



# MedicAide

An informational newsletter for Idaho Medicaid Providers

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

May 2009

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## New Medicaid Management Information System (MMIS) Coming in 2010!

Information is available on the Web at [www.idahommis.dhw.idaho.gov](http://www.idahommis.dhw.idaho.gov); if you have questions contact us at [idahommis@dhw.idaho.gov](mailto:idahommis@dhw.idaho.gov). Watch the *MedicAide* newsletter for more information pertaining to the new MMIS.

March 13, 2009

### MEDICAID INFORMATION RELEASE 2009-02

**To:** Hospital Administrators  
**From:** Leslie M. Clement, Administrator  
**Subject:** Notice of 2009 Medicaid Rates for Swing-bed days and administratively necessary days (AND)

Effective for dates-of-service on or after **January 1, 2009**, Medicaid will pay the following rates:

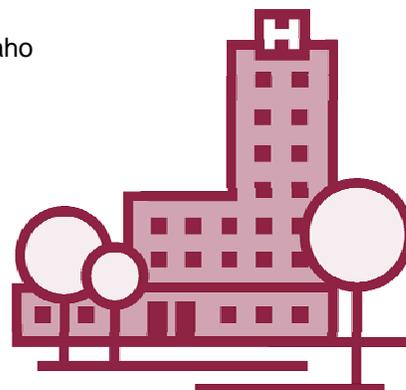
Swing-Bed Day	\$228.25
Administratively Necessary Day (AND)	\$186.32

If you have billed for swing-bed days since January 1, 2009, please submit corrected claim adjustments to EDS in order to receive reimbursement with the new rate(s) listed above.

If you have questions concerning the information contained in this release, please contact the Senior Financial Specialist, Office of Reimbursement, Division of Medicaid at (208) 287-1162.

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

LMC/rs



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

March 12, 2009

**MEDICAID INFORMATION RELEASE #2009-03**

**To:** Medicaid Transportation Providers  
**From:** Leslie M. Clement, Administrator  
**Subject:** Removal of Non-Emergency Transportation Benefit from the Idaho Medicaid Basic Benchmark Benefit Plan

All state agencies have been directed by the Governor (Executive Order 2008-05) to hold back four percent of their general fund budgets for fiscal year 2009 due to the downturn in the state and national economy.

As one of our responses to this, the Division of Medicaid will initiate the removal of transportation services from the Idaho Medicaid Basic Benchmark Benefit Plan. **Beginning April 1, 2009**, non-emergency medical transportation services will no longer be available as a benefit under the Basic Benchmark Benefit Plan.

Non-emergency medical transportation services will remain as a benefit in the Enhanced Benchmark Benefit Plan. Non-emergent transportation coverage continues if you are providing transportation to Medicaid clients who receive the following services: developmental disability, partial care, psycho-social rehabilitation, and community-based long-term care services.

If you have any questions about Medicaid transportation services, please contact the Idaho Medicaid Transportation Unit at (800) 296-0509.

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

LMC/rs

March 26, 2009

**MEDICAID INFORMATION RELEASE 2009-05**

**To:** Prescribing Providers, Pharmacists, and Hospitals  
**From:** Leslie M. Clement, Administrator  
Division of Medicaid  
**Subject:** Preferred Agents for Drug Classes Reviewed at Pharmacy and Therapeutics Committee Meetings on January 16, 2009, and February 20, 2009.

Drug/Drug Classes:	Noted below
Implementation Date:	Effective for dates of service on or after April 1, 2009

Idaho Medicaid is noting preferred agents and prior authorization (PA) criteria for the following drug classes as part of the Enhanced PA Program. The information is included in the attached Preferred Drug List.

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

Questions regarding the Enhanced PA Program can be referred to the Idaho Medicaid

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**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) 455-7244  
(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

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Pharmacy Unit at (208) 364-1829. A current listing of preferred and non-preferred agents and prior authorization criteria for all drug classes is available online at [www.medicaidpharmacy.idaho.gov](http://www.medicaidpharmacy.idaho.gov)

LMC/rs

Agents **bolded** below indicate changes in the Preferred Drug List.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Analgesics, Narcotics Long-Acting	Duragesic <sup>®</sup> , methadone generic, Kadian <sup>®</sup> , and morphine extended release generic  Duragesic <sup>®</sup> is recommended as preferred over generic fentanyl transdermal when the therapeutic prior authorization criteria are met.	fentanyl transdermal generic, Avinza <sup>®</sup> , Opana ER <sup>®</sup> , Oxycontin <sup>®</sup> , and oxycodone extended release generic
Analgesics, Narcotics Short-Acting	propoxyphene/ acetaminophen generic 100mg, acetaminophen/ codeine generic, tramadol generic, hydrocodone/ acetaminophen generic, aspirin/codeine generic, codeine generic, morphine IR generic, oxycodone IR generic, oxycodone/ acetaminophen generic, pentazocine/naloxone generic, hydromorphone generic, tramadol/ acetaminophen generic	<b>levorphanol generic, pentazocine/acetaminophen generic, oxycodone/aspirin generic, propoxyphene generic, meperidine oral generic, Darvon N<sup>®</sup>, Panlor DC/SS<sup>®</sup>, Opana<sup>®</sup>, fentanyl buccal generic, Fentora<sup>®</sup>, hydrocodone/ibuprofen generic, oxycodone/ibuprofen generic, butalbital compound/codeine generic, and dihydrocodeine/acetaminophen/caffeine generic</b>
Angiotensin Modulators	benazepril and benazepril/ HCTZ generic, captopril and captopril/HCTZ generic, enalapril and enalapril/ HCTZ generic, fosinopril and fosinopril/HCTZ generic, lisinopril and lisinopril/HCTZ generic, quinapril and quinapril/ HCTZ generic, Diovan <sup>®</sup> , Diovan HCT <sup>®</sup> , Benicar, Benicar HCT <sup>®</sup> , Micardis <sup>®</sup> , Micardis HCT <sup>®</sup> , Cozaar <sup>®</sup> , Hyzaar <sup>®</sup> , Avapro <sup>®</sup> , and Avalide <sup>®</sup>	Aceon <sup>®</sup> , Teveten <sup>®</sup> , Teveten HCT <sup>®</sup> , Atacand <sup>®</sup> , Atacand HCT <sup>®</sup> , moexepiril and moexepiril/HCTZ generic, Tekturna <sup>®</sup> , Tekturna HCT <sup>®</sup> , trandolapril generic, and ramipril generic
Angiotensin Modulator— Calcium Channel Blocker Combination Drugs	Exforge <sup>®</sup> and Azor <sup>®</sup>	<b>benazepril/amlodipine generic, Tarka<sup>®</sup></b>  <i>Separate component drugs must be used in place of benazepril/amlodipine combinations.</i>

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Anticoagulants, Injectable	Fragmin <sup>®</sup> , Lovenox <sup>®</sup> , and Arixtra <sup>®</sup>	Innohep <sup>®</sup>
Anticonvulsants	<b>Trileptal<sup>®</sup> suspension, divalproex generic,</b> methobarbital generic, phenobarbital generic, clonazepam generic, carbamazepine generic, Carbatrol <sup>®</sup> , Equetro <sup>®</sup> , phenytoin generic, mephobarbital generic, primidone generic, valproic acid generic, Depakote <sup>®</sup> sprinkle, Depakote ER <sup>®</sup> , Depakote <sup>®</sup> , Celontin <sup>®</sup> , Peganone <sup>®</sup> , Gabitril <sup>®</sup> , ethosuximide generic, zonisamide generic <sup>2</sup> , oxcarbazine generic <sup>2</sup> , Lyrica <sup>®2</sup> , gabapentin generic <sup>2</sup> , Topamax <sup>®2</sup> , Keppra XR <sup>®2</sup> , Lamictal <sup>®2</sup> , and Diastat <sup>®</sup>	<b>Trileptal<sup>®</sup> oral, Stavzor<sup>®</sup>,</b> Phenytek <sup>®</sup> , Tegretol XR <sup>®1</sup> , Felbatol <sup>®</sup> , lamotrigine generic <sup>2</sup> and levetiracetam generic <sup>2</sup>  <sup>1</sup> <i>Participants currently receiving Tegretol XR<sup>®</sup> will be “grandfathered” and will not need to switch to a preferred agent.</i>  <sup>2</sup> <i>These anticonvulsants are recommended as preferred for epilepsy and other seizure disorders only. Non-seizure indications will still require that therapeutic prior authorization criteria are met.</i>
Antihistamines, Minimally Sedating	loratadine generic and loratadine syrup, cetirizine generic and syrup	<b>Claritin<sup>®</sup> chew, Semprex D<sup>®</sup>,</b> <b>cetirizine syrup RX, cetirizine RX generic,</b> Clarinex/Clarinex D <sup>®</sup> , Clarinex <sup>®</sup> syrup, Zyrtec/Zyrtec-D <sup>®</sup> , Xyzal <sup>®</sup> , Xyzal <sup>®</sup> syrup, Allegra <sup>®</sup> syrup, Allegra <sup>®</sup> ODT, fexofenadine generic, <b>loratadine D generic, cetirizine D generic</b>
Antimigraine Agents, Triptans	<b>Maxalt/Maxalt MLT<sup>®</sup>,</b> Relpax <sup>®</sup> , Imitrex (oral) <sup>®</sup> , Imitrex (nasal) <sup>®</sup> , and Imitrex <sup>®</sup> SQ	<b>sumatriptan generic, Treximet<sup>®</sup>,</b> Amerge <sup>®</sup> , Axert <sup>®</sup> , Frova <sup>®</sup> , Zomig/ZomigZMT <sup>®</sup> , and Zomig <sup>®</sup> (nasal)  <i>Amerge<sup>®</sup>, and Zomig/ZomigZMT<sup>®</sup> will be “grandfathered” for current patients. These agents will be non-preferred and require prior-authorization for new patients.</i>
Beta Blockers	<b>Levator<sup>®</sup>, Innopran XL<sup>®</sup>,</b> atenolol generic, metoprolol generic, propranolol generic, sotalol generic, nadolol generic, acebutolol generic, labetalol generic, pindolol generic, timolol generic, bisoprolol generic, and carvedilol generic	<b>Bystolic<sup>®</sup>, betaxolol generic,</b> Coreg CR <sup>®</sup>
Bladder Relaxant Preparations	oxybutynin generic, Vesicare <sup>®</sup> , Oxytrol <sup>®</sup> transdermal, and Detrol LA <sup>®</sup>	<b>Enablex<sup>®</sup>, Sanctura<sup>®</sup>, Sanctura XR<sup>®</sup>,</b> oxybutynin ER generic, and Detrol <sup>®</sup>

## 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**  
Trudy DeJong  
601 Poleline, Suite 3  
Twin Falls, ID 83303  
Phone: (208) 736-2143  
Fax: (208) 736-2116  
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

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
BPH Treatments	doxazosin generic, terazosin generic, <b>Proscar</b> <sup>®</sup> , Uroxatral <sup>®</sup> , Cardura XL <sup>®</sup> , Flomax <sup>®</sup> , Avodart <sup>®</sup> , and finasteride generic	There are no agents designated as non-preferred.
Calcium Channel Blockers	Dyncirc CR <sup>®</sup> , verapamil generic, , diltiazem generic , nifedipine IR/ER generic, felodipine ER generic, and amlodipine generic	<b>verapamil ER PM, generic, Cardizem LA</b> <sup>®</sup> , nicardipine generic, Cardene SR <sup>®</sup> , Covera-HS <sup>®</sup> , isradipine generic, and Sular <sup>®</sup>
Erythropoiesis Stimulating Proteins	Aranesp <sup>®</sup> and Procrit <sup>®</sup>	Epogen <sup>®</sup>
Growth Hormone	<b>Genotropin</b> <sup>®</sup> , Nutropin <sup>®</sup> , Nutropin AQ <sup>®</sup> , and Norditropin <sup>®</sup>	<b>Saizen</b> <sup>®</sup> , Tev-Tropin <sup>®</sup> , Serostim <sup>®</sup> , Humatrope <sup>®</sup> , Omnitrope <sup>®</sup> , and Zorbtive <sup>®</sup>  <i>Current therapeutic criteria for growth hormone will continue to be required for all agents.</i>  <i>Patients currently receiving non-preferred agents will be "grandfathered."</i>
Hepatitis C Agents	Pegasys <sup>®</sup> , Peg-Intron <sup>®</sup> , <b>Peg-Intron Redipen</b> <sup>®</sup> , and ribavirin generic	Infergen <sup>®</sup>
Hypoglycemics, Meglitinides	Starlix <sup>®</sup> and Prandin <sup>®</sup>	There are no agents designated as non-preferred.
Hypoglycemics, TZD	Avandia <sup>®</sup> , Actos <sup>®</sup> , Avandamet <sup>®</sup> , Avandaryl <sup>®</sup> , Actoplus Met <sup>®</sup> , and Duetact <sup>®</sup>	There are no agents designated as non-preferred.
Impetigo Agents, Topical	mupirocin ointment generic, and Altanax <sup>®</sup> 5G tube	<b>Altanax</b> <sup>®</sup> <b>10G and 15G</b> , and Bacroban <sup>®</sup> cream
Lipotropics, Other	<b>Niacor</b> <sup>®</sup> , Niaspan <sup>®</sup> , gemfibrozil generic, colestipol generic, Tricor <sup>®</sup> , cholestyramine generic, and fenofibrate generic	<b>Antara</b> <sup>®</sup> , Zetia <sup>®</sup> , Triglide <sup>®</sup> , Welchol <sup>®</sup> , Lipofen <sup>®</sup> , and Lovaza <sup>®</sup>
Lipotropics, Statins	<b>Simcor</b> <sup>®</sup> , <b>Altoprev</b> <sup>®</sup> , Caduet <sup>®</sup> , Lescol/Lescol XL <sup>®</sup> , Lipitor <sup>®</sup> , lovostatin generic, pravastatin generic, and simvastatin generic	Advicor <sup>®</sup> , Crestor <sup>®</sup> , and Vytorin <sup>®</sup>
Multiple Sclerosis Agents	Betaseron <sup>®</sup> , Avonex <sup>®</sup> , Rebif <sup>®</sup> , and Copaxone <sup>®</sup>	There were no agents designated as non-preferred.
Otic Fluoroquinolones	<b>Floxin</b> <sup>®</sup> , ofloxacin generic otic and Ciprodex <sup>®</sup> otic	Cipro <sup>®</sup> HC otic
Phosphate Binders	PhosLo <sup>®</sup> , Fosrenol <sup>®</sup> , and Renagel <sup>®</sup>	Renvela <sup>®</sup> , and calcium acetate generic

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Proton Pump Inhibitors	<b>Prevacid<sup>®</sup> solutab and suspension</b> , Nexium <sup>®</sup> capsule and suspension, and Prevacid <sup>®</sup> capsule	<b>Prilosec<sup>®</sup> OTC, Zegerid<sup>®</sup>, Aciphex<sup>®</sup>, omeprazole generic, pantoprazole generic</b>  <i>All current therapeutic criteria except those associated with the solutab form of Prevacid will be removed.</i>
Sedative Hypnotics	chloral hydrate generic, temazepam generic, triazolam generic, Restoril <sup>®</sup> 7.5 mg, and zolpidem generic	Lunesta <sup>®</sup> , flurazepam generic, Rozerem <sup>®</sup> , Ambien CR <sup>®</sup> , Doral <sup>®</sup> , estazolam generic, and <b>zaleplon generic</b>  <i>Lunesta<sup>®</sup> will be "grandfathered" for current patients.</i>
Skeletal Muscle Relaxants	baclofen generic, chlorzoxazone generic, cyclobenzaprine generic, dantrolene generic, methocarbamol generic, and tizanidine generic	<b>orphenadrine compound generic, orphenadrine generic</b> , carisoprodol generic, carisoprodol compound, Soma <sup>®</sup> , Skelaxin <sup>®</sup> , Zanaflex <sup>®</sup> , and Fexmid <sup>®</sup>
Ulcerative Colitis Agents	balsalazide generic, sulfasalazine generic, mesalamine rectal generic, Asacol <sup>®</sup> , Pentasa <sup>®</sup> , and Canasa <sup>®</sup>	Dipentum <sup>®</sup> and Lialda <sup>®</sup>
Pulmonary Arterial Hypertension (PAH) Agents, Oral	Revatio <sup>®</sup> and Letairis <sup>®</sup>	Tracleer <sup>®</sup>
Cough and Cold Agents	All generic products both prescription and non-prescription Cough and Cold preparations are restricted to Medicaid participants 7 years and older. Quantity limits of 4 oz. per prescription and no more than two prescriptions per six months per participant.	All branded products

\* Use of non-preferred agents must meet prior authorization requirements.

\* Use of any covered product may be subject to prior authorization for quantities or uses outside the Food and Drug Administration (FDA) guidelines or indications.

### **Idaho Medicaid Provider Handbook**

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

## **New Billing Tip Sessions Offered**

Disappointed that the Idaho Health Care Conference was cancelled this year? EDS provider relations consultants (PRCs) will offer a one-hour billing tip session in their regions. This session will cover Medicaid billing tips and the top reasons for denials for multiple provider types, in the **current** Medicaid Management Information System (MMIS).

Sessions are scheduled from 1 to 2 p.m. in Regions 2, 6, and 7 on Tuesday, June 9, 2009. Regions 1, 3, and 5 will be on Wednesday, June 10, 2009, and Region 4 will be on Tuesday, July 14, 2009. Space is limited so plan to pre-register. You can call your local consultant to register using the phone numbers listed in the sidebar on page 5.

**MEDICAID INFORMATION RELEASE 2009-06**

**To:** Residential Habilitation Agencies  
**From:** Leslie Clement, Administrator  
Division of Medicaid  
**Subject:** Residential Habilitation Affiliation Reimbursement Methodology Change

On September 26, 2008, through Executive Order 2008-03, the Governor directed all state agencies to hold back one percent of their general fund budgets in the current fiscal year due to the downturn in the economy. On December 1, 2008, the Governor directed an additional three percent hold-back through Executive Order 2008-05.

As one of our responses to this, effective with claims date of service beginning May 1, 2009, residential habilitation agencies must bill certified family home affiliation fees using 15-minute units for reimbursement, instead of the current bundled daily rate.

**Fee Schedule Changes Effective May 1, 2009: Certified Family Home Affiliation Fee**

Procedure Code	New Reimbursement Rate - 15-Minute Unit	Maximum Allowable Annual Units
0919B Initial Year of Affiliation-Year 1	\$10.95/Unit	140 units per year
0919B Ongoing Year	\$10.95/Unit	120 units/year

The reimbursement rate for residential habilitation affiliation services was derived using the statewide Weighted Average Hourly Rate (WAHR) for a Qualified Mental Retardation Professional (QMRP) and then adjusted for employment-related expenditures, program-related costs, and indirect general and administrative costs.

**Procedures Related to Billing in 15-Minute Units**

Billing in 15-minute units requires a provider to bill a procedure code along with the appropriate number of units of service associated with the service provided. For any single procedure code, a single 15-minute unit for treatment may be billed if it is equal to or greater than eight minutes. (Example: Two units should be billed when the interaction with the participant or collateral contact is equal to or greater than 23 minutes to less than 38 minutes.) Further explanation about billing in increments of 15 minutes can be found in the *Medicaid Provider Handbook*, or you can contact your regional EDS representative.

We believe that some agencies are completing work beyond what is required by the department. We appreciate the work provided by residential habilitation affiliation agencies. Unfortunately because of the recent downturn in the economy, we must clarify the requirements for residential habilitation agencies. These responsibilities are included in *IDAPA 16.03.10.704-705*, *IDAPA 16.04.17-000-500*, *The Medicaid Provider Handbook- Residential Habilitation Section*, and the Medicaid Provider Agreement with Additional Terms.

In order to effectively manage the allowed units, it will be important for residential habilitation providers to assure that the services they provide are reimbursable activities. For example, the department does not require affiliation providers to be on call 24/7 as back up for certified family home (CFH) providers; rather, the department requires the affiliation agency to assist the CFH with developing emergency care measures and crisis and emergency plans. An additional example would be that the department does not require affiliation providers to provide the ongoing training required for CFH provider certification; rather, the department requires that an affiliation agency maintains a copy of the CFH certification, and provides any on-going participant specific training (related to the participant's plan).

In order to assure the services that are provided are consistent with Medicaid expectations, and completed within the allowable units, affiliation providers will do the following:

- Provide oversight of policies and procedures required in rule.
- Comply with their Medicaid Provider Agreement and the Provider Agreement Additional Terms section.
- Assist the CFH with developing emergency care measures and crisis and emergency plans specific to residential habilitation services identified on the Individual Services Plan (ISP).
- Establish and maintain standardized service record documentation.
- Complete quarterly audit and site visit and audit participant satisfaction (during residential habilitation plan monitoring).

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- Provide orientation training (with an initial service plan, or with a new CFH provider placement).
- Provide the additional training required within six months of affiliation.
- Write skills training programs.
- Assure participant rights.
- When the provider is designated as payee, assure a full and complete accounting of participant finances.
- Provide ongoing training specific to the needs of the participant.
- Develop participant implementation plans specific to participant's plan of service residential habilitation program.
- Review strategies for implementing the residential habilitation program with the participant and the provider.
- Monitor the plan (including completion of the provider status reviews at six and 12 months, and meetings about the participant's plan progress or needs).
- Modify the goals and objectives specific to the participant's residential habilitation program plan as necessary.
- Develop a transition plan as necessary.
- Verify the certified family home provider qualifications and certification (obtain a copy of CFH certification).
- Promote participation of participants, guardians, relatives and friends (this includes promotion of visits and activities).
- Communicate in person and by telephone with the participant's service coordinator, their CFH provider, the guardian, and with the participant themselves about the residential habilitation program.
- Attend participant meetings specific to residential habilitation services identified on the individual service plan.

### **Existing Prior Authorizations**

Existing prior authorizations for residential habilitation affiliation will end as of April 30, 2009. Beginning May 1, 2009, providers should be implementing fee for service documentation and claims submissions. No addendums are necessary as the department will automatically provide new annual prior authorizations for existing plans. The new prior authorization issued will be prorated using 120 units/year, for the remaining months in the current authorized service plan. (Example: If four months are left on the current service plan, 40 units will be authorized.) In the example provided, affiliation providers may provide a total of 40 units as necessary through the end of the plan year. Fee for service documentation must describe the affiliation services provided, according to each specific participant implementation plan, and the participant's individual service plan.

### **Advance Prior Authorization for new participants or for participants adding affiliation to their existing Service Plans**

140 units per year of residential habilitation affiliation services will be prior authorized for the first year of affiliation on a participant's annual individual service plan. A prior authorization can be requested in advance for plan development required for a new affiliation participant. Advance prior authorization request forms are available online.

### **Annual Prior Authorization Requests for Ongoing Individual Service Plans**

120 units per year of residential habilitation affiliation services should be included on each participant's annual individual service plan for prior authorization. Fee for service documentation must be consistent with the affiliation services requested and prior authorized on the participant's individual service plan.

A participant may require more than the allowed 120 units if a participant requires a new certified family home placement during the course of their ongoing annual plan. The residential habilitation affiliation provider may request up to 20 additional units through an addendum, in order to facilitate a participant's transition into a new placement.

### **Changes in Affiliation Providers**

Additional units will not be authorized for a change in residential affiliation providers.

If a new affiliation provider takes over affiliation for a participant, the remaining prior authorized units on the participant's annual service plan for affiliation must be transferred through an addendum to the new affiliation provider.

If you have questions related to this information release or about affiliation practices and how they are affected by the change to 15-minute unit billing, please contact the program specialist in the Bureau of Developmental Disability Services, Division of Medicaid at (208) 364-1960.

If you have questions about the reimbursement methodology, please contact the principal financial specialist, Bureau of Financial Operations, Division of Medicaid at (208) 364-1817.

The guidance in this Information Release supersedes any contrary guidance contained in the *Medicaid Provider Handbook*, DD/ISSH Section. Thank you for your participation in Medicaid.

LMC/rs

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# Idaho MMIS Transition News: Trading Partner Agreements

## Are you a trading partner with Idaho Medicaid?

Trading partners can be any of the following:

- Providers
- Health plans
- Billing agencies
- Clearinghouses
- Software vendors

If you wish to send and receive HIPAA-compliant electronic transactions in the new MMIS, you must sign a Trading Partner Agreement (TPA).

The TPA allows you to do the following:

- Submit claims, adjustments, or reversals
- Check claim status
- Check participant eligibility
- Request a Prior Authorization (PA)
- Submit a referral
- Receive a Remittance Advice (RA)
- Receive payments by Electronic Funds Transfer (EFT)

## What does this mean for providers?

When your provider record update (PRU) is finished you will get an approval letter. Use the information in the letter to apply for your TPA. You will apply for your TPA online.

You must have the following:

- National Provider Identifier (NPI) or Idaho Medicaid provider number
- Tax ID
- Case number

## What does this mean for health plans, billing agencies, clearinghouses, and software vendors?

You can go directly to the new online portal to complete your TPA beginning August 1, 2009. Clearinghouses, you will need your Tax ID to log on to the portal when you apply for your TPA. Additionally, billing agencies and software vendors will need to have at least one contracted provider to register as a trading partner. All TPA requests are approved or denied right away. Once approved, you get a confirmation e-mail with a hyperlink to activate your account.

We will provide training in the registration, testing, and certification process tailored specifically to you. We will also provide the needed documentation for clearinghouses and software vendors to become compliant with the new MMIS. Stay tuned for in-depth trading partner registration information outlining the many benefits of online transactions.

## Worried you might miss something important?

Not to worry, an extensive statewide outreach strategy is in development and will include face-to-face group and individual training as well as online training opportunities. Training materials will be available on the Web at [www.idahommis.dhw.idaho.gov](http://www.idahommis.dhw.idaho.gov), and trained staff will be available by phone and e-mail to answer all your questions.

We will be providing more information about the trading partner testing and certification process over the next few months, so continue to watch the *MedicAide* newsletter for information that's important to you.

For questions please e-mail us at [idahommis@dhw.idaho.gov](mailto:idahommis@dhw.idaho.gov)  
MMIS = Idaho Medicaid Claims Processing System

## Idaho MMIS FAQs: Trading Partner Agreements

No.	Question	Answer
1	What is a trading partner?	A trading partner is any person or business who wants to use any secure online feature of Idaho MMIS or who will send and receive HIPAA-compliant X12 information.
2	Who can be a trading partner?	<ul style="list-style-type: none"> <li>• Providers</li> <li>• Billing agencies</li> <li>• Clearinghouses</li> <li>• Health plans</li> <li>• Software vendors</li> </ul>
3	How do I become a trading partner with Idaho Medicaid?	You must apply online to become a registered trading partner. The registration requirements for each type of trading partner are different.
4	How will I know if I've registered properly?	A confirmation page displays your assigned trading partner ID and activation PIN. The activation PIN is also e-mailed to the registering entity. The activation PIN is only used during the initial logon.
5	Why do I need a trading partner ID?	The trading partner ID is unique to the registered entity. It is used to route your specific correspondence to your Web account.
6	If my business has multiple billing/pay-to provider numbers, will I need to establish multiple Trading Partner Agreements (TPA)?	No, create only one trading partner account. You can create additional logons for employees after your registration is approved and activated. This is true for all trading partner types.
7	Will I need to undergo a testing process?	Yes, you must complete system testing if you will send or receive HIPAA-compliant X12 data.
8	Why do I need to test before being certified?	Testing is required to ensure HIPAA compliancy and file structure and integrity.
9	What is a HIPAA-compliant X12 data transaction?	<ul style="list-style-type: none"> <li>• Healthcare claims</li> <li>• Participant eligibility inquiries</li> <li>• Payment/Remittance Advice (RA)</li> <li>• Status requests</li> <li>• Benefit enrollment</li> <li>• Premium payment information</li> </ul>
10	I use Provider Electronic Solution (PES) now to complete the transactions listed in answer 9. Will I complete system testing with Idaho MMIS?	In the new MMIS you will use the Direct Data Entry (DDE) feature in place of your PES terminal. You will not undergo a testing process to use the DDE features of the online portal.
11	As a billing agency, will I need to have contracted providers before I can be certified as a trading partner?	Yes, you must submit information for at least one enrolled Idaho Medicaid provider.
12	As a provider, will I be required to complete my Provider Record Update (PRU) before I can register as a trading partner?	Yes, when your PRU is finished you will get an approval letter. Use the information in the letter to apply online for your TPA.

Continued on page 11 (Idaho MMIS FAQs)

No.	Question	Answer
13	What type of information will health care providers who have a National Provider Identifier (NPI) need to provide to register as a trading partner?	Health care providers who have an NPI will submit their NPI, tax ID, and the PIN number listed in the PRU approval letter.
14	What type of information will atypical providers who do not have an NPI need to provide to register as a trading partner?	You will submit your Idaho Medicaid provider ID, tax ID, and the PIN listed in the PRU approval letter.
15	What type of information will billing agency or software vendors need to provide to register as trading partners?	You will submit your contracted Idaho Medicaid provider's information during registration.
16	What type of information will clearinghouses or health plans need to provide to register as trading partners?	You will submit your tax ID.

## Medicare Crossover Reminder

When your claims automatically cross over from Medicare to Medicaid you must allow sufficient time for the electronic crossover to be processed. You can use the Medicaid Automated Voice Information System (MAVIS) to look up the claim status for crossover claims using the billed amount, dates of service, and the participant Medicaid identification number. If your claims are not crossing over automatically, find out if your provider or group NPI number is registered and linked correctly in the EDS system. Call MAVIS toll free at (800) 685-3757 or in the Boise area at 383-4310 and ask for an agent.

Submitting a paper claim before the electronic claim has processed can result in a duplication of the claim received by the electronic crossover. This duplication may result in payment delays. Also, when submitting a crossover claim, please remember that the total Medicare payment must be entered in the appropriate field (29 of CMS-1500, or 54 of UB-04).

The examples in this article show how to complete the CMS-1500 and UB-04 paper claim forms.

In the CMS-1500 example, the total paid by Medicare (\$80.00) goes into field 29. This amount is subtracted from the total charges (\$120.00). The difference (\$40.00) is entered into field 30.

In the UB-04 example, the total paid by Medicare (\$80.00) goes into field 54. This amount is subtracted from the total charges (\$120.00). The difference (\$40.00) is entered into field 55.

The total charges should always equal the balance due plus the total paid by all other insurance including Medicare. Do not include contractual adjustment calculations or previous Medicaid payments in the paid field.

Remember, avoiding duplication of claims allows faster processing time.

**CMS-1500**

F. \$ CHARGES	G. DAYS OR UNITS	H. SPEC. FAMIL. PLAN	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
120.00			NPI	
			NPI	
28. TOTAL CHARGE \$ 120.00		29. AMOUNT PAID \$ 80.00	30. BALANCE DUE 40.00	
33. BILLING PROVIDER INFO & PH # ( )				
a. NPI		b.		

PHYSICIAN OR SUPPLIER INFORMATION

APPROVED OMB 0938-091

**UB-04**

45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
		120.00		
<b>TOTALS</b>				
54 PRIOR PAYMENTS 80.00	55 EST. AMOUNT DUE 40.00	56 NPI	57 OTHER PRV ID	
61 GROUP NAME		62 INSURANCE GROUP NO.		

# Attention Hospice Providers

At Medicaid, we have recently reviewed our processes and solicited input from hospice providers to ensure that our notification requirements are both reasonable and promote a high standard of care.

We have updated the *Hospice Handbook* and clarified document submission requirements as well as processes related to hospice care. Please visit [www.medunit.dhw.idaho.gov](http://www.medunit.dhw.idaho.gov) and click on *Hospice* for more information and to access a link to the updated handbook and Hospice Notification Form.

The following are required documents for eight-month election and recertification periods:

For *Initial* Hospice Election:

- The hospice election form signed by the participant or legal representative
- The attending physician's recent History and Physical
- The completed Interdisciplinary Plan of Care signed by the hospice medical director
- A certification stating that the participant's prognosis is six months or less, signed by the hospice medical director and the attending physician

For Hospice *Recertification*:

- The hospice agency's updated Interdisciplinary Plan of Care signed by the medical director
- A certification stating that the prognosis is six months or less, signed by the medical director
- Documentation of compliance with CMS eligibility standards for the participant's specific hospice diagnosis (e.g., Local Coverage Determination (LCD) or Criteria Worksheet)

## Timeliness for Medicaid Notification

The Centers for Medicare and Medicaid Services (CMS) requires a hospice agency to notify Medicaid when an individual who is dually eligible (Medicare and Medicaid) receives hospice services. It is the responsibility of the hospice agency to notify Medicare and Medicaid, and any commercial insurance, regarding election, discharge, revocation, death, or transfer between hospice providers. Please note that election and recertification timelines differ between Medicare, Medicaid, and commercial insurance.

Please submit the Hospice Notification Form within **15 working days** of hospice election or any change in patient status. Each hospice agency is responsible for tracking the due date for the eight-month recertification. Due to billing system requirements, late submission of this form may result in delays or other problems with hospice claims processing. Timely notification also helps prevent potential problems for the participant related to non-hospice diagnosis care needs, pharmacy reimbursement, and other care issues. We understand factors outside of the control of the hospice provider may create an occasional need for a retrospective notification (e.g., awaiting eligibility confirmation). These will be handled on a case-by-case basis.

If you have any questions, please contact the Medical Care Unit at (208) 364-1818.

The image contains two screenshots of the Idaho Department of Health & Welfare website. The top screenshot shows the 'Medical Care Unit' page, with a sidebar on the left containing a list of services including 'Hospice', which is circled in red. The bottom screenshot shows the 'Hospice Services' page, with a sidebar on the right containing a list of links including 'Hospice Intake', 'Provider Handbooks', 'Fee Schedules', 'Medicaid Rules', 'Information Releases', 'MAOR-19 Hospice Rates', and 'Resources and Links'. An arrow points to the 'Provider Handbooks' link in the sidebar.

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## What's in a Name? Client Name/Number Mismatch

Claims submitted to Idaho Medicaid will be denied for edit 101 "Client name and/or number does not match client file" if the name submitted on the claim does not exactly match the name as it is listed within the claims processing system. The top reasons that cause claims to set the client (participant) name/number mismatch edit are when claims are submitted with the following:

- A nickname or some other variation of the participant's name is used.  
Example: Mike versus Michael, Sue versus Susan, Edward versus Ed, etc.
- A different last name is used. The participant may have changed names and not informed their self reliance worker, so the change has not been made within the claims processing system.
- The first or last name is misspelled.
- There is a space between letters.  
Example: OConnor is submitted as O Connor, McDonald is submitted as Mc Donald, etc.
- The order of last name, first name, middle name or initial is incorrect.
- Hyphenated last names do not have a comma before the first name to indicate where the last name stops and the first name begins.



Entering the participant's name exactly as it appears on the Medicaid ID card will prevent these errors from occurring. The claims processing system automatically captures only the first five letters of the last name and the first three letters of the first name. Those characters are matched to the name on file within the system. You will see the name data captured from the claim when you look at your Remittance Advice report.

On paper claims, hyphenated last names present a unique situation where the system automatically captures the first five letters of the first part of the last name. The second part of the last name is seen as if it was the first name and the first three letters of that name are captured. When the mismatch occurs, the claim will suspend in the system for manual keying by a data entry clerk. In order to clarify which is the first name and which is the last name, enter a comma after the last name and just before the first name to separate the two and make it clear which characters should be keyed from the claim.

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

When verifying eligibility using MAVIS, you have the option to request that the eligibility information be faxed to you. The faxed information will report the participant's name exactly as it is listed in the system, which is how it should also be submitted on the claim.

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

If you have any questions concerning the information contained here, please contact EDS toll free at (800) 685-3757 or in the Boise area at 383-4310.

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## Service Coordination

Please see the Frequently Asked Questions for Service Coordination and Paraprofessionals on the Idaho Department of Health and Welfare Web site at [www.modernizeMedicaid.idaho.gov](http://www.modernizeMedicaid.idaho.gov).

# Do Not Staple, Fold, Spindle, or Mutilate!

“Throw away your stapler and forget about the paper clips!”

This is the best advice that the EDS mailroom can give to providers as they submit paper claims. From the mailroom point of view, an ideal claim would come in a large envelope with all of the pages stacked and lying flat, with no staples or paper clips. The time spent unfolding and detaching claims slows the overall processing of paper claims.

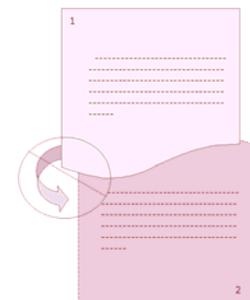
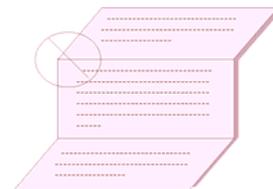
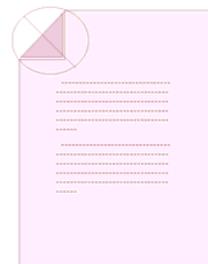
Understandably, providers are concerned that attachments might be separated or lost in handling. To avoid this, staples or paper clips are used to hold the pages together. Instead of helping, this actually slows down the processing of those claims. In some cases, claims can be so damaged by the removal of staples that the claim is rejected for processing!

When a paper claim comes into EDS, it is removed from its envelope, the pages are unfolded, all staples or paper clips are immediately removed, and the claims and attached pages are stacked flat. Claims with attachments are separated from those without attachments. They are scanned to create an electronic file of the claim data for processing and for a permanent image of the claim form with any attached pages. Each claim with its corresponding attachments is stamped with an internal control number (ICN) for tracking.

If paper clips and folded pages slow the process, staples can bring it to a halt. Missed staples can cause mutilation of the claim form if it goes through the scanning machine. Stapled claims are often torn when the staples are removed and important information may be lost when the staple is placed over a required data field. The damaged claim is then returned to the provider for resubmission.

It may be surprising to know that “attachments” really shouldn’t be attached, but should be simply stacked behind the corresponding claim form and mailed in a large envelope without folding the claims. Claims arriving this way can be quickly sorted and prepared for scanning with minimal handling. If you have multiple claims requiring the same attachment, make a copy of the attachment for each claim and stack the claims so that each form has its supporting documentation right behind it, then stack the next claim form with its attachments behind the first, and follow this method for all your claims. Send the stack in an envelope that is large enough to contain the claims without overstuffing.

If your claims do not require any attachments for processing, you can submit them electronically to avoid postage and the time required for mailing and handling. For additional electronic billing information, contact EDS toll free at (800) 685-3757 or in the Boise area at 383-4310 and ask about the free PES software.



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## 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 NPI, General Medicaid Billing, Provider Resources, Using PES Software, and CMS-1500 (08/05).

The next workshop is scheduled from 2 to 4 p.m. in Regions 2, 6, and 7 on Tuesday, June 9, 2009. Regions 1, 3, and 5 will be on Wednesday, June 10, 2009, and Region 4 will be on Tuesday, July 14, 2009.

These training sessions are provided at no cost to providers, but space is limited so please pre-register with your local consultant. Phone numbers for the PRCs are listed in the sidebar on page 5.

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## Determine Whether Participants Are Impacted by IR 2009-03

You can determine whether participants are impacted by IR 2009-03—Removal of Non-Emergent Transportation Benefit from the Idaho Medicaid Basic Benchmark Benefit Plan. Request eligibility and benefit plan information using these methods:

- MAVIS at (800) 685-3757
- EDS PES billing software
- HIPAA-compliant point of service devices (POS)
- HIPPA-compliant EDS-tested vendor software

The following table summarizes the most common eligibility responses and how to interpret whether participants are impacted by the benefits changes in IR 2009-03. An “x” in the table below reflects non-emergent transportation as a non-covered benefit under the participant’s eligibility status.

Eligibility response	Non-emergent transportation no longer available (IR 2009-03)
Benefits restricted to Medicaid Basic Plan services only	x
Medicaid Basic Plan	x
Benefits restricted to pregnancy-related services only	Not impacted
Benefits restricted to Medicare-paid services	Not impacted
Benefits restricted to outpatient pregnancy-related services only	Not impacted
Medicaid*	Not impacted
Medicaid Enhanced Plan*	Not impacted

\* Non-emergent medical transportation services will remain as a benefit in the Enhanced Benchmark Benefit Plan.

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## Tips for UB-04 Claim Form Users to Avoid Processing Delays

Avoid delays in claim processing by putting required identification data for the participant and the provider in the proper fields.

The Patient Name fields of the UB-04, 8a and 8b must contain the participant’s data as follows: 8a must contain the participant’s 7- or 11-digit Medicaid identification number (MID) exactly as it is given in the Eligibility Verification System or on their Medicaid ID card. If your computer system demands an 11-digit MID, enter zeros in the eighth through eleventh positions. Example: 1234567 can be entered as 12345670000. The Patient Name field, 8b, must contain the participant’s name spelled exactly as it is on the Medicaid ID card with the last name first, followed by the first name, and then the middle name or initial.

Your 9-digit Idaho Medicaid provider identification number must be entered on the same line (A–C) that Medicaid is shown as the payer in field 50. If line 50 B has “Idaho Medicaid” entered, then the provider’s Medicaid ID should be on line B as well. Enter appropriate provider numbers for other insurance on the same line as that insurance is listed in field 50 A-C.

If you are experiencing trouble getting your claims processed correctly due to an improper billing ID, make sure you are identifying Medicaid as “Idaho Medicaid” in field 50. Other verbiage may not be identified correctly.

If your claims are not getting processed correctly, make sure all required claim data is entered.

The denial codes on your remittance advice will help you identify the areas that need to be corrected. You can find claim form instructions and examples at the end of section 3 in your *Idaho Medicaid Provider Handbook* at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov).

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## May Office Closure

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

**Memorial Day**  
**Monday, May 25, 2009**

## Reminder that MAVIS

(Medicaid Automated Voice Information Service)

is available at: (800) 685-3757 (toll-free) or  
(208) 383-4310 (Boise local)

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