MedicAide

An Informational Newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **May 2023**

In This Issue

Information Releases

The content of this guidance document is not new law but is an interpretation of existing law prepared by the Idaho Department of Health and Welfare to provide clarity to the public regarding existing requirements under the law. This document does not bind the public, except as authorized by law or as incorporated into a contract. For additional information or to provide input on this document, contact the Idaho Division of Medicaid by emailing medicaidcommunications@dhw.idaho.gov or by calling (208)334-5747.

Laboratory Urine Drug Testing

The Medicaid Program Integrity Unit has identified instances of laboratory providers billing urine drug testing services when services were not medically necessary and/or did not have valid orders. Examples of invalid orders include orders by a licensed or certified healthcare professional who has not performed an evaluation and/or is treating the participant for the condition the test is being ordered for; orders by individuals who are not enrolled by Medicaid as an ordering, referring and prescribing provider; blanket or standing orders; and orders specifying both presumptive and confirmatory testing will be performed simultaneously.

Section 4.3 of the November 2022 Idaho Medicaid Provider Handbook, Laboratory Services, addresses controlled substance and drug testing. It states, in pertinent part:

> Idaho Medicaid reimburses presumptive and confirmatory drug testing when medically necessary (such as in the determination of altered mental status or possible overdose, substance use treatment, and chronic pain treatment). Drug testing is not covered as part of routine physicals or for participation in sports, legal, criminal justice, employment, or administrative purposes. However, tests that meet the coverage requirements of this policy may be used additionally for other purposes. Blanket orders and orders specifying that both presumptive and confirmatory testing will be performed simultaneously are not allowed. A blanket order is considered any order that is not specific to the participant, such as orders a provider establishes for all patients under their care. Drug testing is also subject to the following limitations:
>
> - Tests for specimen validity are included in the reimbursement for the test.
> - To be reimbursable, drug tests must be ordered by a licensed or certified healthcare professional who:
>   - Has performed a face-to-face evaluation of the participant (this may include telehealth if the requirements of the telehealth policy are met);
>   - Is treating the participant for the condition the test is being ordered for; and
>   - Is enrolled with Idaho Medicaid and/or the IBHP.
> - Claims for tests ordered by non-enrolled persons or entities (e.g., non-enrolled recovery support staff, law enforcement personnel, probation, and parole officers, etc.) will be denied and/or are subject to recoupment action. Tests ordered by a healthcare professional on behalf of law enforcement personnel, probation, and parole officers, etc. are also not covered.
>
> Confirmatory (or quantitative) tests, analyzed via liquid chromatography tandem mass spectrometry (LCMS/MS) or gas chromatography mass spectrometry (GC-MS), are significantly more expensive. These tests should be reserved for situations when the result of a presumptive test is disputed by the participant, or the drug of concern cannot be tested for via immunoassay. The majority of drug tests conducted should be presumptive, with only a fraction of those being confirmatory tests...

Section 7 of the November 2022 Idaho Medicaid Provider Handbook, Laboratory Services, addresses documentation requirements. It states in part:

> The laboratory is required to obtain all medical necessity documentation prior to billing for services. Documentation requirements applicable in specific situations are listed throughout the handbook for provider convenience. General documentation requirements are also required and found in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook. If a clinical diagnostic test order does not require a

signature, there must be signed medical documentation such as a progress note by the treating physician or non-physician practitioner.

In addition to standard documentation requirements and quality assurance requirements, laboratories must maintain documentation of:

- Physician or non-physician practitioner's order;
- Documentation supporting medical necessity;
- Identification number of the specimen;
- Means of identifying who the specimen belongs to;
- Name of the ordering physician or non-physician practitioner;
- Date specimen was collected;
- Date specimen was received;
- Test performed;
- Date test was performed;
- Results of test;
- Name and address of laboratory specimen was referred to, if applicable; and
- The referring laboratory that submitted the specimen, if applicable.

See Section 2.3 of the November 18, 2022, Idaho Medicaid Provider Handbook, General Information and Requirements for Providers, for additional information on individual provider types who may order, refer, or prescribe healthcare services or supplies for participants of the Idaho Medicaid program.

Drug testing is not covered as part of routine physicals or for participation in sports, legal, criminal justice, employment, or administrative purposes. Laboratories are responsible for ensuring all services are medically necessary and have valid orders. Services that are not in compliance with Medicaid rules and policies are subject to recoupment and civil monetary penalties.

Qualifying Clinical Trials

The definition of a "qualifying clinical trial" is a trial related to "the prevention, detection, or treatment of any serious or life-threatening disease or condition." This includes a trial funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), or other federal-approved entities.

Routine costs are covered during a clinical trial and include any item or service provided to "prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the participant would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver. The investigational item or service that is the subject of the clinical trial is not covered. Services not covered under the state plan or waiver but required by the clinical trial are not covered.

Routine participant costs are covered regardless of where the clinical trial is conducted, including out-of-state, or based on whether the principal investigator or provider treating the participant in connection with the clinical trial is outside of the network of the participant's MCO. Usual requirements regarding rates, billing processes, and prior authorization for out-of-state care, diagnostics, and interventions apply. Routine participant cost does not include any item or service provided to the participant solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the participant and is not otherwise covered under the state plan or waiver.

Idaho Medicaid requests for an **attestation form** to be completed and faxed to the Medical Care Unit at 877-314-8782 before participants start receiving services through a clinical trial. The attestation form must be signed by the principal investigator (PI) or their delegated authority (if they have a documented process for the delegation of authority) and the participant's health care provider that is providing the care during the trial.

Participation in a clinical trial itself does not require prior authorization (PA). However, services associated with routine medical costs while in a clinical trial may have PA requirements that still apply. Submit completed PA request using an Idaho Medicaid Surgery & Procedure PA form, when required. Fax the complete form and required documentation to 877-314-8779. For participants in an MCO, providers must follow the process required by the MCO.

Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

School-Based Health Centers

A School-Based Health Center (SBHC) is eligible to be a mobile unit. A provider must enroll each of the locations under their pay-to NPI to represent which school the services would be occurring at. If a mobile SBHC provider delivered services at a non-school location, they would need to bill a place of service location that is equivalent to a generic mobile unit in addition to the place of service identifier.

Additional information on School-Based Health Centers can be found in the School Based Health Centers section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook. Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

May 2023 Changes to the APC Prep – Fee Schedule Paid Procedure Codes List

The APC Prep – Fee Schedule Paid Procedure Codes list has been updated to include procedure codes recently added to the Idaho Medicaid Fee Schedule. The additions are effective for dates of service starting on or after those effective dates posted to the Idaho Medicaid Fee Schedule. The APC Prep – Fee Schedule Paid Procedure Codes list has also been updated to remove codes that were identified as not paid according to the Idaho Medicaid Fee Schedule rate effective July 1, 2022. Except for instate Critical Access Hospitals (CAH), Institutions for Mental Disease (IMDs) and State-Owned Hospitals, acute care hospitals will continue to be required to bill a CPT or HCPCS code on each outpatient hospital claim line where procedure codes are required under national billing guidelines.

Manually Priced Pharmaceuticals

Pharmaceuticals reimbursed through Gainwell Technologies that are listed with a zero-dollar amount on the fee schedule are priced at the lowest of the provider's charges or one of the following methods:

- If listed on the wholesale acquisition cost (WAC) list, the code is priced from the list and no documentation is required.
- If the code is not on the WAC list, the code requires documentation for manual pricing.

Additional information about manually priced services can be found in the Manually Priced Goods and Services section of the General Billing Instructions, Idaho Medicaid Provider Handbook. Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Hysterectomies and Sterilizations

Idaho Medicaid is clarifying its policy on hysterectomies and sterilizations. The form for hysterectomies does not require the participant to fill in their Medicaid ID number and date of birth. These fields can be filled in by the provider or printed on the form. Providers will need to adjust their claims for reprocessing.

Sterilization coverage includes tubal ligation (by cautery, occlusion, or ligation), salpingectomy and vasectomy. Opportunistic salpingectomies, which are effective for sterilization and can prevent future ovarian cancer, are also covered if provided during a cesarean section or hysterectomy. Additionally, the sterilization form requires the participant's name to be the same in all three (3) name fields. If the name in these three (3) fields differ from one another, then the Sterilization Consent Form would be deemed invalid.

Additional information on hysterectomies and sterilizations can be found in the Hysterectomy and Sterilization Procedures sections of the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook. Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Signatures on Documentation

Idaho Medicaid is clarifying the requirement for signatures on documentation. All signatures, handwritten or electronic, must be dated. Additionally, electronic signatures are not accepted with the following:

- Created by;
- Received by/for;
- Generated by/for;
- Administratively signed by;
- Dictated but not signed;
- Electronically signed to expedite delivery; or
- Proxy signature (signed via approval letter or statement).

More information about signature requirements can be found in the Documentation section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook. Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Providers Responsible to Maintain Record

The Report Year 2022 PERM audit cited errors for some providers because they were unable to make contact with the provider. Your agreement with Idaho Medicaid requires you to keep your enrollment information correct and current at all times. Please see upcoming 2023 Idaho Health Care Conference coming up later this month Here is the invitation and information on how to register. Gainwell will be presenting a comprehensive overview of how and when to submit Provider Maintenance to reflect changes to an existing Provider record using the Gainwell Provider Enrollment Application system.

Multiple Deliveries

Idaho Medicaid is updating its policy on multiple deliveries to reflect national billing guidance. Delivery of the first baby should be billed with the appropriate CPT® code, one (1) unit, and only the charges for the first delivery. All antepartum or postpartum care for all delivered babies is included in the delivery code for the first baby. Delivery of any additional babies is billed with a delivery code (59409, 59514, 59612, or 59620), modifier 51 and 59, and one (1) unit per baby. If multiple babies are delivered by cesarean, then only one CPT® with one unit is billed for all cesarean deliveries as only one cesarean was performed.

Example 1

A participant was pregnant for the first time with triplets. The delivering provider provided all antepartum and postpartum care. All three babies were vaginal deliveries. The claim would be billed with the following codes:

- *Baby 1: 59400, 1 unit*
- *Baby 2 and 3: 59409, Modifier 51 and 59, 2 units*

Example 2

A participant was pregnant for the first time with triplets. The delivering provider provided all antepartum and postpartum care. All three babies were cesarean deliveries. The claim would be billed with the following code:

- *Baby 1, 2 and 3: 59510, 1 unit*

Example 3

A participant was pregnant for the first time with triplets. The delivering provider provided all antepartum and postpartum care. The first baby was a vaginal delivery, and the other two babies were delivered via cesarean. The claim would be billed with the following codes:

- *Baby 1: 59400, 1 unit*
- *Baby 2 and 3: 59514, Modifier 51 and 59, 1 unit*

Additional information on obstetric care can be found in the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook. Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Present on Admission Indicators and HAC

Idaho Medicaid is updating its policy on the present on admission (POA) indicator requirement for claims involving inpatient admission to only require a POA for diagnoses that appear on the CMS hospital-acquired conditions (HAC) list. POA is defined as present at the time the order for inpatient admission occurs. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission. Providers must resolve issues related to inconsistent, missing, conflicting, or unclear information.

In order to support this change Idaho Medicaid is adding "1" as a POA indicator. Providers may also submit claims with a blank on the POA for diagnosis codes that aren't on the HAC list.

Present on Admission (POA) Indicators		
Code	Definition	Idaho Medicaid
1	Unreported/Not used. Exempt from POA reporting.	This code is equivalent to a blank on the UB-04. Idaho Medicaid will process services as usual if the diagnosis does not require a POA indicator. If the diagnosis requires a POA indicator, Idaho Medicaid will deny the claim.

In order to reduce administrative burden on providers, Idaho Medicaid is also updating its split billing policy for HAC claims. Providers will only need to bill two claims for claims with a diagnosis code on the HAC list and a POA of N or U. One claim will be submitted with an inpatient bill type and covered services. The second claim will be submitted with bill type 0110 (Non-Payment/Zero Claim) for services with HAC diagnoses of N or U. Both claims should have the same date range from admission to discharge to prevent denial for duplicate claims. When splitting the claim, write "Split Claim" in Field/Box 80 of the UB-04 claim form.

Additional information about HAC and POA can be found in the Hospital-Acquired Conditions and the Diagnosis Requirements sections of the Hospital Provider Handbook. Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Attention: All Hospital and Long-Term Care Facility Provider Types! Additional Terms Documentation

An enhancement to the Provider Enrollment Application and the current process in collecting Additional Terms documentation for Hospitals reimbursed using 3M™ All Patient Refined DRG (APR DRG) Software and Long-Term Care Facility provider types is moving through our implementation process, and we anticipate this change to have provider impact by May 1, 2023.

Many providers have already completed the Additional Terms documentation; however, we must require Hospital and Long-Term Care Facilities to repeat their acknowledgement and electronically sign the terms that are presented on the Documents tab in the application during their next maintenance. If a change in ownership is reported the Additional Terms will require re-acknowledgement. Thank you for your cooperation in this matter.

Telehealth Services

Idaho Medicaid is updating its Telehealth Services policy for after the end of the public health emergency on May 11th. Telehealth means providing medically necessary healthcare services without actual physical contact, through the use of electronic means. The participant and the provider are interacting in real-time or "live" from two physically different locations, by video or telephone. Services delivered through telehealth will be considered for reimbursement when rendered within the providers scope of practice and billed according to all applicable administrative rules, policy, and federal and state regulations.

Any covered service may be delivered via telehealth when:

- The service can be safely and effectively delivered via telehealth and the medium utilized;
- The service fully meets the code definition when provided via telehealth;

- The service is billed with the FQ or GT modifier; and
- All other existing coverage criteria are met.

Any written information must be provided to the participant before the telehealth appointment in a form and manner which the participant can understand using reasonable accommodations when necessary. The participant must be informed and consent to the delivery models, provider qualifications, treatment methods, or limitations and telehealth technologies. The rendering provider at the distant site must also disclose to the participant their identity, current location (must be within the United States), telephone number and Idaho license number. If the participant (or legal guardian) indicates at any point that they want to stop using the technology, the service should cease immediately, and an alternative (in-person) appointment should be scheduled.

Medicaid policy is not subject to Medicare restrictions for telehealth unless the participant has Medicare primary. Otherwise, all Medicaid providers, including federally qualified health centers (FQHC's), rural health centers (RHC's), and Indian health clinics (IHC's) may bill for telehealth services according to these guidelines

Reporting of test results only is not covered as a telehealth service.

Video must be provided in real-time with full motion video and audio that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication. Transmission of voices must be clear and audible.

The individual treatment record must include written documentation of evaluation process, the services provided, participant consent, participant outcomes, and those services were delivered via telehealth. The documentation must be of the same quality as is originated during an in-person visit. These documentation requirements are specific to delivery via telehealth and are in addition to any other documentation requirements specific to the area of service (i.e., IEP requirements for school-based services).

Only one eligible provider may be reimbursed per service per participant per date of service. No reimbursement is available for the use of equipment at the originating or remote sites. Reimbursement is also not available for services that are interrupted and/or terminated early due to equipment difficulties. Claims for services delivered via telehealth will be reimbursed at the same rate as face-to-face services.

Idaho Medicaid will now accept places of service 02 (Telehealth provided other than in patient's home) and 10 (Telehealth provided in patient's home). Providers should use these places of service on claims from telehealth going forward. Claims for telehealth must include one of the following modifiers:

- FQ – A telehealth service was furnished using real-time audio-only communication technology.
- GT – A telehealth service was furnished using real-time audio-visual communication technology.

Additionally, providers can also use the following modifier in conjunction with one of the above:

- FR – A supervising practitioner was present through a real-time two-way, audio/video communication technology.

FQHC, RHC or IHS providers should not report the GT or FQ modifier with encounter code T1015 but should include it with each applicable supporting codes.

Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

End of the Federal Public Health Emergency

The Consolidated Appropriations Act, 2023 set the end of what is known as COVID-19 Medicaid Protection as April 1, 2023. Please see Department FAQs. The Department began processing re-evaluations of all individuals who are receiving Medicaid coverage under this protection beginning in February. This process will occur in phases every month through fall 2023.

Starting April 1, a person's Medicaid will discontinue if they are ineligible. When this happens, they will receive a notice from the Department that details their household's Medicaid eligibility results.

The Secretary of Health and Human Services (HHS) has declared the end of the federal public health emergency (PHE) as May 11, 2023. For how that affects Medicaid policy flexibilities, please see Medicaid Participant and Medicaid Provider FAQs. Policy flexibilities were put in place to address dynamic conditions at the height of the pandemic that affected the ability of people to access services. Many flexibilities, such as group sizes, or delaying assessments and service plans, will return to normal operations.

Medicaid Protection

Medicaid Protection was put in place at the beginning of the COVID-19 pandemic and provided continued Medicaid coverage for individuals who may have otherwise been ineligible. Congress has recently passed a bill that ends this continued coverage requirement on April 1, 2023.

This does not mean participant Medicaid coverage will automatically end on April 1, 2023, even if they have been receiving Medicaid as a result of this special protection. Providers should always verify participant eligibility and ask about any other coverage prior to rendering services.

DHW will send notices to participants telling them about any coming changes in their eligibility or benefits, and if they need to complete a re-evaluation.

To ensure they receive notices regarding benefits and re-evaluations, please encourage participants to report any changes in contact information, including phone number and mailing address. idalink.idaho.gov.

Phone
1-877-456-1233

Email
MyBenefits@dhw.idaho.gov

For more information, visit the Medicaid Protection FAQ page.

COVID-19 Testing

Idaho Medicaid will continue to reimburse for COVID-19 testing after the end of the public health emergency on May 11th. Idaho Medicaid covers all medically necessary and Centers for Disease

Control & Prevention (CDC) recommended testing for SARS-CoV-2, the virus that causes COVID-19. Covered services for testing for SARS-CoV-2 includes molecular, rapid antigen and serologic (antibody) tests. An individualized test result for either diagnostic and/or screening services must be obtained to support a claim for reimbursement. Providers should educate participants on symptoms and prevention of COVID-19 when ordering testing. At a minimum, prevention education should include a discussion of the importance and correct use of masks or face coverings, social distancing, hand washing, quarantine and isolation, and the benefits of immunizations for the prevention of COVID-19.

Molecular Testing for SARS-CoV-2

Molecular testing demonstrating the presence of viral RNA is the only way to definitively diagnose an active infection with SARS-CoV-2. These tests may detect the virus 1–2 days before symptoms occur and for a short period after symptoms cease. If clinical suspicion for COVID-19 remains high, self-isolation should be recommended regardless of test result. Molecular testing cannot determine if a person has recovered from a previous infection with the virus. Molecular tests available on the market include:

- Rapid molecular testing at the point of care for results within minutes (up to 4-5 per hour);
- High-throughput platforms that process large numbers of tests within hours (up to 2,000 per day);
- Out-of-state laboratories with capabilities similar to high-throughput platforms with turnarounds in 2–4 days.

Molecular tests for SARS-CoV2 are limited to a total of four (4) tests per participant per month. If additional tests are needed, providers can submit a prior authorization request form to Telligen at https://idmedicaid.telligen.com/.

Rapid Antigen Testing for SARS-CoV-2

Rapid antigen testing is less complex than molecular testing methods and can generally provide results in fifteen to thirty minutes. Rapid antigen tests are available as self-administered at home tests and can be great tools for determining if a mild symptom such as congestion is likely to be COVID-19 before an individual goes to a space where they may be in contact with others (e.g. school, work, or a family gathering). However, these tests are less sensitive than molecular tests and require much more virus in the sample to be detected. These tests may not be effective five days after the onset of symptoms or for those that are asymptomatic. It is recommended that those with a negative result and a high degree of suspicion for infection be tested a second time with a molecular test and be told to isolate while awaiting the results of the follow-up test. At home rapid antigen tests require a prescription from a physician, nurse practitioner, physician assistant, or pharmacist and should be billed to Idaho Medicaid at the pharmacy at the point-of-sale.

Rapid Antigen tests for SARS-CoV2 are limited to a total of four (4) tests per participant per month. If additional tests are needed, providers can submit a prior authorization request form to Telligen at https://idmedicaid.telligen.com.

Coverage of Serologic Testing for SARS-CoV-2

Serologic testing looks for previous infection with the virus, by detecting the presence of antibodies that bind to viral proteins. The extent to which antibodies to SARS-CoV2 confer immunity to reinfection is unclear. Given the high risk of false positive COVID-19 antibody

tests, a second test should be performed to confirm the positive result in addition to assessment of other relevant information, such as clinical history or diagnostic test results. Serologic tests should not be used for diagnosing acute infection, for determining the need for quarantine after exposure or for assessing immunity following COVID-19 vaccination. Serologic testing has limited clinical applicability and is not recommended by the CDC or by the State of Idaho's Testing Task Force for use in directing patient care.

Serologic testing is limited to twice (2) per year without a prior authorization. If additional tests are needed, providers can submit a prior authorization request form to Telligen at https://idmedicaid.telligen.com.

Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

COVID-19 Vaccinations

Idaho Medicaid will continue to reimburse for COVID-19 vaccinations after the end of the public health emergency on May 11th. Idaho Medicaid reimburses for all immunizations when provided in accordance with recommendations by the CDC's Advisory Committee on Immunization Practices (ACIP). All participants 6 months and older are currently eligible for COVID-19 vaccinations. Co-pays do not apply to immunizations (vaccines or their administration). For vaccines supplied by state or federal governments at no cost to the provider, the vaccine must be billed with the SL modifier.

Pharmacies can continue to submit claims for reimbursement through the Magellan Point of Sale (POS) system.

Vaccinations provided by Rural Health Clinics, Indian Health Service providers, and Federally Qualified Health Centers should follow the existing protocol for provision of service. If a participant sees a qualified healthcare professional, the vaccine administration would be included as part of the encounter rate as specified in the IHS, FQHC and RHC Services, Idaho Medicaid Provider Handbook, even if no other service is provided. The vaccine and administration CPT® must be listed under the encounter code for billing. If the participant does not see a qualified health professional, the vaccine administration rate should be billed as fee-for-service, using the COVID-19 vaccine administration codes. Fee-for-service reimbursement is paid at the provider's usual and customary fee up to the Medicaid maximum allowance listed in the Numerical Fee Schedule.

99211-GT for vaccine outreach will no longer be a covered benefit of Idaho Medicaid after the PHE ends on May 11th. Outreach for vaccination reminders is considered to be already reimbursed as part of the Healthy Connections case management payment.

For information on how to access the vaccine for your patients or staff and the most up-to-date information on COVID-19 vaccines in Idaho, please visit https://coronavirus.idaho.gov/covid-19-vaccine/ and https://covidvaccine.idaho.gov/.

Additional information on vaccines and administration can be found in the Immunization and Vaccines section of the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook. Questions and comments about this article may be submitted to the Medical Care Policy Team at MCPT@dhw.idaho.gov.

Survey for Primary Care, OB, and GYN Providers

Calling all Primary Care and OB/GYN Providers! - The HIV, STD, and Hepatitis Prevention Programs within Idaho Department of Health and Welfare, Division of Public Health would like to have a better understanding of STI screening practices for syphilis, hepatitis B virus (HBV) and hepatitis C virus (HCV) among pregnant patients. The feedback from the questionnaire will be used to inform and guide our prevention efforts.

The short questionnaire is anonymous and should take no more than 5 minutes to complete. Thank you for your time and participation with the STI Screening Questionnaire.

STI Screening Questionnaire

May Workshops in Lewiston and Twin Falls!

Please join your Gainwell Provider Relations Consultants (PRC) in-person if you're in the Lewiston or Twin Falls area for a Workshop presentation for a comprehensive overview of how and when to submit Provider Maintenance to reflect changes to an existing Provider record using the Gainwell Provider Enrollment Application system. The Idaho Medicaid Provider Enrollment Application system helps simplify processes for maintenance requests, features dynamic screens, electronic signature options, and less paper transactions. We will share tips on navigating the maintenance process. Join us to learn more!

Limited spaces are available, so please register here today by signing in, searching the Catalog for ID – PRV PEA 2.0 Workshop and enrolling into the session that fits your location. Email your PRC if you need any support with the registration process.

Region 2 Lewiston	Region 5 Twin Falls
May 12, 2023, from 9:30 to 10:30 AM MST	May 17, 2023, from 9:30 to 10:30 AM MST
3rd Floor Conference Room	Conference Room 1
1118 F Street Lewiston, ID	601 Pole Line Road Twin Falls, ID

Idaho Health Care Conference 2023 – Register Today!

Gainwell Technologies is eager to invite providers and their staff personnel to the 30th annual statewide Idaho Health Care Conference (IHCC) in May. This year's conference will be held in-person only at the locations noted below. We will be presenting a comprehensive overview of how and when to submit Provider Maintenance to reflect changes to an existing Provider record using the Gainwell Provider Enrollment Application system. The Idaho Medicaid Provider Enrollment Application system helps simplify processes for maintenance requests, features dynamic screens,

electronic signature options, and less paper transactions. We will share tips on navigating the maintenance process. Join us to learn more!

Join us at the 2023 Idaho Health Care Conference from 8:00 AM to 4:00 PM on the following dates:

- May 11, 2023: North Idaho—Red Lion Templin's Hotel on the River, Post Falls
- May 16, 2023: Eastern Idaho—Shoshone Bannock Casino Hotel, Fort Hall
- May 18, 2023: Treasure Valley—Nampa Civic Center, Nampa

Here is the invitation and information on how to register. We hope you'll attend the conference at a location near you!

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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April 26, 2023

MEDICAID INFORMATION RELEASE MA23-04

To: Medicaid Providers

From: Juliet Charron, Administrator

Subject: YES Participant Eligibility Requirements

YES Program Participants and Medicaid Eligibility

For Medicaid participants to maintain enrollment in the YES Program, these Idaho Medicaid 1915(i) State Plan Authority (SPA) eligibility requirements must be met:

- **Complete a Person-Centered Service Plan (PCSP)** within ninety (90) days of enrollment in the YES Program and update the PCSP at least annually within three hundred and sixty-four (364) days of the previous plan. The PCSP must include all services the member and their family may use during the member's treatment, including any 1915(i) services they will use (currently, the only 1915(i) service is respite). PCSPs can be completed by Target Care Coordinators (TCC) enrolled in the Idaho Behavioral Health Plan (IBHP) provider network, Developmental Disability (DD) Case Managers (CM) with the Division of Family and Community Services, or Wraparound Coordinators or clinicians with the Division of Behavioral Health. Medicaid's contracted Idaho Behavioral Health Plan (IBHP) contractor, currently Optum Idaho, will start sending letters to each member's family to remind them to complete their initial PCSP within the first month of being enrolled in the program, and again starting ninety (90) days prior to the PCSP renewal date.

- **Complete an annual independent assessment** for serious emotional disturbance (SED) each year within three hundred and sixty-four (364) days of the previous assessment. Medicaid's contracted Independent Assessor, currently Liberty Healthcare, will send letters to each member's family starting ninety (90) days prior to their annual renewal date to schedule the assessment.

- **Utilize a 1915(i) service** (currently, the only 1915(i) service is respite) at least one (1) time per eligibility year with a Medicaid-enrolled provider. Respite must also be listed in the member's PCSP.

If a member does not meet any of the above requirements, they may be disenrolled from the YES Program.

Some YES Program members may qualify for Medicaid by other eligibility pathways, such as traditional Medicaid (lower income), certain medical conditions, foster care, or adoption. These members will remain enrolled in Medicaid via that pathway as long as they remain eligible.

All members being disenrolled from the YES Program will receive notice prior to being disenrolled.

Any member struggling to meet any of the 1915(i) eligibility requirements that does not qualify for Medicaid by another pathway may contact the Medicaid YES Program team for support 208-364-1910 or yesprogram@dhw.idaho.gov.

YES Program Participants and Cost Sharing

No sooner than September 1, 2023, the Division of Medicaid will begin cost sharing for some 1915(i) YES Program members. Cost sharing will start being enforced due to CMS guidance that cost sharing be waived during the Public Health Emergency (PHE). Currently the PHE is set to end May 11, 2023. **Cost sharing can include premiums and co-payments. Members whose family income is between one hundred eighty-five percent (185%) and three hundred percent (300%) of the Federal Poverty Guidelines (FPG), will be required to pay a monthly premium. Members whose family income is above 133% of the FPG may be asked to pay a co-pay for certain services.**

Medicaid cost sharing is mandatory under Idaho administrative code *16.03.18. Medicaid Cost-Sharing* and Idaho Code 56-257 Copayments. If a 1915(i) YES Program member's family is required to pay a premium because of their income level, the Department of Health and Welfare's Bureau of Financial Services will send the family a monthly invoice and instructions for how and when to pay the premium. Included with the invoice are instructions to request a hardship waiver for families unable to pay the monthly premium.

The premium is fifteen dollars ($15.00) per month per YES Program member and will not exceed the maximum federally allowable amount of 5% of the family's income. If the member is also enrolled in another Medicaid program that requires monthly premiums, the family will only be responsible for the premium for the other program and will not be asked to pay a premium for the YES Program.

Members required to participate in cost sharing may also be asked by their provider to provide a co-payment of three dollars sixty-five cents ($3.65) per visit for certain outpatient services.

Stakeholder Engagement

The YES Program Team will be holding monthly public YES Program Stakeholder Engagement meetings at minimum though September 2023. Meeting invites can be found on the Department website townhall.idaho.gov/. YES Program team members and other IDHW employees will be available to discuss implementation of SPA requirements and answer questions.

Any member struggling to meet any of the 1915(i) eligibility requirements that does not qualify for Medicaid by another pathway may contact the Medicaid YES Program team for support 208-364-1910 or yesprogram@dhw.idaho.gov.

QUESTIONS

For information about other Medicaid programs and eligibility requirements, please visit: healthandwelfare.idaho.gov.

For questions or support e-mail requests to Medicaid YES Program team at yesprogram@dhw.idaho.gov or call 208-364-1910.

JC/db

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 4, 2023

MEDICAID INFORMATION RELEASE MA23-08

To: Ambulatory Surgical Centers

From: Juliet Charron, Administrator

Subject: Dental Services by Ambulatory Surgical Centers

Idaho Medicaid is updating billing requirements and reimbursement for Ambulatory Surgical Centers (ASC) providing dental services. Idaho Medicaid is adopting the use of the Code on Dental Procedures and Nomenclature (CDT)® by the American Dental Association (ADA)® for ASC providers for billing and reimbursement purposes. Services must be medically necessary and meet all other requirements to be eligible for reimbursement.

ASC providers will continue to bill the appropriate Current Procedural Terminology (CPT)® code when one is applicable to the dental service provided. Effective May 1, 2023, dental procedures without a CPT code will no longer be submitted using T1015, Clinic visit/encounter, all-inclusive. When a service is not represented by a CPT code, ASC providers will instead bill the appropriate CDT code.

Some services may have limitations that require a prior authorization if the amount is exceeded. Prior authorizations for dental services are requested through Idaho Smiles, administered by MCNA Dental. Please call 1 (855) 235-6262 or visit the Idaho Smiles website for more information.

Codes that always require a prior authorization by Idaho Smiles regardless of amount do not require the ASC to directly obtain an authorization. However, to be eligible for reimbursement, ASCs are required to verify the provider performing the procedure has an approved prior authorization. If no prior authorization was obtained for a procedure requiring one, neither the dental provider or the ASC are eligible for reimbursement.

The following dental procedures represented by CDT codes are allowed to be performed in an ASC for Medicaid reimbursement. Providers wishing to request additional dental procedures added to coverage for ASC providers may contact MCPT@dhw.idaho.gov with documentation showing the service is appropriate for an ASC setting.

CDT Codes Eligible for Medicaid Reimbursement			
Procedure Code	Description	Reimbursement	Limitations
D0120	Periodic oral evaluation - established patient	$19.24	1 per 6 months.
D0120	Periodic oral evaluation - established patient	$19.24	1 per 6 months.
D0120	Periodic oral evaluation - established patient	$19.24	1 per 12 months.
D0140	Limited oral evaluation - problem focused	$27.15	1 per 6 months.
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$27.90	1 per 6 months.
D0150	Comprehensive oral evaluation - new or established patient	$27.90	1 per 6 months.
D0150	Comprehensive oral evaluation - new or established patient	$27.90	1 per 6 months.
D0150	Comprehensive oral evaluation - new or established patient	$27.90	1 per 12 months.
D0210	Intraoral - comprehensive series of radiographic images	$59.17	1 per 36 months.
D0220	Intraoral - periapical first radiographic image	$9.22	N/A
D0230	Intraoral - periapical each additional radiographic image	$8.19	N/A
D0240	Intraoral - occlusal radiographic image	$8.70	2 per 24 months.
D0270	Bitewing - single radiographic image	$8.93	1 per 6 months.
D0270	Bitewing - single radiographic image	$8.93	1 per 12 months.
D0272	Bitewings - two radiographic images	$15.87	1 per 6 months.
D0272	Bitewings - two radiographic images	$15.87	1 per 12 months.
D0273	Bitewings - three radiographic images	20.84	1 per 6 months.
D0273	Bitewings - three radiographic images	20.84	1 per 12 months.
D0274	Bitewings - four radiographic images	$23.82	1 per 6 months.
D0274	Bitewings - four radiographic images	$23.82	1 per 12 months.
D1110	Prophylaxis - adult	$41.68	1 per 6 months.
D1120	Prophylaxis - child	$29.17	1 per 6 months.
D1206	Topical application of fluoride varnish	$13.55	1 per 6 months.

CDT Codes Eligible for Medicaid Reimbursement			
Procedure Code	Description	Reimbursement	Limitations
D1351	Sealant-per tooth	$20.83	16 per 36 months
D1510	Space maintainer - fixed, unilateral - per quadrant	$103.20	4 per lifetime.
D1516	Space maintainer - fixed - bilateral, maxillary	$174.66	1 per lifetime.
D1517	Space maintainer - fixed - bilateral, mandibular	$174.66	1 per lifetime.
D1520	Space maintainer - removable, unilateral - per quadrant	$76.41	4 per lifetime.
D1526	Space maintainer - removable, bilateral, maxillary	$143.50	1 per lifetime.
D1527	Space maintainer - removable, bilateral, mandibular	$143.50	1 per lifetime.
D2140	Amalgam-one surface, primary or permanent	$51.25	32 per 12 months.
D2150	Amalgam-two surfaces, primary or permanent	$67.22	32 per 12 months.
D2160	Amalgam-three surfaces, primary or permanent	79.22	32 per 12 months.
D2161	Amalgam-four or more surfaces, primary or permanent	$70.15	32 per 12 months.
D2330	Resin-one surface, anterior	$66.56	32 per 12 months.
D2331	Resin-two surfaces, anterior	$86.53	32 per 12 months.
D2332	Resin-three surfaces, anterior	$105.17	32 per 12 months.
D2335	Resin-four or more surfaces or involving incisal angle (anterior)	$94.20	32 per 12 months.
D2391	Resin-based composite - one surface, posterior	$57.16	32 per 12 months.
D2392	Resin-based composite - two surfaces, posterior	$74.98	32 per 12 months.
D2393	Resin-based composite - three surfaces, posterior	$88.36	32 per 12 months.
D2394	Resin-based composite - four or more surfaces, posterior	$70.15	32 per 12 months.
D2710	Crown - resin-based composite (indirect)	$233.18	32 per 84 months
D2721	Crown-resin with predominantly base metal	$148.84	32 per 84 months
D2740	Crown - porcelain/ceramic	$362.86	32 per 84 months
D2750	Crown-porcelain fused to high noble metal	$362.86	32 per 84 months

CDT Codes Eligible for Medicaid Reimbursement			
Procedure Code	Description	Reimbursement	Limitations
D2751	Crown-porcelain fused to predominantly base metal	$362.86	32 per 84 months
D2920	Re-cement or re-bond crown	$30.75	32 per 60 months.
D2930	Prefabricated stainless steel crown-primary tooth	$101.84	32 per 60 months.
D2931	Prefabricated stainless steel crown-permanent tooth	$107.84	32 per 60 months.
D2932	Prefabricated resin crown	$108.41	32 per 60 months.
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$108.41	32 per 60 months.
D2940	Protective restoration	$29.76	N/A
D2950	Core build-up, including any pins when required	$70.44	32 per 72 months.
D2954	Prefabricated post and core in addition to crown	$79.38	32 per 72 months.
D2980	Crown repair necessitated by restorative material failure	$59.54	32 per lifetime.
D3110	Pulp cap-direct (excluding final restoration)	$19.85	N/A
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament	$49.61	32 per lifetime.
D3221	Pulpal debridement, primary and permanent teeth	$49.61	32 per lifetime.
D3230	Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration)	$59.53	32 per lifetime.
D3240	Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)	$59.53	32 per lifetime.
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$208.37	12 per lifetime.
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$267.91	8 per lifetime.
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$312.56	12 per lifetime.
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$41.68	1 per 36 months.
D4910	Periodontal maintenance	$43.01	2 per 12 months.
D7111	Extraction, coronal remnants - primary tooth	$42.66	N/A
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$57.24	N/A

CDT Codes Eligible for Medicaid Reimbursement			
Procedure Code	Description	Reimbursement	Limitations
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$102.51	N/A
D7220	Removal of impacted tooth-soft tissue	$98.31	N/A
D7230	Removal of impacted tooth-partially bony	$114.68	N/A
D7240	Removal of impacted tooth-completely bony	$148.49	N/A
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	$149.50	N/A
D7250	Removal of residual tooth roots (cutting procedure)	$78.85	N/A
D7280	Exposure of an unerupted tooth	$153.60	N/A
D7510	Incision and drainage of abscess-intraoral soft tissue	$42.66	N/A
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia	$24.46	1 per day
D9420	Hospital or ambulatory surgical center call	$92.27	1 per day

JC/wd

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Provider Training Opportunities

You are invited to attend the following webinars offered by Gainwell Technologies Regional Provider Relations Consultants.

May: PEA Maintenance
A comprehensive overview of how and when to submit Provider Maintenance to reflect changes to an existing Provider record using the upgraded Provider Enrollment Application system. The upgraded Idaho Medicaid Provider Enrollment Application features a new look and feel, simplified processes for maintenance requests and features dynamic screens and electronic signature options, which will result in quicker processing times and less paper transactions. Join us to learn more!

Training is delivered at the times shown in the table below. Each session is open to any region, but space is limited to 25 participants per session, so please choose the session that works best with your schedule. To register for training, or to learn how to register, visit www.idmedicaid.com.

	May	June	July
	PEA Maintenance	**Eligibility**	**Coordination of Benefits**
10-11:00 AM MT	5/17/2023	6/21/2023	7/19/2023
	5/18/2023	6/15/2023	7/20/2023
	5/16/2023	6/20/2023	7/18/2023
2-3:00 PM MT	5/10/2023	6/14/2023	7/12/2023
	5/11/2023	6/08/2023	7/13/2023
	5/18/2023	6/15/2023	7/20/2023
	5/16/2023	6/20/2023	7/18/2023

If you would prefer one-on-one training in your office with your Regional Provider Relations Consultant, please feel free to contact them directly. Provider Relations Consultant contact information can be found on page 25 of this newsletter.

DHW Resource and Contact Information

DHW Website	https://healthandwelfare.idaho.gov/
Idaho CareLine	2-1-1 1 (800) 926-2588
Medicaid Program Integrity Unit	P.O. Box 83720 Boise, ID 83720-0036 prvfraud@dhw.idaho.gov Hotline: 1 (208) 334-5754 Fax: 1 (208) 334-2026
Telligen	1 (866) 538-9510 Fax: 1 (866) 539-0365 http://IDMedicaid.Telligen.com
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)-334-4676 1 (800) 494-4133
Region IV **Boise**	1 (208) 334-4676 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

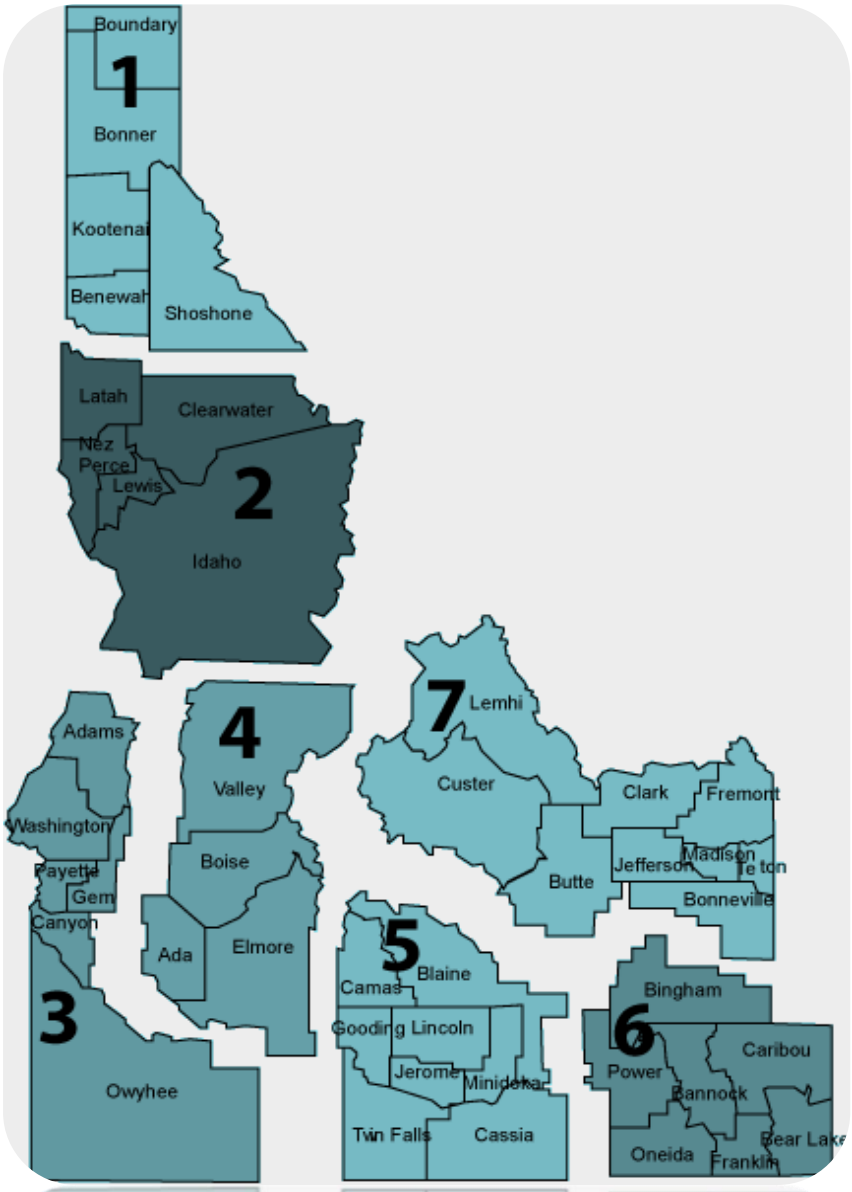
Gainwell Technologies Provider and Participant Services Contact Information

Provider Services	
MACS (Medicaid Automated Customer 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	idproviderservices@gainwelltechnologies.com idproviderenrollment@gainwelltechnologies.com
Mail	P.O. Box 70082 Boise, ID 83707
Participant Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4752 1 (208) 373-1432
Participant Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4752 1 (208) 373-1424
E-mail	idparticipantservices@gainwelltechnologies.com
Mail – Participant Correspondence	P.O. Box 70081 Boise, ID 83707
Medicaid Claims	
Utilization Management/Case Management	P.O. Box 70084 Boise, ID 83707
CMS 1500 Professional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional Crossover/CMS 1500/Third-Party Recovery (TPR)	P.O. Box 70084 Boise, ID 83707
Financial/ADA 2006 Dental	P.O. Box 70087 Boise, ID 83707

Gainwell Technologies Provider Services Fax Numbers

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

Provider Relations Consultant (PRC) Information



Region 1 and the state of Washington
1 (208) 202-5735
Region.1@gainwelltechnologies.com

Region 2 and the state of Montana
1 (208) 202-5736
Region.2@gainwelltechnologies.com

Region 3 and the state of Oregon
1 (208) 202-5816
Region.3@gainwelltechnologies.com

Region 4
1 (208) 202-5843
Region.4@gainwelltechnologies.com

Region 5 and the state of Nevada
1 (208) 202-5963
Region.5@gainwelltechnologies.com

Region 6 and the state of Utah
1 (208) 593-7759
Region.6@gainwelltechnologies.com

Region 7 and the state of Wyoming
1 (208) 609-5062
Region.7@gainwelltechnologies.com

Region 9 all other states (not bordering Idaho)
1 (208) 609-5115
Region.9@gainwelltechnologies.com

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IDAHO DEPARTMENT OF HEALTH & WELFARE

Digital Edition

MedicAide is available online by the fifth of each month at www.idmedicaid.com. There may be occasional exceptions to the availability date as a result of special circumstances. The electronic edition reduces costs and provides links to important forms and websites.

***MedicAide* is the monthly informational newsletter for Idaho Medicaid providers.**
Editor: Shannon Tolman

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