroll or affiliate rending providers. Enrolling rendering providers in provider record is encouraged for PCP names to appear on Provider Directory at Health PAS-OnLine. • PCCM service location name will appear in HC Directory at Health PAS-OnLine. For non-RHC/FQHC/IHS service locations: • Rendering providers must be affiliated to each service location, and rendering provider is required on submitted claims. • Each rendering PCP/PCCM service location will appear in HC Directory on Health PAS-OnLine.
11.	**If I have multiple locations, and chose to enroll members at ONLY one location, how do I complete provider record update, and what impact will this have on Healthy Connections?**	When updating your record, only indicate the PCCM option for the location you wish to enroll members. • HC member roster will be generated listing all enrolled members for the one PCCM location. • Each rendering PCP/PCCM name for the one location will appear in HC Directory at Health PAS-OnLine. • Enrolled members may access care at any of your service locations, with no referral required, if care is rendered by PCP affiliated to PCCM service location.
12.	**Is it important how I name my service location and/or specialty group during provider record update?**	Yes, the name will appear 1. On HC member notices to enrolled members. 2. The HC directory at Health PAS-OnLine. 3. Provided by Medicaid automated customer Service (MACS) for providers verifying eligibility and HC member enrollment.
13.	**Do I bill with a Healthy Connections referral number on my claim?**	No, do not include the HC referral number on your claim as it will cause the claim to fail.
14.	**What if I was already given a referral before the new system went live. Is the old 9-digit healthy Connections number going to work?**	No. The Primary Care Provider will log in as a trading partner, and submit a new referral to generate a system assigned referral number.
15.	**What is a capitation payment for Healthy Connections?**	Each Primary Care Case Management (PCCM) provider receives $3.50 per member per month payment for coordinating the member's health care.

No.	Question	Answer
16.	**I heard that there will be a short time that we are given as a grace period where a Healthy Connections referral will not be required?**	This is correct. The Healthy Connections (HC) information continues to be transitioned into the new MMIS system through the month of July. As a result, you may not be able to verify a member's HC Primary Care Provider (PCP) or if a referral has been issued. For HC members that need to access and receive care in July 2010, referrals will not be required. Attention PCPs: For referrals you issue with a date span that exceeds July 31, 2010, please document the details of the referral to be entered in the system at a later date. Once your members appear on your online Primary Care Roster, you must start issuing referrals through Health PAS-Online. For questions, contact the Healthy Connections Consolidated Unit at 1 (888) 528-5861.

FAQs: Member Benefits, Eligibility, and Records

No.	Question	Answer
1.	**A member has used all 24 chiropractic visits allowed on their benefits and I have been unable to get a prior authorization for additional visits. Can I provide the additional services and bill the member?**	No. The Medicaid member cannot be billed for any services rendered unless you gave them notice, in advance, of the cost of the services and that the services would not be covered by Medicaid. A prior authorization is required for services that exceed a benefit limit.
2.	**Can I look up a member by their MID?**	Yes. You must add three zeros to the front of the member's Medicaid ID (MID) number when searching for the member online or through MACS.
3.	**How do I find out if a member has a specific benefit?**	Include the service code when checking the member's eligibility online.
4.	**How do I verify a member's eligibility status?**	1. Check the member eligibility status using the idmedicaid.com Web site. Instructions are in the *Trading Partner Account (TPA) Check Eligibility* user guide on the Web site. 2. Call the Medicaid Automatic Communications Services (MACS) at 866-686-4272 and choose option 2.
5.	**What information do I need to retrieve eligibility information?**	You need the member's Medicaid ID. If the requester does not have a Medicaid ID, they must supply two of the following three: SSN, DOB, and/or First and Last name.

FAQs: Prior Authorization (PA)

No.	Question	Answer
1.	**Does my claim require a PA (Prior Authorization)?**	Please check the provider handbook to determine whether the service requires a PA. Authorization is still required for all services that have required a PA previously. Currently the PA number should not be included on the claim. If a PA has been approved, the system will automatically fill in the appropriate PA number on each service line.
2.	**I need to request a PA for a service that must be performed right away. Is there a special process I must follow?**	No, the PA request process is the same. You now have more choices in the new system. You can log into the trading partner account to request a PA, send an EDI transaction, or send the PA request to Molina Medicaid Solutions. Contact information is in the *Provider Handbook Directory* on the idmedicaid.com Web site.

FAQs: Provider Enrollment

No.	Question	Answer
1.	**Do pharmacy providers have to enroll with Molina Medicaid Solutions?**	Yes, all pharmacy providers must enroll with Molina Medicaid Solutions through the web site using the new enrollment application or provider record update application.
2.	**How do out-of-state DME providers enter their registration # in the credentialing screen?**	• DME providers with an out-of-state service location address are not required to be registered with the Idaho Board of Pharmacy. Enter "Out-of-state DME" in the registration information field to get past the registration requirement. • Pharmacy providers with a DME or Home Infusion Therapy specialty are required to have a Pharmacy license, and may or may not have this additional Idaho Board of Pharmacy registration number. If you provide the additional registration information to us, we will capture the data in your record.
3.	**I provide Mental Health Clinic services, Case Management services and Children's Service Coordination services from the same location. Can I bill all of these services under the same NPI?**	Yes. When you set up your provider record update or new provider enrollment application you will establish a Service location for each of the services you provide even if the services are all provided from the same physical location. For example, service location 1 would be named Smith's Mental Health Clinic, service location 2 would be named Smith's Case Management Service, and service location 3 would be named Smith's Children's Service Coordination. When you submit a Mental Health Clinic claim you will indicate service location number for that service on the claim. When you submit a Case Management claim you will indicate the case management service location number on the claim. When you submit a Children's Service Coordination claim you will indicate children's service coordination service location number.

No.	Question	Answer
		If a claim is submitted without a service location number, the system will default to the primary service location and try to process the claim based on that sites specialty, which may cause the claim to deny because the codes billed are not appropriate for that service location's specialty.

FAQs: Remittance Advice

No.	Question	Answer
1.	**Where are the Remittance Advice (RA) located online?**	They are located at the Health PAS-OnLine Web site at www.idmedicaid.com. You will need to register as a Trading Partner to reach the secure area where you can access this information. To navigate to the Trading Partner secure area, go to www.idmedicaid.com, click on the Provider tab, and log into the Trading Partner sign in. Once signed in, click on File Exchange, click Reports, and select Remittance Advice to view a list of RAs.
2.	**Can I get a paper remit?**	You can log into your Trading Partner Account at www.idmedicaid.com to view your RAs. You can also print your RA. Once in your trading partner account you can set your RA preferences to indicate you want your RA on paper. If you do not have access to a computer, you can call Provider Services at 1 (866) 686-4272 to request a paper copy.
3.	**Can I have my RA split into separate reports by provider specialty?**	In the new MMIS, RA reports will be sent to the pay-to provider and include all claims for that billing NPI number. The RA lists the claims processed by each service location. The RA includes information about the rendering provider/specialty. These reports cannot be split into separate RA's.
4.	**My June remittance advice reports do not have explanation of the message codes. Where do I get that information?**	Go to the Provider Handbook, Reference folder, located online at www.idmedicaid.com. The descriptions for the message codes are listed in the *HIPAA Remark Code* document.

FAQs: Technical

No.	Question	Answer
1.	**How long will my account stay open when I am logged in my Trading Partner account? Is there a timed automatic log-out?**	A portal log-in times out after 30 minutes. If it locks, log out and back in to continue to access information in your account.

FAQs: Trading Partner

No.	Question	Answer
1.	**Do I have to complete the enrollment process before a clearinghouse or billing agency can bill for me?**	Yes, you must complete the enrollment process and receive your approval notice before a clearinghouse or billing agency can bill for you.
2.	**What if my business has multiple pay-to-providers, will I need to create multiple Trading Partner Accounts?**	No. You create one account. You can then associate additional pay-to-providers to your account by selecting the associate provider's link.
3.	**Does a billing agency or clearing house need to go through enrollment or do they go directly to trading partner?**	Billing agencies and clearinghouses do not need to go through enrollment, they can go directly to Trading Partner, but must have at least one enrolled provider for whom they are billing.
4.	**Is there a limit to the number of users that can access the secure area through a single trading partner account?**	No, the trading partner account administrator (someone in the provider's billing office who will grant access to the trading partner account) can create as many users as they wish to access their trading partner accounts. The administrator will also be able to control what kind of access each user is granted. For more information go to the Trading Partner Registration User Guide at www.idmedicaid.com.

FAQs: Training

No.	Question	Answer
1.	**What training is available?**	Provider Regional Consultants (PRCs) are offering in-person training in the regional offices. Providers must register for these workshops through the Idaho Medicaid Training Center on the provider website www.idmedicaid.com . In addition some open calls are scheduled for PRU assistance. Information about the calls has been posted to the provider website training calendar. Registration is not required for the provider assistance phone calls. If a provider has other questions outside of the training topics, please call 1 (866) 686-4272 for assistance.

FAQs: Developmental Disabilities Agency (DDA)

No.	Question	Answer
1.	**Why do some of my clients show as Ineligible on the portal?**	The online portal provides the same information as is in the core system. This information is provided by the State eligibility system to Molina and is updated each night. It is as up to date as we can provide. We have identified that approx 300 members were incorrectly terminated by the eligibility update process and these members are being corrected.

No.	Question	Answer
2.	**Some procedure codes are showing that prior authorization is required. They have not required this in the past. Is this correct? Some examples are: H2021, H2023, 90887.**	We have validated with Idaho policy that codes H2021 and 90887 do not require prior authorization. Code H2023 has previously, and will continue to require prior authorization.
3.	**The search option for diagnosis codes is not user friendly. I put in Autism and got 0 results found…I had to put in Autistic Disorder to find the code I needed. Is there an easier way?**	The search function looks for all codes matching the description enter. This means the more you enter the less you will get back, and the less you enter the more you will get back. There is a wild card search using the % sign. For example: If you wish to locate Autism and Autistic, enter the characters common to both words, i.e. 'Auti%'.
4.	**Where can I find instructions for claim billing?**	The CMS 1500 claim billing instructions are posted at www.idmedicaid.com, under the Provider tab. Click the **Provider Handbook** link in the left navigation menu. The direct data entry (DDE) billing instructions are posted at www.idmedicaid.com under the Provider tab. Click the **User Guide** link on the left and then choose the *TPA Claim Submission* document from the list.
5.	**What does the related diagnosis code field mean?**	Enter the line number of the diagnosis code(s) that apply to the service line. Please refer to billing instructions for more information.
6.	**Is there a copy function for previous claims? If a person has the same procedures every week, you have to enter them from scratch each week.**	This function is not available in the new MMIS, but will be evaluated as a possible system enhancement in the future.
7.	**Will we have to hand calculate each service for clients receiving multiple services?**	Yes, if you are submitting your claim electronically or on paper. If you are using the direct data entry option through your trading partner account the system will enter the total based on the units and charge entered for the service line.
8.	**Why are so many doctors not found when I use the search function to look them up?**	Only providers who have completed their provider record update/enrollment application and received an approval notice can be found using the search function.
9.	**What criteria can I enter to search for a member?**	Two of the following must be included in the search: **Name, SSN, MID, DOB**. If a name is entered, the search is performed using the first three characters of first name and first five of the last name. *These fields must match our system exactly in order to find the member, or it will display member not found.*

No.	Question	Answer
10.	**What is the difference between (patient) account number and medical record number?**	The patient account number is the number you assigned to your patient in your billing system and is required information on the claim. The medical record number is the number you assigned to your patient's medical record and is not required information on the claim.
11.	**For weekly services such as IBI and DT, is there a way to save information such as authorization numbers and referring physicians?**	Referrals and authorizations are viewable in the Referral and Authorization Status modules. There is no copy function in the online software. Please remember that PA numbers should not be entered on the claim.
13.	**Can Member ID appear automatically in "Claim Information" tab so it can be used in "Patient Account #" section without having to look up and re-enter?**	No, the patient account number is the number you assign to the provider in your billing system.
14.	**To save time, can we enter the numeric Diagnosis Code instead of having to search for and click it for each claim?**	You can enter diagnosis codes directly into the diagnosis fields. There is no need to search for codes if you know the number. Remember to enter the decimal point after the third digit of the diagnosis code or it will not be recognized.
15.	**Can we customize the Code section with a drop-down menu of the Service Codes we use?**	No, the online portal supports all Medicaid providers and cannot be customized to each provider group.
17.	**Are PAs automatically sent to a provider like HC referrals?**	PA notices are posted online for the requesting provider in the secure portion of the portal after logging into the Trading Partner section. A copy is also sent via mail to the member.
18.	**Why are most, if not all, claims coming back with errors after submission showing edits are required?**	With the new ability to adjudicate claims online, it is not unusual to see claims that pend or deny for system edits. If the claim shows pend, that means that we need to manually review the claim for something and will make a determination if the claim is appropriate to pay or must be denied.
19.	**Will we have a regional contact? Does each region have a trainer?**	Each region has a Provider Regional Consultant (PRC) that is responsible for provider support and training. The phone numbers for each are listed in each month's Medicaid newsletter, and can be viewed online at www.idmedicaid.com, under the Medicaid Newsletter link in the left hand navigation menu.
20.	**The instruction guides are very hard to use. Also, I had to go to different guides to find all of my information. Can they be more user friendly?**	As we review the guides for provider usefulness and ease of use we will make modifications to enhance the usability. However, there are some sections related to general instructions and also detailed instructions for each type of provider so that information does not have to be reused in multiple places. This helps avoid discrepancies if all repetitive information is not updated between sections.

No.	Question	Answer
21.	**Information Updates would be extremely helpful. Could we have a help page with FAQ's and recent information on system changes and updates?**	We will continue to add and update the online FAQs to better support the provider community. FAQ's are also included in the monthly Medicaid newsletter. These can be viewed online at www.idmedicaid.com, under the Medicaid Newsletter link on the left hand navigation menu.
22.	**Can we bill multiple days on the same claim line?**	Yes, you can enter multiple days on one claim line up to one week. Each week must be billed on a new line, but multiple lines can be entered on one claim. You do not need to bill a new claim for each week. However, you cannot bill a future date of service.
23.	**What is a modifier?**	A modifier is a 2 digit code that adds clarification to a procedure code. For example, if you bill code H2016 for an individual, you do not use a modifier. If you bill H2016 for a group then you must bill with the HQ modifier to indicate that it is the same procedure but in a group setting.
24.	**What should I use for the Member ID?**	The Member ID is a 10 digit number on the Member ID card. If you have the old 7 digit number, place 3 zero's on the front of the number. Otherwise, use the Member's new 10 digit number. The Member ID can also be retrieved at the online portal or through MACS.

DHW Contact Information

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

Insurance Verification

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

Molina Provider Services Contact Information

Medicaid Claims	
Utilization Management/Case Management	P.O. Box 70083 Boise, ID 83707
CMS 1500 Professional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional	P.O. Box 70085 Boise, ID 83707
UB-04 Institutional **Crossover/CMS 1500/Third Party Recovery (TPR)**	P.O. Box 70086 Boise, ID 83707
Financial/ADA 2006 Dental	P.O. Box 70087 Boise, ID 83707

Provider Services	
MACS **(Medicaid Automated Call Service)**	1 (866) 686-4272 1 (208) 373-1424
Provider Service Representatives **Monday through Friday, 7 a.m. to 7 p.m. MT**	1 (866) 686-4272 1 (208) 373-1424
E-mail	IDproviderenrollment@unisys.com
Mail	P.O. Box 70082 Boise, ID 83707

Molina Provider Services Fax Numbers

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

Prior Authorization Contact Information

DME Specialist, Medical Care P.O. Box 83720 Boise, ID 83720-0036	1 (866) 205-7403 Fax: 1 (800) 352-6044 (Attn: DME Specialist)
Pharmacy PO Box 83720 Boise, ID 83720-0036	1 (866) 827-9967 1 (208) 364-1829 Fax: 1 (208) 327-5541
Therapy and Surgery PA Requests PO Box 83720 Boise, ID 83720-0036	1 (208) 287-1148 Fax: 1 (877) 314-8779
Qualis Health (Telephonic & Retrospective Reviews) 10700 Meridian Ave. N. Suite 100 Seattle, WA 98133-9075	1 (800) 783-9207 Fax: 1 (800) 826-3836 1 (206) 368-2765 http://www.qualishealth.org/cm/idaho-medicaid/overview.cfm

Transportation

Developmental Disability and Mental Health	1 (800) 296-0509, #1172 1 (208) 287-1172
Other Non-emergent and Out-of-State	1 (800) 296-0509, #1173 1 (208) 287-1173 Fax: 1 (800) 296-0513 1 (208) 334-4979
Ambulance Review	1 (800) 362-7648 1 (208) 287-1157 Fax: 1 (800) 359-2236 1 (208) 334-5242

Provider Relations Consultant (PRC) Information

Region I Jennifer Kaufman 1120 Ironwood Drive Suite 102 Coeur d'Alene, ID 83814	1 (208) 666-6859 Jennifer.kaufman@molinahealthcare.com
Region II Jennifer Kaufman 1118 F Street P.O. Box Drawer B Lewiston, ID 83501	1 (208) 666-6859 Jennifer.kaufman@molinahealthcare.com
Region III Christy Stone 3402 Franklin Caldwell, ID 83605	1 (208) 373-1386 Christy.stone@molinahealthcare.com
Region IV Loren Audet 9415 W. Golden Trout Way Boise, ID 83704	1 (208) 373-1385 Loren.audet@molinahealthcare.com
Region V Brenda Rasmussen 601 Poleline, Suite 3 Twin Falls, ID 83303	1 (208) 736-2143 Brenda.rasmussen@molinahealthcare.com
Region VI Brenda Rasmussen 1070 Hiline Road Pocatello, ID 83201	1 (208) 736-2143 Brenda.rasmussen@molinahealthcare.com
Region VII Christy Stone 150 Shoup Avenue Idaho Falls, ID 83402	1 (208) 373-1386 Christy.stone@molinahealthcare.com

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IDAHO DEPARTMENT OF HEALTH & WELFARE

Health and Welfare Office Closures End

With the end of the State Fiscal Year 2010, our Friday office closures have ended. All DHW offices have returned to normal business hours of 8 AM to 5 PM, Monday through Friday.

Digital Edition

As part of our commitment to cost savings, we are using paperless processes wherever possible. The ***MedicAide*** is online and is available electronically by the fifth of each month. Our new digital edition, posted at www.idmedicaid.com also allows links to important forms and web sites, plus it is eco-friendly.

MedicAide **is the monthly informational newsletter for Idaho Medicaid providers.**
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or

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