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General Billing Instructions

The General Billing Instructions, Idaho Medicaid Provider Handbook, is applicable to all provider types, and must be followed except where otherwise stated for a specific provider type. Should the handbook ever appear to contradict relevant provisions of Idaho or federal regulations, the regulations prevail. Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies Idaho Medicaid website.

This handbook covers basic billing information providers need to submit claims and adjustments to Idaho Medicaid for services processed by Gainwell Technologies (GWT). It describes Medicaid billing policies; how to submit claims electronically, on paper, or directly into Health PAS; how to check claim status or where to get help with claim submital. In addition, it describes the prior authorization (PA) process, third party liability (TPL), and claim review requests/pre-appeals/adjustments (both online and paper).

Providers must follow their provider type or service specific handbook as located in the Provider Guidelines. Handbook sections in addition to this one that always apply to providers include:

- General Information and Requirements for Providers; and
- Glossary.

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3.a The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3.a.

References are included throughout the handbook for provider and staff convenience. Not all applicable references have been incorporated into the handbook. Not all references provided are equal in weight.

- Case Law: Includes references to court cases that established interpretations of law that states and providers would be required to follow.
- CMS Guidance: These references reflect various Centers for Medicare and Medicaid Services (CMS) publications that Idaho Medicaid reviewed in the formulation of their policy. The publications are not required to be followed for Idaho Medicaid services.
- Federal Regulations: These references are regulations from the federal level that affected policy development. Usually these include the Code of Federal Regulations, the Social Security Act and other statutes. Federal regulations must be followed.
- Idaho Medicaid Publications: These are communications from Idaho Medicaid to providers that were required to be followed when published. These are included in the handbook for historical reference. The provider handbook supersedes other communications unless the documents are listed in the Policies, Procedures, and Waivers webpage under policies in Medicaid Policies library.
- Idaho State Plan: The State Plan is the agreement between the State of Idaho and the Centers for Medicare and Medicaid Services on how the State will administer its medical assistance program.
- Professional Organizations: These references reflect various publications of professional organizations that Idaho Medicaid reviewed in the formulation of their

policy. Providers may or may not be required to follow these references, depending on the individual reference and its application to a provider's licensure and scope of practice.

- Scholarly Work: These references are publications that Idaho Medicaid reviewed in the formulation of their policy. The publications themselves are not required to be followed for Idaho Medicaid services.
- State Regulations: These references are regulations from the state level that affected policy development. They usually include statute and IDAPA. They are required to be followed.

Some citations may not be available on the internet. Copies of the documents may be requested with a public records request. Guidance for public records requests is available on the Department's website.

1. Medicaid Billing Policies

Once enrolled, providers may bill for services rendered to Idaho Medicaid participants. Providers are not obligated to accept all Medicaid participants on an ongoing, day-to-day basis. Provider enrollment signifies only that a provider will bill Medicaid if they accept a Medicaid participant as a patient. Providers shall charge their usual and customary fee for services and submit those charges to Medicaid for payment consideration unless otherwise instructed.

Providers must accept payment from Medicaid as payment in full for covered services. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for circumstances when a participant may be billed.

If the participant has other insurance, the provider must bill the other insurance and complete all billing requirements for that carrier first, and then bill Medicaid. See the Third-Party Liability section for additional information.

Idaho Medicaid does not support billing and payment by cost centers. Hospitals should bill applicable revenue codes listed in the Hospital, Idaho Medicaid Provider Handbook. Revenue codes not listed are not covered.

To be eligible for reimbursement, providers must abide by Department communications such as Information Releases, MedicAide newsletters, the Idaho Medicaid Provider Handbook, and state and federal regulations. Coverage policies in place at the time of service should be followed. Policies on how to bill may change and be retroactive to the date of service to accommodate the claim system. This is to ensure successful payment of claims without significant delay.

Information provided by Gainwell Technologies (GWT), Idaho Medicaid's contractor, cannot supersede these requirements or substitute the provider's responsibility to understand and follow them.

1.1 References: Medicaid Billing Policies

1.1.1 Federal Regulations

Acceptance of State Payment as Payment in Full, 42 CFR 447.15 (2013). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2022-title42-vol4/pdf/CFR-2022-title42-vol4-sec447-15.pdf.

1.1.2 Idaho Medicaid Publications

"**Medicaid Program Integrity Unit:** Services Must be Billed in Accordance with Medicaid Rules, Regulations and Policies." *MedicAide Newsletter,* October 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202019%20MedicAide.pdf.

1.1.3 State Regulations

"Acceptance of State Payment." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 025.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provided Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Provider Payment, Idaho Code 56-265 (2020). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

1.2 Billing Procedure for Date Spanning

For CMS 1500 Claims, **non-consecutive** dates should not be spanned on a single claim detail. Providers risk claim denials due to duplicate logic, overlapping dates, and/or mutually exclusive edits.

When date spanning, services must have been provided for every day within that span. For example, it would be incorrect to date span the entire week or month when services were only performed on Thursday and Saturday within the same week or January 1 and January 10 within the same month.

Example

For services provided to the participant on the following days:
Thursday, December 11, 2020
Saturday, December 13, 2020
...enter each date on a separate detail line.

Example of Date Spanning		
Date(s) of Service	**Procedure Code**	**Charges**
12/11/2020 – 12/11/2020	XXXXX	$ XXX.XX
12/13/2020 – 12/13/2020	XXXXX	$ XXX.XX

For UB-04 Claims, non-consecutive dates can be spanned on a single claim, however, providers should be careful to not create an outpatient claim that overlaps an inpatient claim. Outpatient claims that overlap inpatient claims will be denied unless otherwise stated in the Idaho Medicaid Provider Handbook.

1.2.1 References: Billing Procedure for Date Spanning

(a) Idaho Medicaid Publications

"Date Spanning." *MedicAide Newsletter,* August 2005.

"Date Spanning Clarification." *MedicAide Newsletter,* June 2008.

"Date Spanning Clarification." *MedicAide Newsletter,* October 2005.

1.3 Billing 15-Minute Timed Codes

Several CPT® and HCPC codes used for evaluations, therapy modalities, procedures, and collateral contacts specify that one (1) unit equals 15 minutes. Providers must bill procedure codes for the services they delivered using CPT® codes and the appropriate number of units of service. The beginning and ending time of the treatment must be recorded in the participant's medical record with a note describing the treatment. Only time spent directly working with the participant is counted. For any single CPT® code, providers may bill a single 15-minute unit for treatment that is greater than or equal to eight (8) minutes and less than 23 minutes in a day. Time intervals for treatments lasting 23-minutes or longer on a single date of service are as follows:

Units for 15 Minute Timed Codes	
Number of Units	Time Interval
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

The pattern remains the same for treatment times over two hours. Providers should not bill for services performed for less than eight (8) minutes. The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

When more than one service represented by codes and measured in 15-minute increments is performed on a single date of service, the total number of minutes for all services should be added together to determine the number of units that can be billed for that date of service. Multiple timed services should not be combined into a single billing code. See the "Units for 15 Minute Timed Codes" table above to determine how many units are billable. The total number of units billable should be distributed based on the time spent per code to best fit the allowed units. See the examples below for appropriate time coding.

Billing Multiple 15 Minute Timed Codes			
	Time Spent	Billed Units	Explanation
Example 1			
Code 1	36 minutes	3	According to the chart above, "Units for 15 Minute Timed Codes" 71 minutes equals 5 units. Each of the codes was billed for 30 minutes so should be billed at least a minimum of 2 units each. Since Code 1 took more time than Code 2 the remaining unit should be assigned there even though by itself Code 1 wouldn't qualify for 3 units.
Code 2	35 minutes	2	
Total	71 minutes	5	
Example 2			
Code 1	20 minutes	2	According to the chart above, "Units for 15 Minute Timed Codes" 40 minutes equals 3 units. Each of the codes was billed for at least 15 minutes so should be billed at least 1 units each. Since both services took the same amount
Code 2	20 minutes	1	
Total	40 minutes	3	

			of time, the provider can assign the remaining unit to either code they decide.
Example 3			
Code 1	33 minutes	2	According to the chart above, "Units for 15 Minute Timed Codes" 40 minutes equals 3 units. Code 1 was provided for 2 full units. Since Code 2 did not meet the 8-minute threshold for 1 unit, compare the unassigned time from Code 1 (3 minutes) with Code 2 (7 minutes). Bill the remaining unit with the code that has the largest unassigned time i.e., Code 2.
Code 2	7 minutes	1	
Total	40 minutes	3	
Example 4			
Code 1	16 minutes	1	According to the chart above, "Units for 15 Minute Timed Codes" 49 minutes equals 3 units. All codes performed would qualify for a single unit on the chart above, but since they were performed on the same day the time is added up to determine the number of billable units. Since all the codes qualify for 1 unit, the units are divided equally among the top codes. Although Code 4 isn't being reimbursed directly, it must still be documented since its time is being reimbursed in the other codes.
Code 2	10 minutes	1	
Code 3	10 minutes	1	
Code 4	8 minutes	0	
Total	44 minutes	3	
Example 5			
Code 1	7 minutes	1	According to this section 21 minutes is eligible for 1 unit. As all the codes were performed for the same amount of time, the performing professional selects once to bill with the 1 unit. Although Codes 2 and 3 aren't being reimbursed directly, they must be documented since their time is being used to justify the reimbursement for Code 1.
Code 2	7 minutes	0	
Code 3	7 minutes	0	
Total	21 minutes	1	

1.3.1 References: Billing 15-Minute Timed Codes

(a) CMS Guidance

"Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services." *Medicare Claims Processing Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf.

"Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

(b) Idaho Medicaid Publications

Billing for 15 Minute Units, Information Release MA08-11 (5/1/2008). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13216&dbid=0&repo=PUBLIC-DOCUMENTS.

"Billing Time-Based Codes: 15 Minute Units, and Other Timed Codes in Fee-For-Service Medicaid." *MedicAide Newsletter,* August 2019,

https://www.idmedicaid.com/MedicAide%20Newsletters/August%202019%20MedicAide.pdf
.

1.4 Electronic Visit Verification (EVV)

Home Health agencies and Personal Assistance Agencies (PAA) must submit Electronic Visit Verification (EVV) data to the state's EVV Aggregator to be eligible for payment of certain claims in compliance with Section 12006(a) of the 21st Century Cures Act. The state's EVV Aggregator and related certification and training materials are provided by Sandata (www.sandata.com).

PAA EVV data is reviewed quarterly by the Bureau of Long-Term Care (BLTC). The required compliance threshold is automatically verified visit data for 85% or more of visits that occur in the reporting period. Any provider that has 15% or more of its EVV visits manually verified in any quarter will be required to improve. The EVV Provider Help Aid is available to assist providers.

As part of its EVV data monitoring process, the BLTC will identify providers that were deficient in the reporting quarter.

- If the provider is deficient for the second consecutive calendar quarter, the provider will receive a request for an EVV Action Plan. The provider must return the completed action plan via email to BLTCQA@dhw.idaho.gov. The provider will receive an approval or denial of their plan from a BLTC Quality Assurance Specialist.
- If the provider was not deficient during the previous quarter, an email notification will be sent with an EVV Response Form. The agency must return the completed form via email to BLTCQA@dhw.idaho.gov. Technical assistance is available by request.

1.4.1 Request with No Provider Response

Providers that do not respond to requests will have their payment for claims held and a referral will be made to Medicaid Program Integrity Unit.

1.4.2 EVV: Applicable Providers and Services

Electronic Visit Verification (EVV) data submittal is required for the following providers and services:

Home Health	
Service	Revenue Code
Aide Services	0571
Audiology Services	0470
Audiology Services – Diagnostic	0471
Audiology Services – Treatment	0472
Occupational Therapy	0431
Physical Therapy	0421
Skilled Nursing	0551
Speech-Language Pathology	0441

Personal Assistance Agency	
Services	**HCPCS**
Attendant Care	S5125
Homemaker	S5130
Respite	T1005
Personal Care Services	T1019
Family Personal Care Services	T1019 V1

1.4.3 EVV: Vendor Requirements

Agencies are empowered to choose any Electronic Visit Verification (EVV) vendor that is certified and compatible with the Sandata EVV Aggregator. Technical Specifications and related information are available on the DHW Website in the Electronic Visit Verification Resource Library and by contacting Sandata.

Compliant EVV systems must capture the following six (6) data elements to validate service delivery:

1. Participant receiving the service,
2. Individual providing the service,
3. Type of billable service,
4. Location of the service,
5. Date of the service, and
6. Time the service begins and ends.

1.4.4 References: Electronic Visit Verification (EVV)

(a) CMS Guidance

Electronic Visit Verification (EVV), Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification-evv/index.html.

(b) Federal Regulations

21st Century Cures Act. Section 12006(a). "*Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid*". https://www.congress.gov/bill/114th-congress/house-bill/34/text.

(c) Idaho Medicaid Publications

"Attention Home Health Agencies: EVV Claim Denials Beginning October 1, 2021." *MedicAide Newsletter*, September 2021, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202021%20MedicAide.pdf.

"Attention Home Health and PCS Providers - Claim Impacts and Denials." *MedicAide Newsletter*, July 2021, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202021%20MedicAide.pdf.

"Attention Home Health and PCS Providers - Claim Processing Timeline." *MedicAide Newsletter*, February 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202023%20MedicAide.pdf.

"Attention Home Health and PCS Providers – Upcoming Claim Impacts." *MedicAide Newsletter*, June 2021, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202021%20MedicAide.pdf.

"Attention Home Health and PCS Providers – What Is EVV and How to Prepare." *MedicAide Newsletter*, February 2021, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202021%20MedicAide.pdf.

"Attention Personal Assistance Agencies and Home Health Agencies: EVV Claim Denials Beginning July 1, 2021." *MedicAide Newsletter*, May 2021, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202021%20MedicAide.pdf.

"Electronic Visit Verification (EVV)." *MedicAide Newsletter*, April 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf.

"EVV 2023 Changes to Compliance Monitoring." *MedicAide Newsletter,* January 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202023%20MedicAide.pdf.

"Implementation of Federal Electronic Visit Verification (EVV) Regulations – Upcoming Stakeholder Webinar." *MedicAide Newsletter*, December 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202018%20MedicAide.pdf.

1.5 False or Improper Claims

Providers are liable for claims for services submitted on their behalf. Any provider, who knowingly or should have known, submitted claims for items or services not provided as claimed, or upcoded claims, may be liable for criminal and/or civil monetary penalties and exclusion from the Medicare and Medicaid programs. This includes misrepresentation of services as being provided by a physician, when they were provided by another provider type, and services that are known, or should have been known, not to be medically necessary.

1.5.1 References: False or Improper Claims

(a) Federal Regulations

"Civil Monetary Penalties." Social Security Act, Sec. 1128A (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm.

"Criminal Penalties for Acts Involving Federal Health Care Programs." Social Security Act, Sec. 1128B (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm.

False or Improper Claims, 42 CFR 1001.901 (2017). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec1001-901.pdf.

Fraud and Kickbacks and Other Prohibited Activities, 42 CFR 1001.951 (2017). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec1001-951.pdf.

1.6 Hospice Participants

Providers can check a participant's hospice status by calling Gainwell Technologies at 1 (866) 686-4272 and asking a customer service representative to check the participant record for a hospice alert for the date of service. When a participant is on hospice care, the hospice agency is responsible for all services related to the hospice diagnosis. If a provider bills for services not related to the participant's hospice diagnosis to expedite payment, the provider may submit a claim via direct data entry (DDE) using the provider's Trading Partner Account (TPA) and attach supporting documentation that the services are not related to the hospice diagnosis. Supporting documentation can include a visit summary or an explanatory letter.

Any issues or questions concerning services for hospice participants should be referred to the hospice provider.

1.7 340B Pharmacy Billing

Congress created the Medicaid rebate program to lower the cost of pharmaceuticals reimbursed by state Medicaid agencies. Congress extended to safety-net providers the same kind of relief from high drug costs that Congress provided to the Medicaid program with the Medicaid rebate law with the 340B requirements. This may apply to the outpatient pharmacy program, hospitals, and to physician-administered drugs.

Providers who obtain status as a 340B pharmacy and receive reduced costs from the manufacturer must determine if they will provide drugs from their 340B stock to Idaho Medicaid participants. According to regulations, 340B providers may bill in one of two ways:

- "carve Medicaid in"
- "carve Medicaid out"

Providers choosing to "carve Medicaid in" have to enroll with Idaho Medicaid as a 340B entity and provide a copy of their completed Health Resources and Services Administration (HRSA) 304B registration. Under this option, providers must use their 340B stock for Medicaid participants. This applies to the provider's inpatient services, outpatient clinics and retail pharmacies. Contract pharmacies, however, are not eligible under the 340B program unless they separately enroll.

Carved-in 340B providers must only bill for drugs from their 340B stock for those drugs received under that program. Providers must bill no more than the acquisition price on 340B claims and append the UD modifier for primary Medicaid or commercial plan claims. Providers billing Medicare as primary must use the JG or TB modifier, as applicable. Reimbursement will be limited to the provider's actual acquisition cost not to exceed the 340B ceiling price with a professional dispensing fee.

Providers that choose the option to "carve Medicaid out" must use drugs purchased through regular rates and prices. The provider is required to bill their usual and customary price for these drugs on their claims and will be paid at the usual rate. A carved-in provider that elects to withdraw from the program must provide thirty (30) days' notice.

1.7.1 References: 340B Pharmacy Billing

(a) Idaho Medicaid Publications

"Billing 340B Pharmacy Claims." *MedicAide Newsletter,* December 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202023%20MedicAide.pdf.

(a) Federal Regulations

Limitation on Prices of Drugs Purchased by Covered Entities, 42 USC 256b (2023). Government Printing Office, https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap6A-subchapII-partD-subpartvii-sec256b.pdf.

(b) State Regulations

"340B Covered Entity Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 215.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Prescription Drugs: Provider Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 215.01.c.ii. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provided Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

1.8 Place of Service

Idaho Medicaid recognizes all places of service (POS), however, not all services are eligible for every POS.

Places of Service	
Code	Place
01	Pharmacy
02	Telehealth provided other than in patient's home
03	School (School-based Services Only)
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
09	Prison/Correctional Facility
10	Telehealth provided in patient's home
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
19	Outpatient Hospital - Off Campus
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility- Partial Hospitalization

53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

1.8.1 Office

Idaho Medicaid uses the Medicare definition and criteria for place of service 11 (office). An office is defined as the location where the provider routinely provides outpatient services and is operated during the hours that the provider engages in treatment at that location. The office space must be owned, leased, or rented by the provider/group and used for the exclusive purpose of operating the practice during those hours.

1.9 Prior Authorization

A prior authorization (PA) is a written, faxed or electronic approval from the Department that permits payment or coverage of an item or service that is only covered by such an authorization. This section only covers PAs for services billed through Gainwell Technologies (GWT). Some items and services always require a PA, such as:

- Items and services identified on the Numerical Fee Schedule;
- Services listed in the Appendix of the Hospital, Idaho Medicaid Provider Handbook for ICD-10-PCS codes that always require a PA.
- Service Coordination services for children with special health needs;
- Community-based Crisis Services;
- Home and community-based services (HCBS) for the following waivers:
    - Adult Developmental Disabilities (DD) Waiver; and
    - Aged and Disabled (A&D) Waiver;
- Personal care services, including family personal care services (FPCS);
- Preventative Health Assistance (PHA) services;
- Cosmetic and reconstructive surgery;
- Services/procedures for participants under the age of 21, identified as medically necessary as part of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT);
- Surgery related to obesity;
- Transition Management for referral and relocation assistance after extended hospitalization;
- Transplants;
- Transportation by an ambulance or individual/commercial transportation provider for non-emergency Medicaid covered services from an Idaho Medicaid medical provider; and
- Any urgent/emergency inpatient or outpatient treatment where the procedure or diagnosis code appears on the select pre-authorization list must be reviewed by Telligen within one working day of admission. The surgical procedures on the select pre-authorization list must be authorized regardless of the place of service. The diagnoses on the select pre-authorization list are for inpatient only.

Other services may only require a PA under these circumstances:

- The participant has exhausted their benefit;
- The participant does not meet the established criteria, but can demonstrate a medical need; or
- The participant has an additional benefit such as EPSDT services or a waiver that can only be accessed through a prior authorization.

Items and services that require a PA must receive approval before they can be delivered to the participant except as otherwise noted. It is the provider's responsibility to verify the participant's eligibility on the date of service and to request any required PA. PA requirements specific to a service or item are listed throughout the handbook for the provider's convenience.

For information regarding whether a prior authorization is required, providers can use the below resources for services billed to GWT:

- Check participant eligibility and PA requirements through their Trading Partner Account at www.idmedicaid.com;
- Check the Idaho Medicaid Numerical Fee Schedule available online for CPT® and HCPCS that always require a PA; and
- See the Appendix in the Hospital, Idaho Medicaid Provider Handbook for ICD-10-PCS codes that always require a PA.

PA requests are rejected when there is no clear indication that a prior authorization is required. Providers should note the reason for the request in the notes section of the portal or form when the item or service does not always require a prior authorization.

Urgent requests may be submitted by writing "urgent" on the request form. Urgent requests should only be submitted when the participant needs equipment, services, or supplies to discharge from a facility or to prevent immediate admission to one. Urgent requests for discharge, must include the expected date of discharge on the request form.

Requests for a PA or an approved authorization for services does not guarantee payment. All other Department requirements must be met. Authorizations only confirm medical necessity criteria has been met for the item or service based on the documentation submitted. The Department's, or its designee's, review of prior authorizations includes general criteria requirements in addition to any item specific criteria. Reviews do not determine if a provider or place of service is appropriate or any other considerations. Reimbursement is dependent on the participant's eligibility on the date authorized services are rendered. The claim for reimbursement must meet all applicable requirements such as:

- Policy requirements;
- Be appropriate and effective treatment for the participant's current medical condition;
- Be furnished by providers with the appropriate credentials;
- Be the most cost-effective method of meeting the participant's medical needs; and
- Meet all federal and state regulations.

Medicaid issues written notifications of authorization or denials for all written requests for PA. Participants receive a Notice of Decision by mail with information on appeal rights and how to request a hearing if they disagree with the Department's decision. Providers receive notifications based on their profile's preferences. If the participant or provider disagrees with the Department's decision they can request a reconsideration or file an appeal.

Approved authorizations are valid only for the period between the start and stop dates. If the service is to be delivered outside of the approved dates, a new PA request must be submitted. Requests should be made before the expiration of the previous authorization to avoid breaks in care. Providers billing for authorized services or items must include PA numbers on the appropriate claim line or they will deny. Claims for inpatient services must have prior authorization numbers on the header or each claim line, or the claim will deny. Some authorizations may also include modifiers as part of the approval. Authorizations that include a modifier must include it on the claim line, or it will deny. The PA number and any required modifier are found on the paper Notice of Decision (NOD) letter or online through the Trading Partner Account (TPA) under View Authorizations.

Medical items or services subject to a PA by Idaho Medicaid's designated authorizing entity, will deny for payment, if provided prior to obtaining authorization unless otherwise specified. Exceptions may be allowed on a case-by-case basis, if the provider demonstrates an effort to submit a timely request or due to events beyond the control of the provider, a prior authorization was not obtained; e.g., a hospital discharge, outside of business hours, etc. An explanation of the delay in submission must accompany the PA request and include any supporting documentation with a request for an exception. Providers may not bill Medicaid participants for services not reimbursed by Medicaid because the PA was not obtained in a timely manner or because the provider failed to verify that a PA was required.

If an individual is not eligible for Medicaid at the time items or services requiring a PA were provided but was subsequently found eligible pursuant to retroactive Medicaid eligibility, a request must be submitted with all required documentation within 30 days of the date the

provider became aware of the individual's Medicaid eligibility. The item or service will be reviewed by the Department retroactively using the same medical necessity guidelines that apply to other prior authorization requests. If approved, the provider should refund any amount previously collected from the participant for the item or service to the participant.

The Directory, Idaho Medicaid Provider Handbook contains addresses and telephone numbers for entities that review prior authorizations. Depending on the service, a PA may be received from the:

- Division of Medicaid Central Office
- Regional Developmental Disabilities Program
- Bureau of Long Term Care (BLTC)
- Telligen, the Quality Improvement Organization (QIO)

Participants with Medicare as their primary insurance do not require a PA from Idaho Medicaid for Medicare approved items and services. If the services are not covered by Medicare, or the participant has another primary payor, prior authorizations from Medicaid are required as if the participant had Medicaid primary.

1.9.1 References: Prior Authorization

(a) CMS Guidance

Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health, 81 Federal Register 5,530 (February 2, 2016). Government Printing Office, https://www.govinfo.gov/content/pkg/FR-2016-02-02/pdf/2016-01585.pdf.

State Medicaid Director Letter (09/04/1998). Center for Medicaid and State Operations, Department of Health and Human Services, https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD090498.pdf.

State Medicaid Director Letter# 03-006 (07/14/2003). Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd071403.pdf.

(b) Federal Regulations

Excessive Claims or Furnishing of Unnecessary or Substandard Items and Services, 42 CFR 1001.701 (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec1001-701.pdf.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(10)(d) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

Sufficiency of Amount, Duration, and Scope, 42 CFR 440.230(d) (2019). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec440-230.pdf.

(c) Idaho Medicaid Publications

"Modifiers and Prior Authorization (PA)." *MedicAide Newsletter, October 2015*, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202015%20MedicAide.pdf.

"Prior Authorization Number on Claims." *MedicAide Newsletter, February 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202014%20MedicAide.pdf.

(d) State Regulations

"Prior Authorization (PA)." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 007.07. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Prior Authorization (PA)." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.08. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Retroactive (Backdated) Medicaid Eligibility." *IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, & Disabled,"* Sec. 51.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160305.pdf.

"Retroactive Medical Assistance Eligibility." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 150. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160301.pdf.

1.9.2 Medicaid Prior Authorization

Idaho Medicaid issues a written notification of authorization or denial for all written requests for prior authorization (PA). Notices include PA numbers and may include modifiers which must be used when billing for approved services. To render a service that requires a Medicaid PA, download and complete the appropriate form. Fax the form and documentation justifying the medical necessity of the procedure to the fax number on the form.

Direct all requests for PAs to the appropriate contractor or Department unit as listed in the *Directory*, Idaho Medicaid Provider Handbook.
The requests should include:

- Participant name and Medicaid Identification (MID) number
- Signed physician's order
- A list of all items and a price quote for each
- Prescriber's statement of diagnosis and medical necessity for applicable drugs
- Requesting provider
- Additional information as identified by the reviewing entity

Prior Authorization Dates of Service
The PA letter indicates the length of time the authorization is valid. The dates of service billed must occur on or after the start date and on or before the expiration date indicated on the PA letter. If the PA expiration date occurs before services are provided, a new PA must be requested. To prevent a disruption or break in service to the participant, request a PA as soon as the need for additional services is identified.

Modifiers and Prior Authorization (PA)
The PA letter will specify when a modifier has been added to the PA. Modifiers are used to increase accuracy in compensation, coding consistency, editing, and to capture payment data. At times, reviewers for Idaho Medicaid may attach a modifier to a procedure code when a PA is approved.

When a provider receives notification of an approved PA, it is essential to check the authorization to determine if a modifier is attached to any of the approved procedure codes. If there is a modifier attached to any approved code on the approved PA, that modifier must be used when billing for the service or the claim will deny.

Modifiers other than those listed on the approved PA may also be appropriate in billing for the service and should be included on the claim.

Prior Authorization (PA) Forms
PA forms for many service and provider types can be found on the Idaho Gainwell Technologies Medicaid website. Specific prior authorization instructions can be found in the specific provider type handbook.

Physician Administered Drugs (PAD) Requiring PA
Certain PADs require prior authorization. Refer to the Numerical Fee Schedule on the DHW website.

Pharmacy PAs
Please see the Idaho Medicaid Pharmacy Claims Submission Manual at https://idaho.fhsc.com/providers/manuals.asp.

1.9.3 Telligen Prior Authorization

The Division of Medicaid contracts with Telligen, a quality improvement organization (QIO), for pre-admission medical necessity reviews for selected diagnoses and procedures as well as prior authorizations for select services. Telligen also conducts concurrent reviews of all inpatient admissions for hospitals that are not reimbursed under All Patient Refined Diagnosis Related Groups (APR DRG) if they exceed a specified number of days. Additionally, Telligen conducts retrospective reviews when necessary and conducts DRG validation reviews. For specific instructions on how to request these reviews, see Telligen's Provider Manual at Idmedicaid.telligen.com, or contact Telligen directly using the following contact information.

Telligen
670 E Riverpark Ln. Suite 120
Boise, ID 83706
Phone 1 (866) 538-9510
Help desk e-mail: idmedicaidsupport@telligen.com

Telligen only accepts prior authorization requests, medical record updates for post payment medical necessity, and APR DRG validation reviews through its online Qualitrac portal.

Telligen staff may request additional documentation to establish medical necessity for the item or service. The requested documentation must be received by Telligen within two (2) working days, or the request may be denied.

(a) References: Telligen Prior Authorization

(i) Idaho Medicaid Publications

"Changes to QIO Prior Authorization and Post Payment Review Submission Procedures." *MedicAide Newsletter, June 2023*, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202023%20MedicAide.pdf.

(ii) State Regulations

"Retrospective Review." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 020.07. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

1.9.4 Modifying a Prior Authorization

Modifications may be requested by contacting the issuers of the prior authorization (PA) with the PA number, requested change and justification. Submit any additional documentation if the change is not supported by the original submission.

1.9.5 Status of a Prior Authorization

The status of a prior authorization (PA) requests may be checked online for Telligen PAs on Telligen Qualitrac and the Department PAs on the Gainwell Technologies portal. Once the review is complete, a Notice of Decision is mailed to the participant if the item or service is partially or fully denied. The notice includes information on their appeal rights and how to request a hearing.

Providers do not have appeal rights for PAs; however, they may submit additional documentation for reconsideration of their request. Providers must include the prior authorization number on their request for it to be considered with the previous documentation. If the prior authorization number is not provided, a denial may be issued for an incomplete request.

1.9.6 Prior Authorization Reconsiderations

(a) Department Reconsiderations

Providers should request reconsiderations of a prior authorization (PA) decision when requests are denied for incompleteness, extenuating circumstances should be considered, or additional documentation is submitted to support medical necessity. Reconsiderations shall be requested within 28 days of the Department's decision. Providers must include the PA number on the request and include previous documentation for it to be considered. If the PA number is not provided, a denial may be issued for an incomplete request. Reconsiderations are submitted to the same reviewer as the original request when possible.

Upon completion of the reconsideration review, Idaho Medicaid or its designee will issue a second Notice of Decision for Medical Benefits. If the provider or participant disagrees with the PA reconsideration decision made by Idaho Medicaid or its designee, they may file a Request for Appeal. The provider or participant has 28 days from the mailing date of the second Notice of Decision for Medical Benefits to submit a formal appeal.

(b) Telligen Reconsiderations

Advisory letters sent from Telligen to physicians, hospitals, and participants provide two (2) options for appeals, Reconsiderations and Department Appeals. Reconsiderations are optional, 1st level appeals. Providers must complete Reconsiderations with Telligen before submitting an appeal to the Department's Appeals Coordinator. Reconsiderations must be submitted within 180 days of receipt of the Notice of Decision. Another peer physician will review the medical records, and any new information submitted. The provider will be notified of the determination within 30 days. If a provider disagrees with the final decision or chooses not to go through the reconsideration process, they can submit a Department Appeal.

Telligen Reconsiderations can be expedited when they meet the definition of an urgent care case shown in the Telligen provider manual (Idmedicaid.telligen.com). Urgent requests can be made by telephone, fax, or in writing within two (2) business days after notification. Telligen completes the request within two (2) business days of receipt. Providers who disagree with the results of the expedited request determination or have not submitted one, have an option of submitting a standard request.

A Department Appeal may be requested after the reconsideration process is exhausted with Telligen. When the provider chooses not to submit a request for Reconsideration, the appeal must be received in writing by the Department's Appeals Coordinator within 28 days from the mailing date of the Notice of Decision letter that the provider is appealing. For more information on Department Appeals, please see the Prior Authorization Appeals section of this handbook.

1.9.7 Prior Authorization Appeals

Providers and participants may appeal a prior authorization (PA) decision made by Idaho Medicaid or its designee within 28 days, in-person, by telephone, or by sending a request in writing by mail or e-mail. Appeals can be pursued when there is a disagreement about the PA decision and the previously provided documentation. Appeals should not be used to submit new documentation for consideration. Participants and Providers should use the Prior Authorization Reconsideration process if they have additional details that may change the Department's decision.

Appeals are requested by submitting a cover letter detailing why the formal appeal is requested and including a copy of the PA denial letter. Appeals are sent to:

Division of Medicaid
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036
Fax: 1 (208) 364-1811
MedicaidAppeals@dhw.idaho.gov

(a) References: Prior Authorization Appeals

(i) Federal Regulations

Application, 42 CFR 435.907 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2022-title42-vol4/pdf/CFR-2022-title42-vol4-sec435-907.pdf.

Request for Hearing, 42 CFR 431.221 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2022-title42-vol4/pdf/CFR-2022-title42-vol4-sec431-221.pdf.

(ii) State Regulations

Appeal and Fair Hearing, Idaho Code 56-216 (1941). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-216.

Board — Composition — Officers — Compensation — Powers — Subpoena — Depositions — Review — Rules, Idaho Code 56-1005(6) (2009). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH10/SECT56-1005.

Board — Composition — Officers — Compensation — Powers — Subpoena — Depositions — Review — Rules, Idaho Code 56-1005(7) (2009). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH10/SECT56-1005.

Contested Cases, Idaho Code 67-5240 (1992). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title67/T67CH52/SECT67-5240.

Exhaustion of Administrative Remedies, Idaho Code 67-5271 (1992). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title67/T67CH52/SECT67-5271.

General Order No. 1. Office of Administrative Hearings. https://oah.idaho.gov/general-order-no-1.

IDAPA 62.01.01, "*Idaho Rules of Administrative Procedure*." Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"Prior Authorization (PA)" *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.08. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Right of Review, Idaho Code 67-5270 (1992). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title67/T67CH52/SECT67-5270.

1.9.8 Transferring a Prior Authorization

Participants have the right to choose their provider and may change providers at any time. There are some exceptions such as the Healthy Connections program. The initial prior authorization (PA) does not automatically transfer when the participant chooses a new provider. The participant or their parent or guardian is required to contact the issuing authority verbally or in writing of their intent to change providers. Transfers through Telligen require the newly selected provider to submit an updated Prior Authorization Form indicating the request is for a transfer. Supporting documentation is not necessary to transfer an existing PA.

1.10 Professional and Technical Components

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. The professional and technical components together are referred to as the "global service". Professional (26) and technical (TC) component modifiers were established for some services to distinguish the portion of a service provided by a physician or other qualified healthcare professional.

The technical component includes charges for personnel and materials, space, equipment, and other facility charges and is generally billed by the entity that provides the testing equipment. Providers must use the appropriate CPT® of HCPCS code with the TC modifier to identify a charge for the technical component. Providers must use the appropriate CPT® or HCPCS code with the 26 modifier to identify a charge for the professional component of a diagnostic service/procedure which includes supervision, interpretation, and a written report. If the technical and professional components of a service are performed by the same provider, the service would be billed using the appropriate CPT code without modifier 26 or TC.

The introduction of the American Medical Association, CPT, 2016 edition, defines results, testing, interpretation, and report and states:

"Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of test results. Certain procedures or services described in a CPT involve a technical component (e.g.; tests) which produces "results" (e.g.; data; images, slides). For clinical use, some of these results require interpretation. Some CPT descriptors specifically require interpretation and reporting to report that code."

There are CPT codes that describe professional-only and technical-only services that would be billed without a 26 or TC modifier. The Center for Medicare and Medicaid Services (CMS) Professional Component/Technical Component indicators in the National Physician Fee Schedule (NPFS) Relative Value File can be used to help determine whether a CPT code is eligible for separate reimbursement for professional and technical services.

1.10.1 References: Professional and Technical Components

(a) Idaho Medicaid Publications

"**Medicaid Program Integrity Unit:** Correct Billing for Procedures with Professional and Technical Components." *MedicAide Newsletter,* November 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202016%20MedicAide.pdf.

1.11 Manually Priced Goods and Services

Procedure codes which appear on the Medicaid Numerical Fee Schedule with a reimbursement amount of $0.00 must have the appropriate documentation for the code to be priced correctly with the exception of pharmaceuticals on the wholesale acquisition cost (WAC), 340B supplied pharmaceuticals, and anesthesia codes. If the code is prior authorized and not a pharmaceutical, the documentation must be sent with the prior authorization request. If the code is not prior authorized, then the documentation must be attached to the claim. Services on claims or authorization requests without the required attachments will deny. Documentation must be legible and not handwritten. Providers can only alter documentation from third parties when multiple items or services are listed and it's necessary to draw attention to the item or service being provided, or to cover lines that do not apply to the current request.

Amounts invoiced directly to the Department must be at the provider's usual and customary rate, which is the amount the provider charges to Medicare beneficiaries and other patients liable for such charges, as supported by the provider's records. This amount must be adjusted to reflect the provider's billing policies so that the amount reflects what the provider receives through reasonable collection efforts.

Pharmaceuticals listed on the WAC list, except those supplied as 340B drugs, are paid at the lower of the provider's charges or the WAC price for the drug. 340B drugs are paid at the provider's charge. No documentation is necessary for items on the WAC list or from 340B supplies. To accurately price all other drugs, provide the actual amount given to the patient when billing. Pharmaceuticals not on the WAC list are priced using the tangible goods methodology. In addition to the methodology's required documentation, for pricing providers must supply:

- The description of the procedure code or its billable units (i.e. 1mg); and
- An explanation of the units billed on the service line (i.e. 32 units billed for procedure code measured at 1mg to indicate 32mg were provided).

Genetic laboratory tests, imaging, radiology and surgical procedures are priced by the Medical Care Unit based off the submitted documentation. Acceptable documentation for these services includes an invoice on letterhead with:

- The Department as the entity being invoiced;
- The Idaho Medicaid provider as the invoicing entity;
- A date of invoice (Dates after the date of service are acceptable);
- For genetic testing use the date the specimen was obtained, or the test was ordered, or for surgical procedures the date of the surgery; and
- The service provided and corresponding procedure code.

Tangible goods are priced at cost + 10% + shipping for pricing using invoices, or 75% of the Manufacturer's Suggested Retail Price (MSRP). Documentation cannot be handwritten. Documentation is unacceptable if its date is after the date of service except where otherwise noted. Acceptable documentation for tangible goods includes:

- Screenshot of online purchase with confirmation number;
- Invoices from the manufacturer or wholesaler including:
    - The name of the provider as the entity being invoiced;
    - The manufacturer or wholesaler's information as the invoicing entity;
    - A date of invoice, order, ship, or capture within the past 365 days for nonperishable goods or the date of service for perishable items. Dates after the date of service will result in denial unless the invoice includes:
        - Participant's full or last name;
        - Participant's medical record number;

        - A date of service and physician's name that match the claim; or
        - A purchase order with the date of service, with the participant's medical record number, full or last name, and the invoice containing the purchase order number.
    - The procedure code;
    - The provider's cost after discounts;
    - Units of measurement (i.e. box, carton, package, each, etc.); if applicable;
        - The quantity within the unit of measurement, such as the number of items within the box; and
    - All pages of the invoice or total for all charges, and the quantities of all the items left visible, if shipping and handling reimbursement are requested;
- Invoices from the provider for the professional services in customizing and/or fabricating goods (invoices for a good being customized, but was fabricated by a third party must meet the manufacturer or wholesaler invoice requirements); or
- Manufacturer's Suggested Retail Price (MSRP) as demonstrated by:
    - A catalog published within the past 365 days;
    - A recent advertisement; or
    - Other documentation directly from the manufacturer such as a quote.

Codes are not manually priced for acute care hospitals reimbursed under APR DRG methodologies and are instead paid out at a percent of covered charges. See the Hospital, Idaho Medicaid Provider Handbook for a list of codes.

1.11.1 References: Manually Priced Goods and Services

(a) Idaho Medicaid Publications

"Change in C-code Reimbursement for DRG Reimbursed Acute Care Hospitals." MedicAide Newsletter, January 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf.

"Claims Documentation." *MedicAide Newsletter,* May 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202018%20MedicAide.pdf.

"Documentation for Manually Priced Goods and Services." *MedicAide Newsletter,* August 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202019%20MedicAide.pdf .

"Manually Priced Pharmaceuticals." MedicAide Newsletter, May 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

(b) State Regulations

"Customary Charges." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 005.14. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provided Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Records." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 035. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

1.12 Timely Filing Limit

Timely filing refers to the requirement that a complete claim be submitted to any carrier within a time period specified by the carrier.

For an Idaho Medicaid claim to be considered as filed on a timely basis, the complete claim must be submitted, and an Internal Control Number (ICN) assigned within 12 months (365 days) of the start date of service or in the case of an institutional claim from the through date of service. There are three exceptions to this requirement:

1) Services for dually eligible participants (those who have both Medicare and Medicaid) provided through fee-for-service network provider must be billed to Idaho Medicaid within 12 months (365 days) of the start date of service or six (6) months of the date of payment/date of the Explanation of Benefits (EOB) or Medicare Remittance Notice (MRN), whichever is greater. (See the *Medicare Processing* section for more information on processing paid or denied Medicare claims.)
2) If the participant is approved for Medicaid coverage after the date of service, DHW issues a detailed Notice of Action (NOA) explaining the retroactive eligibility. To be considered within the timely filing limits, the claim for this participant must be submitted within 12 months (365 days) of the *notice* date on the letter. (See the *Participant Retroactive Eligibility* section for more information.)
3) Inpatient claims with a length of stay exceeding 12 months (365 days) must be submitted within 60-days of discharge to be considered timely.

Claims submitted within the timely filing period do not need to be in a paid status to be considered for timely filing. They can be in a paid, pended, or denied status if they are in the processing system within 365 days of the start date of service for professional claims or within 365 days of the through date of service for institutional claims.

1.12.1 References: Timely Filing Limit

(a) CMS Guidance

State Medicaid Director Letter# 01-020. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd070301.pdf.

(b) Federal Regulations

Timely Claims Payment, 42 CFR 447.45 (1990). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec447-45.pdf.

(c) Idaho Medicaid Publications

"Changes to Timely Filing." *MedicAide Newsletter,* April 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf.

"Changes to Timely Filing." *MedicAide Newsletter,* June 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf.

Clarification of Timely Filing Requirements, *Information Release MA04-59* (12/15/2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Clarification of Timely Filing Requirements." *MedicAide Newsletter,* October 2008.

"Submitting Claims After the One Year Deadline." *MedicAide Newsletter,* October 2001.

"Timely Filing." *MedicAide Newsletter,* June 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202011%20MedicAide.pdf.

"Timely Filing Documentation." *MedicAide Newsletter,* July 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202010%20MedicAide.pdf.

"Timely Filing Requirements: Clarification for Retroactive Eligibility." *MedicAide Newsletter,* December 2006.

"Timely Filing Requirements: Clarification for Retroactive Eligibility." *MedicAide Newsletter,* July 2007.

(d) State Regulations

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01.d. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

1.12.2 Documentation to Support Timely Filing

When billing Idaho Medicaid, it is important to include documentation with your claim of a qualifying exception to the timely filing period. Documentation accepted for an exception to timely filing includes:

- Paper claims which require an Explanation of Benefits (EOB) from Medicare and display the paid date
- Retro Eligibility document/Notice of Action for the participant
- County Indigent Fund Notification

When you send an EOB from any payer for any reason, it must include the other payer's processing information to support the submitted claim. Additional required documentation from the other payer is the page which explains the applicable remark codes, so the payment/denial information can be correctly interpreted.

The documentation can be mailed with a paper claim or scanned and attached to your Health PAS-Online entry.

(a) References: Documentation to Support Timely Filing

(i) Idaho Medicaid Publications

"Changes to Timely Filing." *MedicAide Newsletter,* June 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf.

"Proof of Timely Filing." *MedicAide Newsletter,* March 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/March2011%20MedicAide.pdf.

"Timely Filing Documentation." *MedicAide Newsletter,* July 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202010%20MedicAide.pdf.

1.12.3 Participant Retroactive Eligibility

Claims for Idaho Medicaid participants who receive retroactive eligibility must be submitted no more than 365 days from the date on the retroactive eligibility approval letter issued to the participant. The retroactive eligibility approval letter, also called the *Notice of Action*, should be attached, if available, to the claim for timely filing documentation. If the notice is unavailable, the provider should write and attach a letter attesting to when and how they received notification of the participant's eligibility, and request Gainwell Technologies review the claim under retroactive eligibility for timely filing. If the claim is denied the claim review process may be used for further consideration.

(a) References: Participant Retroactive Eligibility

(i) Idaho Medicaid Publications

"Changes to Timely Filing." *MedicAide Newsletter,* April 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf.

"Changes to Timely Filing." *MedicAide Newsletter,* June 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf.

Clarification of Timely Filing Requirements, *Information Release MA04-59* (12/15/2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Clarification of Timely Filing Requirements." *MedicAide Newsletter,* October 2008.

"Submitting Claims After the One Year Deadline." *MedicAide Newsletter,* October 2001.

"Timely Filing." *MedicAide Newsletter,* June 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202011%20MedicAide.pdf

"Timely Filing Requirements: Clarification for Retroactive Eligibility." *MedicAide Newsletter,* December 2006.

"Timely Filing Requirements: Clarification for Retroactive Eligibility." *MedicAide Newsletter,* July 2007.

(ii) State Regulations

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01.d. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

1.12.4 Provider Retroactive Eligibility

If the provider was not enrolled on the participant's date of service, the claim must still be submitted within timely filing requirements regardless of the provider's enrollment date.

(a) References: Provider Retroactive Eligibility

(i) Idaho Medicaid Publications

Clarification of Timely Filing Requirements, *Information Release MA04-59* (12/15/2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Clarification of Timely Filing Requirements." *MedicAide Newsletter,* October 2008.

"Timely Filing Documentation." *MedicAide Newsletter,* July 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202010%20MedicAide.pdf.

1.12.5 Medicare Processing

A participant who has both Medicare and Medicaid (Duals) coverage is considered dually eligible. See Third Party Liability for more information about Duals.

Providers must bill Medicare first for services and follow their billing requirements. If Medicare denies a claim for timely filing, Medicaid will also deny it for timely filing. Most of the time claims processed by Medicare are sent electronically to Medicaid for processing. These electronically forwarded claims are called crossover claims.

If the Medicare claim is not included in the electronic crossover or for those situations where it is necessary to bill Medicaid after Medicare has paid, it is necessary to submit a paper claim or an electronic claim within 6 months of the date of the Medicare payment or denial. That date will be the date of the Explanation of Benefits (EOB)/Medicare Remittance Notice (MRN). The applicable EOB/MRN should be attached to the claim; be sure to include the page with the processing information about the claim you are submitting and the page that explains the applicable remark codes.

(a) References: Medicare Processing

(i) CMS Guidance

State Medicaid Director Letter# 03-004. Center for Medicaid and State Operations, Department of Health and Human Services, https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd040803.pdf.

(ii) Idaho Medicaid Publications

"Changes to Timely Filing." *MedicAide Newsletter,* April 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf.

"Changes to Timely Filing." *MedicAide Newsletter,* June 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf.

"Submitting Claims After the One Year Deadline." *MedicAide Newsletter,* October 2001.

"Timely Filing." *MedicAide Newsletter,* June 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202011%20MedicAide.pdf.

"Timely Filing Documentation." *MedicAide Newsletter,* July 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202010%20MedicAide.pdf.

"Timely Filing Requirements: Clarification for Retroactive Eligibility." *MedicAide Newsletter*.

"Timely Filing Requirements: Clarification for Retroactive Eligibility." *MedicAide Newsletter,* July 2007.

1.12.6 Third Party Insurance

Claims for participants with third party insurance other than Medicare, must be submitted to Idaho Medicaid within timely filing requirements *regardless* of whether the other insurance has processed the claim, paid or denied the claim. Claims denied by third party carriers for timely filing will also be denied by Idaho Medicaid.

(a) References: Third Party Insurance

(i) Idaho Medicaid Publications

Clarification of Timely Filing Requirements, *Information Release MA04-59* (12/15/2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Clarification of Timely Filing Requirements." *MedicAide Newsletter,* October 2008.

"Submitting Claims After the One Year Deadline." *MedicAide Newsletter,* October 2001.

"Timely Filing." *MedicAide Newsletter,* June 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202011%20MedicAide.pdf.

"Timely Filing Documentation." *MedicAide Newsletter,* July 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202010%20MedicAide.pdf.

"Timely Filing of Claims with Third Party Insurance." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

1.12.7 Prior Authorization

Claims requiring Prior Authorization (PA) must be submitted within timely filing requirements *regardless* of the date the PA was issued.

(a) References: Prior Authorization

(i) Idaho Medicaid Publications

Clarification of Timely Filing Requirements, *Information Release MA04-59* (12/15/2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Clarification of Timely Filing Requirements." *MedicAide Newsletter,* October 2008.

"Timely Filing." *MedicAide Newsletter,* June 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202011%20MedicAide.pdf.

"Timely Filing Documentation." *MedicAide Newsletter,* July 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202010%20MedicAide.pdf.

1.12.8 Resubmissions

If a claim is resubmitted beyond timely filing requirements with proof of timely filing attached, but the claim includes services that did not appear on the original claim, those additional services will be denied. Additional services or changes to the dates of service should be submitted on a separate claim form with documentation of timely filing if the submission is beyond the timely filing requirements.

(a) References: Resubmissions

(i) Idaho Medicaid Publications

"Changes to Timely Filing." *MedicAide Newsletter,* April 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf.

"Changes to Timely Filing." *MedicAide Newsletter,* June 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf.

"Timely Filing." *MedicAide Newsletter,* June 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202011%20MedicAide.pdfh

"Timely Filing Documentation." *MedicAide Newsletter,* July 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202010%20MedicAide.pdf.

1.13 Usual and Customary Fees

Providers shall charge their usual and customary fee for services and submit those charges to Medicaid for payment consideration unless otherwise instructed. The Department generally reimburses at the lesser of billed charges or the established reimbursement cap for the item or service. When there are retrospective rate increases or decreases, the adjusted rates are added to the system and DHW initiates mass adjustments to previously paid claims for that time period that the rates have been adjusted. If the original claim was billed at the Medicaid allowed amount and the rate is increased retrospectively, the adjusted claim will pay at the original billed amount. The provider will not receive additional reimbursement.

The Office of the Inspector General may exclude any provider from receiving money from the Medicare and Medicaid programs if they are found to be billing substantially more than their usual charges or costs for services and items.

1.13.1 References: Usual and Customary Fees

(a) Idaho Medicaid Publications

"Why is it Necessary to Bill Usual and Customary Charges." *MedicAide Newsletter,* November 2008.

(b) Federal Regulations

Excessive Claims or Furnishing of Unnecessary or Substandard Items and Services, 42 CFR 1001.701 (2017). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec1001-701.pdf.

(c) State Regulations

"Provided Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 230.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2. Claim Form Instructions

2.1 Participant Identification

The participant's name is used in conjunction with the Medicaid identification number (MID) when submitting claims to verify coverage. Claims will be returned if a matching participant is not identified.

The Health Insurance Portability and Accountability Act (HIPAA) compliant Idaho Gainwell Technologies Medicaid secure website allows the provider to search for the participant's name as it is on file with Medicaid. The provider is required to enter only the first five letters of the participant's last name and the first three letters of the participant's first name.

Common errors that are made when entering the name on the claim form include:

- Spelling mistakes and typing errors;
- Name not entered in correct order, or the participant may use a hyphenated last name;
- When entering a two-word last name, not starting with the lead name. (E.g., Van S. Glen Garry, Glen is the beginning of the last name not Garry.);
- Using a nickname or a participant's preferred spelling from the provider's records instead of the proper name on file with Medicaid;
- Participant's legal name has changed, and the participant has not updated their records with Medicaid or the provider; and
- Parent's name used for minor child with a different last name.

The Medicaid Identification Number (MID) is the only number accepted for processing claims. When entering the number on the claim form, do not use:

- Participant's Social Security number
- Another family member's MID
- Any letters, symbols, or hyphens

2.2 CMS-1500 Instructions

Claims for professional services must be submitted on the CMS-1500 form except where noted in provider specific sections of the Idaho Medicaid Provider Handbook. Only fields required for billing the Idaho Medicaid program are shown on the following table. Additional fields should not be completed. Claims will be rejected when required information is not entered into the appropriate field. An example of the form can be found in the CMS-1500 Claim Form Appendix.

Paper claim forms can only be submitted with a maximum of six-line items. If services or items provided exceed six lines, then additional claim forms must be submitted. Each form must be completed with all the required elements and totaled separately.

Required Fields for CMS-1500 Form		
Field No.	Field Name	Notes
1a	Insured's ID	Enter the participant's Idaho Medicaid Identification Number (MID).
2	Patient's Name	Enter the participant's name exactly as it appears on the participant's Idaho Medicaid ID card. Enter as last name, first name, middle initial.
3	Patient's Birth Date	Enter the patient's date of birth formatted as MMDDCCYY.
3	Sex	Check the appropriate box indicating the patient's gender: F – Female; M – Male; or U – Unknown.
5	Patient's Address	Enter participant's street address.
5	City	Enter the city of the participant's address.
5	State	Enter the two (2) character abbreviation for the participant's state of residence.
5	Zip	Enter the five or nine-digit zip code of the participant's address.
10	Is patient's condition related to:	
10a	Employment?	Indicate if this condition is related to the participant's employment; if yes, then a date is required in box 14.
10b	Auto Accident? Place (State)	Indicate if this condition is related to an auto accident. If yes, enter two-digit state abbreviation where the auto accident occurred and a date is required in box 14.
10c	Other Accident?	Indicate if this condition is related to an accident other than an auto accident. If yes, a date is required in box 14.
10d	Claim Codes	If applicable, enter a valid two-digit condition claim code. A maximum of six (6) two-digit alphanumeric codes may be entered. A space must be used between each code.
14	Date of Current Illness, Injury, or Pregnancy (LMP)	Only required if any box in field 10 is marked Yes. Enter the date of accident, injury, or when the illness began, or the date of the last menstrual period (LMP) for pregnancy and if services being billed are subsequent to initial encounter in a MMDDYY format.

Required Fields for CMS-1500 Form		
Field No.	Field Name	Notes
17	Name of Referring, Ordering, or Supervising Provider	If required by specialty, enter the referring, ordering, or supervising physician's name formatted: Last Name, First Name, Middle Initial. Enter a qualifier of **DN** for referring provider, **DK** for ordering provider, or **DQ** for supervising provider.
17b	Referring, Ordering, or Supervising Physician NPI	If required by specialty, enter the referring, ordering, or supervising physician's ten-digit NPI.
19	Additional Claim Information	Use as a "remarks" field to indicate information helpful for claims processing, e.g. injury/accident – how, where, and when injury/accident happened. Other information may be required here per sections of the Idaho Medicaid Provider Handbook.
21 (A-L)	Diagnosis or Nature of Illness or Injury	Enter up to twelve (12) ICD-10-CM codes. The primary diagnosis must be listed in field 21(A). If applicable, B, C, and other diagnoses in 21 (A-L). Always enter the entire diagnosis code **including** the decimal point. Enter a zero for ICD-10-CM codes in the ICD Ind. field. **Note**: External Cause of Injury/Morbidity codes are not billable as the primary diagnosis on CMS 1500 claims.
22	Resubmission Code	Only enter a value in this field if sending a replacement or void to a previously submitted claim, otherwise leave blank. Enter "7" if claim is a replacement claim. Enter "8" if this claim voids a previously submitted claim.
22	Original REF. NO.	Only enter a value in this field if sending a replacement or void to a previously submitted claim, otherwise leave blank. Enter the claim ID number of the original claim to be voided or replaced.
23	Prior Authorization Number	Required if services need a PA. Enter the PA number exactly as it appears on the Notice of Decision. Do not enter a referral number as it will cause the claim to deny.
24A (unshaded)	Date of Service - From/To	Enter the from and to date(s) the service was provided, using the format **MMDDYY.**
24A (shaded top)	NDC code	If appropriate, enter **N4** followed by the eleven-digit NDC code.
24B (unshaded)	Place of Service	Enter the appropriate two-digit numeric code.

Required Fields for CMS-1500 Form		
Field No.	Field Name	Notes
24B (shaded top)	NDC Unit of measure	Required if NDC code is present in 24A. Enter the appropriate two-digit NDC unit of measure: F2 – International Unit GR – Gram ME – Milligram ML – Milliliter UN – Unit
24C (unshaded)	EMG	If the services performed are related to an emergency, mark this field with an **X**.
24C-D (shaded top)	NDC number of Units	Required if NDC code is present in 24A. **Enter the actual metric decimal quantity (units) administered to the patient.** If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal point and three numbers may follow the decimal.
24D (unshaded)	Procedures, Services, or Supplies	Enter the appropriate five-character HCPCS procedure code to identify the service provided.
24D (unshaded)	Modifier	If applicable, add up to four (4) appropriate HCPCS two-digit modifier(s).
24D (shaded top modifier section)	NCD Unit Price	Required if NDC code is present in 24A. Enter unit price corresponding to NDC code.
24E (unshaded)	Diagnosis Pointer	Required if diagnosis code in field 21 is present. Use A-L for the corresponding diagnosis code entered in field 21.
24F (unshaded)	Charges	Enter the usual and customary fee for each line item or service. Do not include tax.
24G (unshaded)	Days or Units	Enter the quantity or number of units of the service provided. Maximum value of 9999999. Remove any zeros leading a value (i.e. 01 is written as 1).
24H (unshaded)	EPSDT Family Plan	If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I (shaded)	ID. Qualifier for service line rendering provider	Enter service line rendering provider id only if provider rendering the service is different than billing provider. Enter qualifier **1D** followed by Idaho Medicaid provider number in 24J, only if Rendering Provider is not registered with an NPI.
24J (shaded top)	Rendering Provider ID Number	Enter service line rendering provider id only if provider rendering the service is different than billing provider. Enter Rendering Provider Medicaid ID only if Rendering provider is not registered with an NPI.
24J (unshaded)	Rendering Provider NPI	Enter service line rendering provider NPI only if provider rendering the service is different than billing provider.
25	Federal Tax ID Number	Enter the nine-digit Federal Tax ID.

Required Fields for CMS-1500 Form		
Field No.	Field Name	Notes
26	Patient Account Number	Enter participant's account number.
28	Total Charge	Enter total of all service line charges.
32: Line 1	Service Facility Name	Required if Service Facility Location is present in 32a. Enter name of service facility only if Service Location is different than Billing Provider name in box 33, otherwise leave box 32 blank. If this is included, the service facility must be affiliated with the billing facility.
32: Line 2	Service Facility Address line 1	Required if Service Facility Location is present in 32a. Enter the street address of the Service Facility, only if Service Location address is different than Billing Provider address in box 33. When a provider is performing services from home, use the address of their primary office (i.e. home or office address depending on where they usually provide services).
32: Line 3	Service Facility Address line 2	Enter additional service facility address line if needed and service location if different than billing provider address in box 33.
32: Line 3 or 4	Service Facility City, State and Zip Code	Required if Service Facility Location is present in 32a. Enter Service Facility city, state, and zip code, only if Service Location address is different than Billing Provider address in box 33, otherwise leave box 32 blank.
32a	Service Facility Location ID (NPI)	If you bill with an NPI, enter the ten-digit NPI followed by a dash and the three-digit service location identifier only if the services were rendered at a location other than that of the billing provider in box 33. Do not enter any other value in box 32a. For example, **1234567890-001**. If this is included, the service facility must be a part of your billing facility.
32b	Service Facility Location ID (blank)	If you bill with an Idaho proprietary number (not an NPI), enter the eight-digit provider ID followed by a dash and the three-digit service location identifier only if rendered at a location other than that of the billing provider in box 33. Do not enter any other value in box 32b. For example, **M1234567-001** or **A1234567-001**. If this is included, the service facility must be a part of your billing facility.
33: Line 1	Billing Provider Name	Enter the billing provider's name.
33: Line 2	Billing Provider Address line 1	Enter street address of the billing provider.
33: Line 3	Billing Provider Address line 2	Enter additional address information for the billing provider, if needed.
33: Line 3 or 4	Billing Provider city, state, and zip code	Enter the billing provider's city, state, and zip code.
33a	NPI Number	Required, if billing with an NPI. Enter the ten-digit NPI number of the billing provider.

Required Fields for CMS-1500 Form		
Field No.	Field Name	Notes
33b	Billing Provider Medicaid ID	Required if not billing with an NPI in 33a. Enter the qualifier 1D followed by the provider's eight-digit proprietary Idaho Medicaid provider number with no spaces in between.

2.2.1 References: CMS-1500 Instructions

(a) Idaho Medicaid Publications

"Attention Paper Billers." *MedicAide Newsletter, October 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202014%20MedicAide.pdf.

"Changes for the New CMS-1500 Paper Claim Form." *MedicAide Newsletter, April 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202014%20MedicAide.pdf.

"CMS-1500 Claim Form Updates: Medicare to Accept Revised Form Starting January 2014." *MedicAide Newsletter, October 2013*, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202013%20MedicAide.pdf.

"New Claim Denial Edits." *MedicAide Newsletter, December 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202014%20MedicAide.pdf.

"New CMS 1500 Claim Form." *MedicAide Newsletter,* December 2006.

"October 1, 2007 Deadlines: Important Notice – CMS-1500 (08/05) and UB-04 Claim Forms." *MedicAide Newsletter,* September 2007.

(b) State Regulations

"Provided Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.3 UB-04 Instructions

Claims for facilities must be on the UB-04 form, otherwise known as uniform billing with the CMS-1450 form, except where noted in provider specific sections of the Idaho Medicaid Provider Handbook. Providers should follow National Uniform Billing Committee (NUBC) guidelines when submitting claims unless otherwise indicated. The table below provides information for filling out the form. Do not enter any data or documentation on the claim form that is not listed as required in this section or specified in another section of the handbook. Fields that are always required are marked with an asterisk next to the field number. The notes column provides additional circumstances when a field may be required as well as clarification of what should be entered into the field. A maximum of twenty-two (22) line items per claim can be accepted; if the number of services performed exceeds twenty-two (22) lines, prepare a new claim form and complete the required data elements; total each claim separately. An example of the form can be found in the UB-04 Claim Form Appendix.

UB-04 Claim Form Instructions		
Field No.	Field Name	Notes
1*	PROVIDER INFO	Required to contain billing Provider's Name, Address, City, State, and Zip Code.
2	SERVICE FACILITY NAME AND ADDRESS SERVICE FACILITY ID	Leave box 2 blank unless service location is different than billing provider name and address in box 1. If applicable, enter name and address of service facility. Enter the 12 or 14-digit Service Facility Identifier following the Service Facility name and address in box 2 only if service location identifier is different than billing provider box 1.
3a*	PAT. CNTL #	Required to have the participant's unique alpha-numeric control number assigned by the provider.
3b*	MED REC #	Required to have the number assigned to the participant's medical/health record.
4*	Type of Bill	Required to have four digits: • First digit: 0 (always). • Second digit: Type of facility. • Third digit: Type of care. • Fourth digit: Sequence of the bill for a specific episode of care. If the fourth digit is a 7 or 8, ensure the original claim number is in box 64.
5*	Fed. Tax No.	Required to have the numerical 9 digit Federal Tax ID.
6*	Statement Covers Period	Required to have the beginning and ending service dates for the period included on the bill. Enter each date as MMDDYY or MMDDCCYY.
8a*	Patient's Medicaid Member ID	Required to have the participant's Idaho Medicaid ID number exactly as it appears on their Medicaid ID card.
8b*	PATIENT NAME	Required to have the participant's name and address.
9a*	Patient's Address	Required to have the participant's street address.
9b*	Patient's City	Required. Enter the city of the participant's address.

UB-04 Claim Form Instructions		
Field No.	Field Name	Notes
9c*	Patient's State	Required to have the participant's state.
9d*	Patient's Zip	Required. Enter the five or nine-digit zip code of the participant's address.
10*	Date of Birth	Required to have the participant's date of birth. Enter each date as MMDDCCYY.
11*	Sex	Required to have the participant's one digit gender code: F – Female; M – Male; or U – Unknown.
12	Admission Date	Required if service is for an inpatient, hospice or nursing facility stay. The date the participant entered the facility must be entered as MMDDYY.
13	Admission Hour	Required if services are for inpatient, outpatient, hospice or nursing facility. Enter the 2-digit hour the participant was admitted for inpatient or outpatient care in military time. Examples: 01 for 1:00 a.m.; 10 for 10:00 a.m.; 22 for 10:00 p.m..
14	Admission Type	Required for inpatient services. Enter one (1) digit admission type code.
15	Admission Source	Required for inpatient services. Enter one (1) digit admission source.
16	Discharge Hour (DHR)	Required on final Inpatient The 2-digit hour in military time the participant was discharged. Examples: 01 for 1:00 a.m.; 10 for 10:00 a.m.; 22 for 10:00 p.m..
17	Patient Status (STAT)	Required for inpatient services.
18-28	Condition Codes	Use the codes listed in the NUBC billing manual. Enter up to 11 codes. If services are for home health, the participant has Medicare and is not homebound, use Condition Code 12. Condition codes are required, but not currently used in claims processing.
31a thru 34a	Occurrence Code and Occurrence Date	Use the codes listed in the NUBC billing manual and enter the date of the occurrence for up to eight instances.
31b thru 34b	Occurrence Code and Occurrence Date	Use the codes listed in the NUBC billing manual and enter the date of the occurrence for up to eight instances.
35a-b and 36a-b	Occurrence Span Code and Occurrence Span From and Through Date	Enter Occurrence Code (s) and their related date spans formatted as MMDDYY. If services are for home health, enter the dates of the physician signed plan of care for the date of the occurrence. The Statement Covers Period must be the same as or within the occurrence span dates.

UB-04 Claim Form Instructions		
Field No.	Field Name	Notes
39* a-d, 40* a-d, 41* a-d	Value Codes and Amounts	Required to have value codes and corresponding amounts/days. Limited to twelve codes. For day fields use: Value code 80 = Covered Days. Value code 81 = Non-Covered Days. Value code 82 = Coinsurance Days. Value code 83 = Lifetime Reserved Days.
42*	Revenue Code	Required. Enter the 4-digit Revenue Code for the service provided. Revenue code 0001 is no longer to be used for the total charges; the total charges are to be entered in the designated box on line 23.
43	Description	Drugs must be billed with the NDC qualifier of N4 with the 11-digit NDC number, the unit of measurement, **the metric decimal quantity or units administered to the patient** and the unit price. If reporting a fraction of a unit, use the decimal point. Do not enter a space between the qualifier and NDC, or hyphens or spaces within the NDC number. The NDC number being submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered. Example: N499999999999 ML 22.4 300.99 The unit of measurement codes are: F2: International Unit GR: Gram ML: Milliliter ME: Milligram UN: Unit
44	HCPCS /RATE/ HIPPS CODE	Required only for outpatient claims with revenue codes that require a CPT® or HCPCS. If a CPT® or HCPCS code is required, it will be noted next to the code in the provider specific handbook's appendix table. Enter the appropriate CPT® or HCPCS procedure code, followed by up to four modifiers.
45	Service Date	Required for all outpatient services. Enter the line item service date.
46*	Service Units	Required. Enter the total number of covered days or LOA as units of service.
47*	Total Charges	Required. Enter the total charge for the service line.
48	Non-Covered Charges	Required if there are non-covered services. Enter service line non-covered charges.
Line 23 Column 47*	TOTAL CHARGES All LINES	Required if there are non-covered services. Enter service line total charge.
Line 23 Column 48	TOTAL NON-COVERED CHARGES ALL LINES	Required if there are non-covered services. Enter service line non-covered charges.

UB-04 Claim Form Instructions		
Field No.	Field Name	Notes
In Fields 50 and 51, each field has three (3) lines: A, B, and C. If Medicaid is the only payer, enter all Medicaid data on line A. If there is one (1) other payer in addition to Medicaid, enter all primary payer data on line A and all Medicaid data on line B. If there are two (2) other payers in addition to Medicaid, enter all primary payer data on line A, all secondary payer data on line B, and all Medicaid data on line C.		
50*	Payer Name	Required. Enter the name identifying each payer organization from which the provider received some payment for the bill. Enter the name of the third party payer if applicable using the following instructions: 50A for the primary payer, 50 B for the secondary payer, and 50C for the tertiary payer. Enter "Medicaid" for the State Medicaid payer identification. Medicaid will always be the payor of last resort.
51* A, B, C	Health Plan ID	Required. If Field 56 is blank: Provider number must be 10 digits.
56*	NPI	Required. Enter billing provider's NPI.
58	Insured's Name	If the participant's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the participant's Medicaid ID card. Enter the last name first, followed by the first name, and middle initial. Enter the participant Medicaid data in the same line used to enter the Medicaid provider data. Example: Medicaid provider information is entered in 50A, and then the Medicaid participant data must be entered in 58A.
59	P. REL	Patient's relationship to insured. See the UB-04 Manual for the 2-digit relationship codes.
60*	Insured's Unique ID	Required. Enter all of the insured's unique ID numbers assigned by each payer organization. The participant's Medicaid ID number must be entered and correspond with the Medicaid entry in field 50 A, B, or C. If Medicaid is primary, enter the participant's Medicaid ID in Field 60A. If Medicaid is secondary, enter the participant's Medicaid ID in Field 60B. If Medicaid is tertiary, enter the participant's Medicaid ID in Field 60C.
63	Treatment Authorization Codes	Required for services that need a prior authorization. Enter the PA number exactly as appears on the Notice of Decision. Do not enter a referral number as it will cause the claim to deny.
64	Document Control Number	Required if submitting a replacement or void to a previously submitted claim. Should not be used otherwise. Enter the Claim ID Number of the claim to be adjusted or voided.
66*	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	Required. This qualifier is used to indicate the version of ICD being used. ICD-10 is noted with a zero (0) in the field.
67*	DX: principal diagnosis code	Required. Enter the valid ICD-10-CM diagnosis code that describes the principal diagnosis for services rendered.

<table>
<tr><th colspan="3">UB-04 Claim Form Instructions</th></tr>
<tr><th>Field No.</th><th>Field Name</th><th>Notes</th></tr>
<tr><td>67* A-Q</td><td>Other diagnosis codes and Present On Admission (POA) indicator</td><td>Required. This field is for reporting all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment of the patient or the length of stay. The ICD-10 code completed to its fullest character must be used.

The present on admission (POA) indicator applies to diagnosis codes (i.e., principal, secondary, ICD-10 W codes) for general acute-care hospitals or other facilities, as required by law or regulation for public health reporting. The indicator should be added in the shaded box next to the corresponding diagnosis code. Use the following values for POA.
<table>
<tr><th>Code</th><th>Definition</th></tr>
<tr><td>Y</td><td>Present at the time of inpatient admission</td></tr>
<tr><td>N</td><td>Not present at the time of inpatient admission</td></tr>
<tr><td>U</td><td>Documentation is insufficient to determine if condition is present on admission</td></tr>
<tr><td>W</td><td>Provider is unable to clinically determine whether condition was present on admission or not</td></tr>
</table></td></tr>
<tr><td>69</td><td>ADMIT DX</td><td>Required for inpatient claims.</td></tr>
<tr><td>70 a, b, c</td><td>Patient Reason DX</td><td>Additional patient reason diagnosis required for outpatient.</td></tr>
<tr><td>72</td><td>External Cause Code - ECI</td><td>Enter the ICD-10-CM code for the external cause of an injury, poisoning or adverse effect.</td></tr>
<tr><td>74</td><td>Principal Procedure Code and Date</td><td>Required for inpatient claims. Enter the ICD-10-PCS code identifying the principal surgical, diagnostic or obstetrical procedure. Procedure date is required if procedure code is used, formatted as MMDDYY.</td></tr>
<tr><td>74a-e</td><td>Other Procedure Code and Date</td><td>Enter all secondary surgical, diagnostic or obstetrical procedures. Use the appropriate ICD-10-PCS coding. Procedure date is required if procedure code is used, formatted MMDDYY.</td></tr>
<tr><td>76 (Name and NPI) *</td><td>Attending Physician NPI</td><td>Required. Enter the Attending Physician’s NPI. Ambulance claims only require an NPI in the Attending Physician field for non-emergency trips when a physician is present.</td></tr>
<tr><td>76 (QUAL and ID)</td><td>Attending Physician Last and First Name</td><td>Required if Attending Physician NPI is present.</td></tr>
<tr><td>77 (Name and NPI)</td><td>Operating Physician</td><td>Required if billing surgical services.</td></tr>
<tr><td>78 (Name and NPI)</td><td>Other Physician</td><td>Required if billing for items or services ordered, referred, or prescribed by another physician.</td></tr>
</table>

UB-04 Claim Form Instructions		
Field No.	Field Name	Notes
79 (Name and NPI)	Other Physician	Required if other rendering, operating, or referring provider exists.
80	Remarks	Use remarks field to indicate any additional information helpful for claims processing, e.g. injury/accident – how, where, and when injury/accident happened.

2.3.1 References: UB-04 Instructions

(a) Idaho Medicaid Publications

"Attention Institutional (UB04) Claim Submitters." *MedicAide Newsletter, December 2010*, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202010%20MedicAide.pdf.

"Attention Paper Billers." *MedicAide Newsletter, October 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202014%20MedicAide.pdf.

"Changes to UB04 Paper Claims Requirements." *MedicAide Newsletter,* October 2013, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202013%20MedicAide.pdf.

"New Claim Denial Edits." *MedicAide Newsletter, December 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202014%20MedicAide.pdf.

"October 1, 2007 Deadlines: Important Notice – CMS-1500 (08/05) and UB-04 Claim Forms." *MedicAide Newsletter,* September 2007.

2.4 Provider Signature

A provider or their authorized agent must sign in the claimant's certification field on every claim submitted or complete a signature on file form, and provide their ten-digit NPI or eight-digit Idaho Medicaid Provider Number. Claims that are not signed, do not have a signature on file form with Idaho Medicaid, or do not have a provider number are returned.

The signature on file form is used to submit paper claims without a hand written signature or to submit electronic claims. It replaces computer-generated, stamped or typewritten signatures. A copy of the completed signature on file form is maintained by Gainwell Technologies and must exactly match the information in the claimant's certification field on the claim form. Never submit paper claims with the claimant's certification field blank. Enter *Signature-on-File* or have the provider sign in field **31** of the CMS-1500 claim form.

3. Required Coding

Idaho Medicaid uses codes as listed in the most current version of:

- Category I Current Procedural Terminology (CPT)® from the American Medical Association (AMA);
- Code on Dental Procedures and Nomenclature (CDT)® from the American Dental Association (ADA)®;
- Healthcare Common Procedure Coding System (HCPCS) from the Centers for Medicare & Medicaid Services (CMS);
- International Classification of Diseases Clinical Modification (ICD-10-CM) from the World Health Organization (WHO); and
- International Classification of Diseases Procedure Coding System (ICD-10-PCS) from the World Health Organization (WHO).

Providers are expected to select a code from one of these sets that best defines the service provided. The provider must bill the most specific code to the service provided. As part of correct coding requirements, miscellaneous, not otherwise classified or unlisted codes should not be used if specific codes are available. Only exceptions published by Idaho Medicaid are permitted. While Idaho Medicaid publications may provide guidance on coding requirements for certain services, staff will not code claims for providers or tell providers how to code outside of published guidance.

Adequate documentation must be attached to the claim to support the use of the unlisted code. Documentation should include a definition or description of the item or service, the need, time, effort and equipment necessary to provide the item or service. If a provider bills for an unlisted or unspecified code, it is their responsibility to determine if the item or service it represents meets the requirements of medical necessity as listed in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

3.1 References: Required Coding

3.1.1 Federal Regulations

Administrative Requirements: Code Sets, 45 C.F.R. Sec. 162, Subpart J (2000). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-part162.pdf

Health Insurance Portability and Accountability Act of 1996. P.L. 104-191 (1996). Government Printing Office, https://www.govinfo.gov/content/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf

3.1.2 Idaho Medicaid Publications

"Billing for Services Using Unlisted Codes." *MedicAide Newsletter, February 2018*, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202018%20MedicAide.pdf.

"**Medicaid Program Integrity:** Billing for Services Using Unlisted Procedure Codes." *MedicAide Newsletter, May 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202014%20MedicAide.pdf.

"Claims Processing and Diagnosis Codes." *MedicAide Newsletter, March 2013*, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202013%20MedicAide.pdf.

"Medicaid Coverage of C-Codes." *MedicAide Newsletter, February 2018*, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202018%20MedicAide.pdf.

"National Medical, Billing, and Coding Guidance Resources." *MedicAide Newsletter,* March 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf.

3.1.3 State Regulations

"Provided Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.2 HCPCS Requiring NDC for Medications

Providers billing CPT® 90476-90756 or HCPCS codes for pharmaceuticals starting with an A, C, J, S or Q must include the National Drug Code (NDC) on the claim line and the unit of measurement for the drug given or dispensed to the patient. Manually priced codes for drugs must follow the Manually Priced Goods and Services section of this handbook. See the CMS-1500 Instructions and UB-04 Instructions sections for additional information on billing drugs, and the NDC Format for Billing PAD for additional requirements including billing with an 11 digit NDC.

3.2.1 References: HCPCS Requiring NDC for Medications

(a) Idaho Medicaid Publications

All Professional Providers Billing Medications with HCPCS Codes, Information Release MA04-06 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Billing HCPCS J Codes for Hospital, Outpatient, and Professional Providers." *MedicAide Newsletter,* December 2006.

"Hospital, Outpatient, Professional Providers Billing HCPCS that Require National Drug Codes." *MedicAide Newsletter,* October 2008.

"Hospital Outpatient and Professional Providers Billing Medications with HCPCS." *MedicAide Newsletter,* December 2004.

"Hospital Outpatient and Professional Providers Billing Medications with HCPCS (J, S, and Q codes)." *MedicAide Newsletter,* March 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202019%20MedicAide.pdf.

"Medicaid Coverage of C-Codes." *MedicAide Newsletter, February 2018*, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202018%20MedicAide.pdf.

Professional Providers Reporting Medications with HCPCS, Information Release MA03-69 (2003). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Reminder for Hospital, Outpatient, and Professional Providers When Billing HCPCS that Require NDC Codes." *MedicAide Newsletter, November 2007*.

"Reminder to All Hospital, Outpatient, and Professional Providers Billing Medications with HCPCS." *MedicAide Newsletter, January 2018*, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202018%20MedicAide.pdf.

"S, J, and Q Codes." *MedicAide Newsletter, August 2004*.

3.3 Modifiers

Modifiers are mandatory in certain circumstances. Refer to the most recent Current Procedural Terminology (CPT®) Manual for specific guidance using modifiers. Anatomical modifiers are required when the procedure is unilateral (left arm/right arm). If the procedure is a unilateral code, and there is no more specific code available as with 28126 (Resection, single toe, each) or 28153 (Resection, head of phalanx, toe), it may be billed as many times as anatomically appropriate—for this example, ten times, with use of the appropriate modifier to identify each toe. This section of the handbook is not inclusive of all modifiers accepted by Idaho Medicaid.

Surgical Modifiers Affecting Reimbursement		
Modifier	Percentage of Fee Schedule	Modifier Description
50	150%/75%	Bilateral Procedure
51	100%/50%/25%	Multiple Procedures
53	75%	Discontinued Procedure
54	80%	Surgical care only
55	20%	Post-op management only
58	100%	Staged or Related Procedure or Service By the Same Physician During the Postoperative Period
62	62.5% each	Two surgeons
78	80%	Unplanned return to operating room for a related procedure following initial procedure for related procedure during post-op period
80	20%	Assistant physician surgeon
81	20%	Minimum assistant physician surgeon
82	10%	Assistant physician surgeon when qualified resident surgeon not available
AS	20% of 85%	Assistant surgeon is a physician assistant, nurse practitioner, or clinical nurse specialist

3.3.1 References: Modifiers

(a) Idaho Medicaid Publications

Clarification of Medicaid Reimbursement Policy for Billing the Components of the Global Surgical Procedure Codes, Information Release MA04-55 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"**Medicaid Program Integrity:** Correct Coding for Assistant Surgeon vs. Surgical Assist." *MedicAide Newsletter,* May 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202018%20MedicAide.pdf.

3.3.2 Coronary Artery Modifiers

Claims must use anatomical modifiers when appropriate to identify which coronary artery a procedure was performed on.

Coronary Artery Modifiers	
Modifier	Description
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LM	Left main coronary artery
RC	Right coronary artery
RI	Ramus intermedius coronary artery

(a) References: Coronary Artery Modifiers

(i) Idaho Medicaid Publications

"Once in a Lifetime Procedures and Modifiers." *MedicAide Newsletter,* May 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202017%20MedicAide.pdf.

3.3.3 Eyelid Modifiers

Claims must use anatomical modifiers such as E1-E4 when appropriate to identify which eyelid a procedure was performed.

Eyelid Modifiers	
Modifier	Description
E1	Upper, left eyelid
E2	Lower, left eyelid
E3	Upper, right eyelid
E4	Lower, right eyelid

(a) References: Eyelid Modifiers

(i) Idaho Medicaid Publications

"Once in a Lifetime Procedures and Modifiers." *MedicAide Newsletter,* May 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202017%20MedicAide.pdf.

3.3.4 Finger Modifiers

Claims must use anatomical modifiers such as FA and F1-F9 when appropriate to identify which finger a procedure was performed.

Finger Modifiers	
Modifier	Description
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit

(a) References: Finger Modifiers

(i) Idaho Medicaid Publications

"Once in a Lifetime Procedures and Modifiers." *MedicAide Newsletter,* May 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202017%20MedicAide.pdf.

3.3.5 Modifier 22: Increased Procedural Services

Increased procedural services are reported by appending modifier 22 to the usual procedure code when additional work factors require the physician's technical skill and involves significantly increased work, time and complexity. Modifier 22 is not used for Evaluation and Management (E/M) services.

To request additional Medicaid reimbursement, you must submit the following information with your claim:

- Operative Report;
- A short narrative explaining why the modifier is appropriate. Examples:
  - A great deal of risk and difficulty due to a patient with extreme comorbidities (listed);
  - Technical difficulty of procedure;
  - Additional time to complete beyond a normal procedure.
- Note amount of time an uncomplicated procedure would take and the time the modifier procedure took; and
- Amount or percentage of additional reimbursement you are requesting.

(a) References: Modifier 22

(i) Idaho Medicaid Publications

All Physicians and Mid-Level Practitioners, Information Release MA00-54 (2000). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Billing Modifier 22 – Increased Procedural Services." *MedicAide Newsletter,* December 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202012%20MedicAide.pdf.

3.3.6Modifier 24: Unrelated Evaluation and Management

Modifier 24 represents unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period. Modifier 24 is permissible when the service is:

- Unrelated to the surgical diagnosis;
- A treatment of an underlying condition;
- A complication resulting from the surgery except when it would be included in the global payment; or
- An added course of treatment which is not part of the normal recovery from surgery.

(a) References: Modifier 24

(i) Idaho Medicaid Publications

Clarification of Medicaid Reimbursement Policy for Billing the Components of the Global Surgical Procedure Codes, Information Release MA04-55 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Global Surgery Policy." *MedicAide Newsletter,* October 2008.

3.3.7 Modifier 25: Separately Identifiable Service

The global surgical package includes all necessary services normally furnished before (preoperative), during (intraoperative) and after (postoperative) a procedure by the surgeon or by members of the same group within the same specialty. The global surgical package applies to physicians, or qualified non-physician healthcare professionals, services in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center and physician office.

Modifier 25 is appended to an evaluation and management (E&M) code when a significant separately identifiable service is provided by the same physician or other qualified healthcare professional on the same day of the procedure or other service. E&M performed on the same date as a minor procedure are usually included in the payment for the procedure regardless of if the provider performing the E&M and surgeon are different so long as they're in the same group. The service provided with a modifier 25 must be unrelated to the decision to have a surgery. The diagnoses for the E&M and procedure do not have to be different to qualify separately from the global.

(a) References: Modifier 25

(i) CMS Guidance

"Chapter 1 – General Correct Coding Policies." *National Correct Coding Initiative Policy Manual for Medicaid Services,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html.

(ii) Idaho Medicaid Publications

"Modifier 25." *MedicAide Newsletter,* June 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202019%20MedicAide.pdf.

3.3.8 Modifier 50: Bilateral Procedure

Modifier 50 is used for bilateral procedures occurring during the same session. The code is billed on a single line with the modifier 50 to represent both procedures as a single occurrence. It is inappropriate to append this modifier to add-on codes or codes that already include bilateral in their description. Modifier 50 is not used with modifiers RT and LT. Modifier 50 is valid for professional and facility claims.

Modifier 50 Bilateral Procedure	
Procedure	Reimbursement Method
Primary Procedure	The primary surgical procedure billed with modifier 50 will be priced at the billed amount or 150% of Medicaid's allowed amount, whichever is less.
Secondary Procedure	If another procedure is billed with modifier 50 in the same session, it will be priced at the billed amount or 75% of Medicaid's allowed amount, whichever is less.

(a) References: Modifier 50

(i) Idaho Medicaid Publications

"Reminder – When to Use Modifier 50 for Bilateral Procedures." *MedicAide Newsletter,* December 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202012%20MedicAide.pdf.

(ii) Professional Organizations

American Hospital Association (2024). Chapter VII, Appendix 4. Modifiers Used for Facility Reporting. Uniform Billing Editor. Draper, UT.: OPTUM.

American Medical Association (2019). Appendix A: Modifiers. CPT® Changes 2020: An Insider's View (pp. 234). Chicago, Ill.: American Medical Association.

3.3.9Modifier 51: Multiple Surgical Procedures

When multiple surgical procedures or deliveries are performed at the same session by the same individual, modifier 51 should be applied to any procedure after the first unless contradicted by the CPT® Manual. Ambulatory Surgical Centers (ASC) must also append modifier 51 to claims for multiple surgical procedures. Modifier 51 is only for use on professional and ASC claims. It is not used for other facility claims. In the event that the claim line for the primary procedure is denied, the system will process the next paid claim line as the primary procedure and ignore modifier 51 for that line's reimbursement.

Modifier 51 Reimbursement	
Procedure	Reimbursement Method
Primary Procedure	The primary surgical procedure billed **without** modifier 51 will be priced at the billed amount or 100% of Medicaid's allowed amount, whichever is less.
Secondary Procedure	The next (secondary) procedure billed with modifier 51 will be priced at the billed amount or 50% of Medicaid's allowed amount, whichever is less.
Additional Procedures	Any additional procedures billed with modifier 51 will be priced at the billed amount or 25% of Medicaid's allowed amount, whichever is less.

(a) References: Modifier 51

(i) Idaho Medicaid Publications

"**Medicaid Program Integrity Unit:** Reimbursement Reminder for Physicians and Mid-Level Providers." *MedicAide Newsletter,* December 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202018%20MedicAide.pdf.

"Reimbursement Reminder for Physicians and Mid-Level Providers." *MedicAide Newsletter,* May 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202012%20MedicAide.pdf.

(ii) Professional Organizations

American Hospital Association (2024). Chapter VII, Appendix 4. Modifiers Used for Facility Reporting. Uniform Billing Editor. Draper, UT.: OPTUM.

3.3.10 Modifier 52: Reduced Services

Under certain circumstances when necessary a healthcare professional may reduce or discontinue radiology procedures and other services that do not require anesthesia. Modifier 52 shall be appended to the code when appropriate per the applicable edition of the CPT® manual published by the American Medical Association. Modifier 52 is valid for professional and facility claims. Modifier 52 will reduce the allowed Medicaid maximum reimbursement amount by 25% to reimburse the provider 75% of the allowed amount.

(a) References: Modifier 52

(i) Idaho Medicaid Publications

Reimbursement Reduction for Modifiers 52 and 53, Information Release MA16-09 (7/18/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho.

(ii) Professional Organizations

American Hospital Association (2024). Chapter VII, Appendix 4. Modifiers Used for Facility Reporting. Uniform Billing Editor. Draper, UT.: OPTUM.

3.3.11 Modifier 53: Discontinued Procedure

Circumstances may dictate that a surgical or diagnostic procedure be discontinued by a healthcare professional after it was started. Modifier 53 shall be appended to the code when appropriate per the applicable edition of the CPT® manual published by the American Medical Association. This modifier is not permitted on claims for outpatient hospital services or ambulatory surgical centers unless otherwise specified.

Modifier 53 reduces the allowed Medicaid maximum reimbursement amount by 25% to reimburse the provider 75% of the allowed amount.

(a) References: Modifier 53

(i) Idaho Medicaid Publications

Reimbursement Reduction for Modifiers 52 and 53, Information Release MA16-09 (7/18/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho.

3.3.12 Modifier 54: Surgical Care Only

Modifier 54 represents pre-operative and intra-operative care. Modifier 54 should be appended when the provider has no intention of providing post-operative care. This is common for surgeries performed in the emergency room. In the event that a provider bills for a surgery in the emergency room with a modifier 54, and the participant returns to the provider for post-operative care, the provider may bill a new claim with the same CPT® for the procedure and Modifier 55. Modifier 54 reimburses the lesser of the provider's usual and customary fee or 80% of the Numerical Fee Schedule.

(a) References: Modifier 54

(i) Idaho Medicaid Publications

Clarification of Medicaid Reimbursement Policy for Billing the Components of the Global Surgical Procedure Codes, Information Release MA04-55 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Global Surgery Policy." *MedicAide Newsletter,* October 2008.

3.3.13 Modifier 55: Postoperative Care Only

Modifier 55 should be appended when the provider only provides post-operative care or for emergency room situations described under Modifier 54. The modifier should be appended to the CPT® code for the procedure being followed up on and not an evaluation and management code. Modifier 55 reimburses the lessor of the provider's usual and customary fee or 20% of the Numerical Fee Schedule.

(a) References: Modifier 55

(i) Idaho Medicaid Publications

Clarification of Medicaid Reimbursement Policy for Billing the Components of the Global Surgical Procedure Codes, Information Release MA04-55 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Global Surgery Policy." *MedicAide Newsletter,* October 2008.

3.3.14 Modifier 56: Preoperative Management Only

Modifier 56 is an informational only modifier and does not affect reimbursement.

(a) References: Modifier 56

(i) Idaho Medicaid Publications

Clarification of Medicaid Reimbursement Policy for Billing the Components of the Global Surgical Procedure Codes, Information Release MA04-55 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

3.3.15 Modifier 57: Decision for Surgery

Modifier 57 (Decision for surgery) is appended to the E&M code when the decision for surgery is being made to perform a major procedure. This is regardless of whether both services were provided by the same or different providers.

(a) References: Modifier 57

(i) CMS Guidance

"Chapter 1 – General Correct Coding Policies." *National Correct Coding Initiative Policy Manual for Medicaid Services,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html.

3.3.16 Modifier 58: Staged or Related Procedure

Modifier 58 (Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period) is paid at 100% of the usual and customary charges or the rate on file, whichever is less.

The use of Modifier 58 by an outpatient hospital may represent:

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

Modifier 58 is not intended for use to report a problem that requires a return to the operating room. These are a component of the global billing for surgeries.

(a) References: Modifier 58

(i) Idaho Medicaid Publications

"Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period." *MedicAide Newsletter,* August 2008.

(ii) State Regulations

"Provided Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.3.17 Modifier 59: Separate Encounters and Distinct Procedures

NCCI Procedure-to-Procedure (PTP) edits with a Correct Coding Modifier Indicator (CCMI) of "1" allow providers to use modifiers to indicate medical necessity for procedures or services that would usually not be reported together, but in particular circumstances are appropriate. Modifier 59 is often inappropriately billed and must be used per the criteria of this section. The Modifier cannot be used to simply bypass the NCCI edit.

Providers must have documentation supporting the use of Modifier 59. Documentation must support a different session, different procedure or surgery (i.e., different session or site), different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Contiguous structures in the same organ or anatomic region do not constitute treatment of different anatomic sites. Services with modifier 59 do not require a different diagnosis from the conflicting procedure.

Modifier 59 may be used for two timed codes provided in the same session as long as the services are provided sequentially. There must be a clear end to the services in one code before services in the other code begin.

Modifier 59 may be used for, but is not limited to, anesthesia services.

Modifier 59 must only be used for a diagnostic procedure which precedes a therapeutic procedure when the diagnostic is used as a basis to decide to perform the therapeutic procedure. In order to qualify the diagnostic cannot:

- Overlap with a therapeutic intervention or services required for one;
- Be a service that would otherwise be required for the intervention; or
- Be an inherent component of a surgical procedure.

Modifier 59 must only be used for a diagnostic procedure after a therapeutic procedure when the diagnostic is not a common or necessary follow-up to the procedure. In order to qualify the diagnostic cannot:

- Overlap with a therapeutic intervention or services required for one;
- Be a service that would otherwise be required for the intervention; or
- Be an inherent component of a surgical procedure.

If another modifier is appropriate, it must always be used instead of modifier 59. This includes modifiers that are more anatomically specific, such as RT, LT, F1-F9, etc., and modifiers XE, XS, XP and XU, which were created to replace most of the functions modifier 59 supplies. Modifier 59 should never be used for evaluation and management services.

(a) References: Modifier 59

(i) CMS Guidance

"Proper Use of Modifiers 59, XE, XP, XS, and XU." *MLN Fact Sheet MLN1783722, March 2023,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf.

(ii) Idaho Medicaid Publications

"Modifier 59." *MedicAide Newsletter,* December 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202014%20MedicAide.pdf.

"NCCI Edits for Medicaid Services, and Modifiers 59, XE, XS, XP, and XU." *MedicAide Newsletter,* July 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202018%20MedicAide.pdf.

3.3.18 Modifier 62: Two Surgeons

Idaho Medicaid recognizes and reimburses based of modifier 62 for surgical procedures utilizing two surgeons. Services billed with a 62 modifier are paid at 62.5% of the Numerical Fee Schedule.

3.3.1 Modifier 66: Surgical Team

Idaho Medicaid recognizes and reimburses based of modifier 66 for surgical procedures utilizing a surgical team.

3.3.2Modifier 76: Repeat Procedure

Modifier 76 (repeat procedure by the same physician) is used for multiple or identical services provided to a participant on the same day. When billing with modifier 76, the first claim line with the code should not contain the modifier. The modifier should appear on the subsequent code. A service repeated multiple times that would be billed with modifier 76 should have all units after the first unit billed on a single line. The Modifier must not be used to simply bypass a duplication of service edit.

Example

For three EKGs provided to the participant on the same day the claim lines would be billed:

Example of Modifier 76			
Date(s) of Service	**Procedure Code**	**Modifier**	**Units**
01/01/2024	93010	N/A	1
01/01/2024	93010	76	2

Modifier 76 may be used for, but is not limited to, physician services including anesthesia and surgical services. Providers must have documentation supporting the use of modifier 76.

3.3.1 Modifier AS: Surgery Assistance

Surgical codes for assistant-at-surgery services provided by a physician assistant or nurse practitioner, must be billed under their provider number with an AS modifier. Services billed with an AS modifier are paid at 20% of the Numerical Fee Schedule.

3.3.2 Modifier EP: EPSDT

The EP modifier represents services approved under Early & Periodic Screening, Diagnostic & Treatment (EPSDT) benefit. All claims for services prior authorized as EPSDT must have the EP modifier on the claim line.

3.3.3 Modifier GA: Non-covered

Modifier GA indicates that the item or service does not meet Medicaid criteria or requirements and the provider has a document where the participant accepts financial responsibility. Claim lines appended with the modifier will be denied appropriately. Items and services with a prior authorization do not have to include the modifier for reasons of medical necessity.

Items and services being provided outside of established criteria for Idaho Medicaid must be prior authorized to be eligible for payment. The Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook has requirements for noticing a participant when an item or service is expected to be their fiscal responsibility.

(a) References: Modifier GA

(i) CMS Guidance

"Auto Denial of Claim Line(s) Items Submitted With a GZ Modifier" *CMS Pub 100-04 Medicare Claims Processing, Transmittal 2148.* February 4, 2011. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2148CP.pdf.

3.3.4Modifier GX: Non-covered

Modifier GX indicates that the item or service is not a Medicaid benefit and the provider has a document where the participant accepts financial responsibility. Claim lines appended with the modifier will be denied appropriately. Items and services with a prior authorization do not have to include the modifier for reasons of medical necessity.

The Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook has requirements for noticing a participant when an item or service is expected to be their fiscal responsibility.

(a) References: Modifier GX – Non-covered

(i) Idaho Medicaid Publications

"The Use of KX, GA, GX, GY and GZ Modifiers." *MedicAide Newsletter,* April 2025, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202025%20MedicAide.pdf.

3.3.5 Modifier GY: Non-covered

Modifier GY indicates that the item or service is not a Medicaid benefit. Claim lines appended with the modifier will be denied appropriately. Items and services with a prior authorization do not have to include the modifier for reasons of medical necessity.

The Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook has requirements for noticing a participant when an item or service is expected to be their fiscal responsibility.

(a) References: Modifier GY – Non-covered

(i) CMS Guidance

"Auto Denial of Claim Line(s) Items Submitted With a GZ Modifier" *CMS Pub 100-04 Medicare Claims Processing, Transmittal 2148.* February 4, 2011. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2148CP.pdf.

(ii) Idaho Medicaid Publications

"The Use of KX, GA, GX, GY and GZ Modifiers." *MedicAide Newsletter,* April 2025, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202025%20MedicAide.pdf.

3.3.6Modifier GZ: Non-covered

Modifier GZ indicates that the item or service does not meet Medicaid criteria or requirements and the provider does not have a document where the participant accepts financial responsibility. Claim lines appended with the modifier will be denied appropriately. Items and services with a prior authorization do not have to include the modifier for reasons of medical necessity.

Items and services being provided outside of established criteria for Idaho Medicaid must be prior authorized to be eligible for payment. The Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook has requirements for noticing a participant when an item or service is expected to be their fiscal responsibility.

(a) References: Modifier GZ

(i) CMS Guidance

"Auto Denial of Claim Line(s) Items Submitted With a GZ Modifier" *CMS Pub 100-04 Medicare Claims Processing, Transmittal 2148.* February 4, 2011. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2148CP.pdf.

(ii) Idaho Medicaid Publications

"The Use of KX, GA, GX, GY and GZ Modifiers." *MedicAide Newsletter,* April 2025, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202025%20MedicAide.pdf.

3.3.7 Modifier JW: Medical Waste of Drugs and Biologicals

The JW modifier is used on Medicare Part B claims with drugs or biologicals from single use vials and packages. Single-use products are only intended for use by a single patient or procedure. The modifier is appended on claim lines for units that are not administered to a patient, and must be discarded as wastage. Wastage is defined as the amount of a drug or biologic leftover in a vial or package after a portion of the same vial or package is administered to a Medicaid participant.

Idaho Medicaid covers the wastage of drug or biological products administered by injection or infusion using the JW modifier for drugs and biologics billed using C, J, Q or S HCPCS codes. Wastage is only reimbursable for drugs or biologics that only come in a single-use vial or package as identified by the manufacturer. Drugs that are available in a multi-dose vial or package are not available for wastage reimbursement. Reimbursement is limited to the difference between the amount ordered/administered for the participant and the minimum amount needed to equal the nearest whole vial or package. The nearest whole vial or package is calculated using the vial or package size and dose that results in the least amount of waste available on the market. If possible, administered doses should be rounded to the nearest vial to avoid wastage.

Examples

If the physician orders 100 mg of a drug, and the drug is manufactured in both a 50 mg single-use vial and a 150 mg single-use vial, then no wastage is reimbursable as two 50 mg vials meet the amount ordered.

If the physician orders 180 mg of a drug, and the drug is manufactured in both a 100 mg single-use vial and a 150 mg single-use vial, then Idaho Medicaid will only reimburse for 20 mg of wastage, the result of using two 100 mg vials. If the provider only has 150 mg single-use vials on the date of service, 120 mg will be wasted. However, Idaho Medicaid will still only reimburse for 20 mg of wastage. The remaining 100 mg of wasted drug is excess wastage that is not eligible for reimbursement. The 100 mg becomes a business expense or loss incurred by the provider due to not having the 100 mg vials available when needed.

Reimbursement is not available for:

- Drugs and biologics in excess of what is ordered and billed without the JW modifier;
- Drugs and biologics in excess of the minimum wastage amount possible per this policy;
- Drugs and biologics available in multi-dose vials or multi-use packages;
- Drugs and biologics discarded due to expiration when no amount of the discarded vial or pack was administered to the participant;
- Wastage of an amount less than a whole unit of billing per the HCPCS code's long description;
- Drugs and biologics in which any portion of the vial or package was administered to a patient other than the Medicaid participant. This includes another Medicaid participant;
- Drugs and biologics that require a prior authorization for which no prior authorization was obtained;
- Drugs and biologics included in the encounter rate for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC);
- Drugs and biologics not purchased by the practice site (e.g. study drugs provided by the study sponsor and compassionate use programs);
- Medication waste resulting from overfill of the single dose vial;

- Medication waste resulting from a missed/failed patient visit;
- Skin substitutes; and
- Drug and biologic wastage for the same drug or biologic from multiple single-use vials or packages opened during the same encounter.

The medical record for claims with the JW modifier must contain the following information on the drug:

- The authorized prescriber order;
  - Orders with dosages based on specific measurements such as weight, surface area, etc., must include those measurements;
- The amount of drug or biologic administered; and
- The amount of drug or biologic discarded or wasted;
  - Must include date and time of disposal;
  - The reason for disposal; and
  - The name, licensure, and signature of the person discarding the drug or biologic.

Claims for drug or biologic wastage must be billed on the same claim as the administered portion of the drug. Wastage in compliance with this section is billed on a separate line item with the modifier JW. The date of service for this claim line must be the last covered administration according to the plan of care or if the participant dies, the date of death.

(a) References: Modifier JW

(i) CMS Guidance

"Billing and Coding: JW and JZ Modifier Billing Guidelines." *Billing and Coding Article A55932*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55932.

"Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims." *Medicare Claims Processing Manual,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf.

"Chapter 17 – Drugs and Biologicals." *Medicare Claims Processing Manual,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf.

Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy Frequently Asked Questions. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/JW-Modifier-FAQs.pdf.

(ii) Idaho Medicaid Publications

"JW Modifier." *MedicAide Newsletter,* March 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf.

Medical Waste of Drugs and Biologicals, Information Release MA20-39 (9/18/2020). Division of Medicaid, Department of Health and Welfare, State of Idaho,

https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3224&dbid=0&repo=PUBLIC-DOCUMENTS&cr.

3.3.8 Modifier KX: Medical Policy Met

Idaho Medicaid does not utilize the KX modifier to confirm medical necessity for all services submitted for reimbursement. Items and services that utilize or require the KX modifier are noted throughout the Idaho Medicaid Provider Handbook. The submission of a claim without the GA, GX, GY or GZ modifier is an attestation by the billing provider that the service meets all Idaho Medicaid requirements for coverage including meeting criteria and regulatory requirements.

(a) References: Modifier KX – Medical Policy Met

(i) Idaho Medicaid Publications

"The Use of KX, GA, GX, GY and GZ Modifiers." *MedicAide Newsletter,* April 2025, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202025%20MedicAide.pdf.

3.3.9Modifier TB: 340B Pharmacy Claims

The TB modifier is used for primary Medicare plan claims to bill drugs provided under the 340B program. See the 340B Pharmacy Billing section for more information.

3.3.10 Modifier TL: Infant Toddler Services

The TL modifier represents Early Intervention Services provided by the Infant Toddler Program. All claims for these services must have the TL modifier on the claim line.

3.3.11 Modifier UD: 340B Pharmacy Claims

The UD modifier is used for primary Medicaid or commercial plan claims to bill drugs provided under the 340B program. See the 340B Pharmacy Billing section for more information.

(a) References: Modifier UD

(i) Idaho Medicaid Publications

"Billing 340B Pharmacy Claims." *MedicAide Newsletter,* December 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202023%20MedicAide.pdf.

3.3.12 Modifier XE: Separate Encounter

The XE modifier is used to replace the use of Modifier 59, Distinct Procedural Services, for a service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.

(a) References: Modifier XE

(i) Idaho Medicaid Publications

"Modifier 59." *MedicAide Newsletter,* December 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202014%20MedicAide.pdf.

"NCCI Edits for Medicaid Services, and Modifiers 59, XE, XS, XP, and XU." *MedicAide Newsletter,* July 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202018%20MedicAide.pdf.

3.3.13 Modifier XP: Separate Practitioner

The XP modifier is used to replace Modifier 59, Distinct Procedural Services, for a service that is distinct because it was performed by a different practitioner.

(a) References: Modifier XP

(i) Idaho Medicaid Publications

"Modifier 59." *MedicAide Newsletter,* December 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202014%20MedicAide.pdf.

"NCCI Edits for Medicaid Services, and Modifiers 59, XE, XS, XP, and XU." *MedicAide Newsletter,* July 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202018%20MedicAide.pdf.

3.3.14 Modifier XS: Separate Structure

The XS modifier is used to replace Modifier 59, Distinct Procedural Services, for a service that is distinct because it was performed on a separate organ/structure.

(a) References: Modifier XS

(i) Idaho Medicaid Publications

"Modifier 59." *MedicAide Newsletter,* December 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202014%20MedicAide.pdf.

"NCCI Edits for Medicaid Services, and Modifiers 59, XE, XS, XP, and XU." *MedicAide Newsletter,* July 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202018%20MedicAide.pdf.

3.3.15 Modifier XU: Unusual Non-Overlapping Service

The XU modifier is used to replace Modifier 59, Distinct Procedural Services, for a service that is distinct because it does not overlap usual components of the main service.

(a) References: Modifier XU

(i) Idaho Medicaid Publications

"Modifier 59." *MedicAide Newsletter,* December 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202014%20MedicAide.pdf.

"NCCI Edits for Medicaid Services, and Modifiers 59, XE, XS, XP, and XU." *MedicAide Newsletter,* July 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202018%20MedicAide.pdf.

3.3.16 Right and Left Side Modifiers

Claims must use anatomical modifiers such as right (RT) and left (LT) when appropriate to identify the side of the body a procedure was performed on.

(a) References: Right and Left Side Modifiers

(i) Idaho Medicaid Publications

"Once in a Lifetime Procedures and Modifiers." *MedicAide Newsletter,* May 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202017%20MedicAide.pdf.

3.3.17 Toe Modifiers

Claims must use anatomical modifiers such as TA and T1-T9 when appropriate to identify the toe a procedure was performed on.

Toe Modifiers	
Modifier	Description
TA	Left toe, great toe
T1	Left toe, second digit
T2	Left toe, third digit
T3	Left toe, fourth digit
T4	Left toe, fifth digit
T5	Right toe, great toe
T6	Right toe, second digit
T7	Right toe, third digit
T8	Right toe, fourth digit
T9	Right toe, fifth digit

(a) References: Toe Modifiers

(i) Idaho Medicaid Publications

"Once in a Lifetime Procedures and Modifiers." *MedicAide Newsletter,* May 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202017%20MedicAide.pdf.

3.4 Diagnosis Codes

Idaho Medicaid only accepts diagnosis codes identified in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) from the World Health Organization (WHO). The claims processing system requires all diagnosis on claims codes be entered with the decimal point. This applies to paper, electronic or online/direct data entry claims.

Claims should be coded to the highest level of specificity. Unspecified diagnoses codes should be the exception. Some services are restricted in the provider handbook or posted policies for specific circumstances as identified by diagnoses codes. If an unspecified code does not appear on these lists, but is the appropriate diagnoses, check the policy or handbook with the restriction for instructions on alternate billing options. For example, some policies may allow claims with a KX modifier for uncovered diagnoses. If alternate billing options aren't provided:

- For inpatient hospital stays, please, follow Telligen's default processes.
- For other claims follow the claim review and Medicaid review process.

3.4.1 References: Diagnosis Codes

(a) Federal Regulations

Code Sets, 45 C.F.R. Sec. 162, Subpart J (2000). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2022-title45-vol2/pdf/CFR-2022-title45-vol2-part162-subpartJ.pdf.

(b) Idaho Medicaid Publications

"Attention All Providers: Unspecified Diagnoses Codes." *MedicAide Newsletter, January 2018*, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202018%20MedicAide.pdf.

"Claims Processing and Diagnosis Codes." *MedicAide Newsletter, March 2013*, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202013%20MedicAide.pdf.

"CMS Update to Claims Processing Guidance for ICD-10." *MedicAide Newsletter, March 2014*, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202014%20MedicAide.pdf.

"Effective 10/1/2015, ICD-10 Codes Required." *MedicAide Newsletter,* September 2015, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202015%20MedicAide.pdf.

3.4.2ICD-10 Updates During Inpatient Stays

If an update to ICD-10 codes becomes effective during an ongoing inpatient stay, providers should split bill to have the most appropriate diagnosis on each claim.

For example, a participant's stay is 01/01/2018 to 01/31/2018, and new ICD-10 codes become effective 01/16/2018. Claim #1 should have the original diagnosis for 01/01/2018 to 01/15/2018. Claim #2 would have the new diagnosis for 01/16/2018 to 01/31/2018.

(a) References: ICD-10 Updates During Inpatient Stays

(i) Idaho Medicaid Publications

"ICD-10 Updates During Inpatient Stays." *MedicAide Newsletter, February 2018*, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202018%20MedicAide.pdf.

3.5 National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) is a program developed by CMS that uses correct coding methodologies to reduce overpayments to providers due to incorrect coding on claims. NCCI edits are comprised of Procedure-to-Procedure Edits and Medically Unlikely Edits. Section 6507 of the Affordable Care Act directed all State Medicaid programs to implement use of NCCI methodologies that are "compatible" with claims filed with Medicaid. This is to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid.

Idaho may not override an edit through the prior authorization process. However, an edit may be overridden through the claim reconsideration and appeals process. The state may seek an exemption from CMS for an individual code only when the MUE is contrary to state policy, such as the case where Idaho instructs a provider to bill in 15-minute increments and the national code description does not designate a time frame for the code.

NCCI edits are updated on a quarterly basis, with new edits added each quarter. For additional information and instruction as well as lists of current edits, providers should access the Medicaid NCCI page.

3.5.1 References: National Correct Coding Initiative

(a) CMS Guidance

Medicaid NCCI Technical Guidance Manual, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/ncci-medicaid/medicaid-ncci-technical-guidance-manual.

(b) Federal Regulations

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

(c) Idaho Medicaid Publications

Implementation of Medicaid National Correct Coding Initiative (MCDNCCI), Information Release MA11-05 (4/04/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13235&dbid=0&repo=PUBLIC-DOCUMENTS.

"National Correct Coding Initiative (NCCI)." *MedicAide Newsletter,* December 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202010%20MedicAide.pdf.

"National Medical, Billing, and Coding Guidance Resources." *MedicAide Newsletter,* March 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf.

"NCCI Announcement." *MedicAide Newsletter,* April 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202011%20MedicAide.pdf.

"NCCI Edits for Medicaid Services, and Modifiers 59, XE, XS, XP, and XU." *MedicAide Newsletter,* July 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202018%20MedicAide.pdf.

3.5.2 Procedure-to-Procedure (PTP) Edits

Procedure-to-procedure (PTP) edits define pairs of Current Procedural Terminology (CPT)® and HCPCS codes that should not be reported together for a variety of reasons. One reason a combination may not be allowed is that one code is considered a component of another. These edits apply to claims with a combination of the same participant, provider and date of service.

(a) References: Procedure-to-Procedure (PTP) Edits

(i) Idaho Medicaid Publications

Implementation of Medicaid National Correct Coding Initiative (MCDNCCI), Information Release MA11-05 (4/04/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13235&dbid=0&repo=PUBLIC-DOCUMENTS.

"NCCI Edits for Medicaid Services, and Modifiers 59, XE, XS, XP, and XU." *MedicAide Newsletter,* July 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202018%20MedicAide.pdf.

3.5.3 Medically Unlikely Edits (MUE)

Medically Unlikely Edits (MUEs), or units-of-service edits, define for each CPT® and HCPCS code the number of units of service that would be medically necessary for most participants in most situations. Services that exceed an MUE will be denied. However, if services are medically necessary beyond the MUE, providers can bill additional units on another claim line with the SC modifier. This modifier indicates that the provider has reviewed the medical documentation and determined additional services are medically necessary.

The Centers for Medicare and Medicaid Services (CMS) implemented an outpatient hospital MUE of zero to any services that should be limited to an inpatient hospital setting to ensure patient safety. Procedure codes with an MUE of zero for outpatient hospital procedures can be found at CMS.gov under the National Correct Coding Initiative. Modifiers cannot be used to override the zero MUE.

(a) References: Medically Unlikely Edits (MUE)

(i) Idaho Medicaid Publications

Implementation of Medicaid National Correct Coding Initiative (MCDNCCI), Information Release MA11-05 (4/04/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13235&dbid=0&repo=PUBLIC-DOCUMENTS.

4. Claim Submission

Providers may submit claims by:

- Electronic Data Interchange (EDI);
- Direct data entry (DDE) into Health PAS-Online, Trading Partner Account (TPA); and
- By mail on original, preprinted paper claim forms.

Electronic claim submission has many benefits, including a reduced number of errors, faster payments, and easier claim tracking.

Once a completed claim is submitted it is assigned a claim number. Claim numbers begin with the two-digit year and three-digit day-of-the-year to denote the date the claim was received. Claims that are adjusted or reversed will retain the date the original claim was submitted to ensure compliance with timely filing. Adjusted claims will have an A1 suffix, while reversed claims will have an R1 suffix.

4.1 References: Claim Submission

4.1.1 Idaho Medicaid Publications

"Educational Tip – Claim # Formatting." *MedicAide Newsletter,* February 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202024%20MedicAide.pdf.

4.2 Electronic Claims Submission

All providers must register as trading partners with Gainwell Technologies (GWT) via the Idaho Gainwell Technologies Medicaid website. Registration includes electronically signing a trading partner agreement for HIPAA compliance in order to receive a trading partner ID, which is used on the X12 transactions as an identifier of the submitting provider.

Registering as a trading partner will also allow you access to the secure portion of the website for all real time claim entries, inquiries, and status requests. The secure website allows for ease of access to reports including the remittance advice. Please see the Trading Partner Account (TPA) User Guide in the User Guides online.

GWT offers two methods for electronic claims submission.

1. EDI is a HIPAA compliant X12 claim transaction referred to as an 837, which is submitted using online File Exchange upload. For EDI claim submission and billing instructions, please refer to the appropriate HIPAA X12 *Vendor Specifications Companion Guides* located at Health PAS-Online at www.idmedicaid.com. Electronic claims that are not in the correct HIPAA compliant format will be rejected.
2. DDE is the web-based entry of claims into the Health PAS-Online secure provider portal.

When billing electronically, providers must complete all HIPAA required data elements; however, not all of the information is used by Idaho Medicaid in claims processing. The following HIPAA required data elements for an electronic HIPAA 837 claim submission are not used by Idaho Medicaid.

- Release of medical data
- Benefit assignment
- Patient signature
- Social Security number
- Tax ID number and qualifier
- Entity type qualifiers
- Provider and participant address
- Participant ID qualifier
- Participant date of birth
- Participant gender

4.2.1 Vendor Software and Clearinghouses

Providers subject to Electronic Visit Verification (EVV) requirements can use EVV software from any EVV vendor after it is tested and certified as compliant with the MMIS Aggregator managed by Sandata. Software vendors are not allowed to test their product with Gainwell Technologies (GWT) Medicaid Solutions. GWT will not endorse any specific software application. Any testing of third party software must be performed by a registered provider. Contact the GWT Technical Help Desk if you have any questions regarding this process.

Providers who wish to bill electronically and who bill more than one insurance carrier should consider using a clearinghouse. Clearinghouses are private companies that handle insurance claims for multiple carriers. The advantage for the provider is that claims are entered only once for the clearinghouse. The clearinghouse then forwards the claim to the appropriate insurance carriers (including Idaho Medicaid). A list of all currently registered Clearinghouses and Billing Agencies is available on Health PAS-Online by selecting the link titled **Registered Clearinghouses and Billing Agencies**. GWT will furnish the specifications, free of charge, to any vendor upon request. Once the clearinghouse has successfully transmitted enough test data to become production certified with the MMIS, providers using their services may begin using the clearinghouse to submit claims.

Since providers use a variety of different billing software brands, it is not possible to give exact information on how to complete any specific electronic eligibility or claim form. Providers can review the EDI Companion Guides, available on the Idaho GWT Medicaid website, for a general example of HIPAA-compliant electronic transaction formats. See the next section for details about registering as a trading partner to begin testing.

4.3 Paper Claim Forms

Several different types of claim forms are used to bill services to Medicaid. The following forms are the only paper forms accepted by Idaho Medicaid:

- CMS 1500 (Red drop out form)
- UB-04 (Red drop out form)

All paper claims are electronically scanned for processing. The printed versions of the claim forms are machine readable which means they are printed using special paper, special color inks, and within precise specifications. For this reason, only original color forms can be used for scanning. Forms that cannot be scanned are returned to the provider.

To ensure paper claims are scanned correctly, follow these guidelines:

- Use the specified original claim form referenced above. Photocopies cannot be scanned and will be returned to the provider.
- Check the Claim Form Instructions;*CMS-1500 Instructions* or the *UB04-Instructions*, Idaho Medicaid Provider Handbooks for your specific provider type for the required fields.
- Do not enter any data or documentation on the claim form not listed as required. When billing Medicaid there is no need to enter data into fields that are not required.
- Use black ink or a typewriter with a good ribbon or a printer with a good ink cartridge. Change the ribbon or ink source if the print is too light.
- When using a typewriter or printer, make sure the form is lined up correctly, so it prints evenly. Claims cannot be processed when the information is not in the correct field or not within the box. If completing the form by hand, print neatly.
- Be sure to stay within the box for each field.
- When entering an X in a check-off box, be sure that the mark is centered in the box.
- White correction fluid is acceptable, but no other alterations should be made on the form.
- Do not use bold font.

Do not staple or paper clip any attachments to the claim form. Check the Provider Guidelines for your specific provider type handbook to see if an attachment is required. Providers have the option to upload claim attachments through the Idaho Gainwell Technologies Medicaid website when entering claims through a Trading Partner Account (TPA). Attachments should be scanned completed forms, word processing, or spreadsheet documents.

If an attachment is required, providers can continue to send claims via US mail. Do not fold the form. Mail it flat in a 9 x 12 envelope (minimum size).

Mail to the appropriate address found in one of the following tables.

Claim Mailing Addresses	
Address	Claim Type
Gainwell Technologies PO Box 70084 Boise, ID 83707	CMS 1500 UB-04 Inpatient UB-04 Hospice UB-04 LTC UB-04 Home Health UB-04 Medicare Primary Third Party Recovery (TPR)

Claim Mailing Addresses	
Address	Claim Type
Gainwell Technologies PO Box 70087 Boise, ID 83707	UB-04 Outpatient Financial (Adjustments, refunds, etc.)

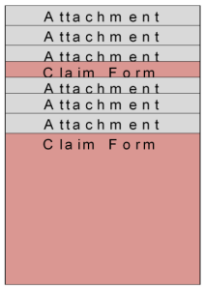
Send correspondence in a separate envelope or mark the outside of the claim envelope *Correspondence Enclosed*.

4.4 Attachments

Attachments are additional documentation required to support the processing and payment of a claim. *Please ensure all attachments are legible.*

Attachments may include:

- Third Party Explanation of Benefits (EOB)
- Medicare Remittance Notice (MRN)/Explanation of Medicare Benefits (EOMB)
- Certificate of Medical Necessity CMS-484—Oxygen (CMN)
- Pharmacy prescription
- Consent forms
- Manufacturer's MSRP
- Manufacturer's invoice showing provider cost and shipping as applicable



If a claim has an attachment, do not staple or clip it to the claim. Place it behind the claim form, as illustrated in the figure to the left.

If multiple claims refer to the same attachment, then make separate copies of the attachment for each claim.

If multiple claims are sent together, then stack the claims with each claim followed by its own attachment(s). See the diagram at left.

If an attachment has information on both sides of the page, then make a copy of the backside and include it with the claim.

If an attachment such as a sales receipt is on a small slip of paper, then copy or tape it onto an 8 ½" by 11" inch piece of paper.

If the submission is related to timely filing, it is required that you attach the Medicaid RA. If the submission is a claim review request or the like, attaching the RA will help explain the history of the claim and previous processing.

If no attachments are required, then consider submitting the claim electronically.

Examples of Documentation Required for Billing		
Example	Required Documentation	Solution
Three claims submitted for the same participant with one MRN/EOMB which covers the three claims	One copy of the MRN/EOMB for each claim	Submit services for all three claims on one claim form and include one EOMB **or** Submit three claims and include one copy of the MRN/EOMB with each claim

Examples of Documentation Required for Billing		
Example	Required Documentation	Solution
Corrected claims submitted which were previously denied	Include the RA explaining the previous denial	It is required to include the RA with claim. When the date on the claim exceeds the timely filing limit (one year from date of service) enter the claim number/ICN from the RA in the comment field of the claim and attach the applicable RA.
Two claims submitted, the first is marked *continued,* and one attachment is included to explain the use of a *dump* code for a lab test	None	Total each claim separately and enter the name of the lab test in **Field/Box 19**
Two claims submitted with one invoice attached	One copy of the invoice for each claim	Include one invoice copy with each claim form

4.5 Claim Status

Gainwell Technologies (GWT) has 30-days from the date of submission to render an initial disposition on a claim. Providers can determine the status of their claims through Gainwell Technologies in four ways:

- Through the weekly Remittance Advice (RA). See *Remittance Advice Analysis,* Idaho Medicaid Provider Handbook for information on RAs.
- Calling Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272.
- The electronic claim status request and response transaction (HIPAA 276/277).
- Online through the Gainwell Technologies Idaho Medicaid website.

Questions specific to a claim in a denied status must use the secure messaging option through the provider's trading partner account.

MACS Inquiry: Providers can check the status of electronic and paper claims sent to Gainwell Technologies for processing by calling MACS and selecting the claims information option. For more information on how to access MACS and check claim status, refer to the *MACS User Guide* in the User Guides on the Idaho GWT Medicaid website.

Electronic Inquiry: Idaho Medicaid supports the HIPAA transaction known as the 276/277, Electronic Claim Status Inquiry and Response. This transaction allows providers to inquire on the status of claims and health plans to return the requested information. Providers should contact their software vendor or clearinghouse to determine if their vendor supports the claim status inquiry and response transactions.

Online Inquiry: This option is available to providers who have a trading partner account. More information about verifying eligibility online can be found in the *Eligibility Verification* section of the Trading Partner Account (TPA) User Guide.

Potential claim statuses include:

- DENY: The claim or claim line has been denied for reimbursement. A remittance message will be included with more information on why.
- PAY: The claim line is approved to pay.
- PEND: The claim requires manual review by a Claims Resolution Specialist, and will change to a PAY or DENY status once completed.

5. Adjustments

Adjustments are permitted on a claim only if the information on the original claim is updated. Adjustments cannot be used to add additional services or units, or change the date of service or billed charges. If the claim requires additional line items, or changes to the initial date of service, a new claim is required. Providers have two (2) years from the start date of service to adjust a claim except for institutional claims and Medicare crossover claims. Institutional claims have two (2) years from the through date of service. Medicare crossover claims have two (2) years from the date of the Medicare Remittance Notice. Documentation should be included to support timely filing. In accordance with the provider agreement, providers are required to immediately repay identified overpayments.

For claims that are under two (2) years old from the applicable date, providers must adjust their own claims via an EDI 837 transaction or through their Trading Partner Account (TPA). For those providers who do not have the capability to use either method, a Claim Review Request Form must be submitted stating in the **Comments** field why the provider is unable to adjust the claim electronically; additionally, the provider must also request the claim be reversed, and include a new modified claim form with the Claim Review Request Form, located on the Forms page of Gainwell Technologies' (GWT's) Idaho Medicaid website.

For providers seeking to adjust claims that are beyond two (2) years old from the applicable date, it is considered a recoupment. For these claims, you must refund via check for both partial and complete recoupments and include the Overpayment Form located on the Forms page of GWT's Idaho Medicaid website.

The Remittance Advice (RA) will show any adjustments made. For more information on an RA see the *Remittance Advice Analysis,* Idaho Medicaid Provider Handbook.

5.1.1 References: Adjustments

(a) CMS Guidance

State Medicaid Director Letter# 01-020. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd070301.pdf.

(b) Federal Regulations

Timely Claims Payment, 42 CFR 447.45 (1990). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec447-45.pdf.

(c) Idaho Medicaid Publications

"Changes to Timely Filing." *MedicAide Newsletter,* April 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf.

"Changes to Timely Filing." *MedicAide Newsletter,* June 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf.

Clarification of Timely Filing Requirements, *Information Release MA04-59* (12/15/2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Clarification of Timely Filing Requirements." *MedicAide Newsletter,* October 2008.

"**Reminder to All Providers:** No Claims Adjustments to Dates of Service." *MedicAide Newsletter,* January 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202017%20MedicAide.pdf.

"Timely Filing." *MedicAide Newsletter,* June 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202011%20MedicAide.pdfh

"Timely Filing Documentation." *MedicAide Newsletter,* July 2010, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202010%20MedicAide.pdf.

5.2 Electronic Adjustments

Providers can submit electronic adjustments to Gainwell Technologies using Health PAS-Online or their vendor software. Attachments can be submitted via EDI and attachments are necessary to support and explain the adjustment. Please see the *Claim Status* section of the Trading Partner Account (TPA) User Guide for instructions. When submitting electronic adjustments, use claim frequency 8 to void a claim or claim frequency 7 to replace a claim.

5.3 Paper Adjustments

When a claim is paid incorrectly, resubmit a completed claim form indicating the original claim number and claim frequency code. If resubmitting on a CMS 1500, the frequency code of eight (8) to void a claim, or claim frequency seven (7) to replace a claim is placed in **Field/Box 22** along with the original claim number. If resubmitting on a UB-04 claim form, the last digit of the bill type is considered the frequency code. In **Field/Box 4**, the bill type must show a seven (7) or eight (8) in the frequency position and the original claim number in **Field/Box 64**. See the Claim Form Instructions for detailed information.

6. Claim Reconsideration and Appeals

Claim reconsideration and appeals follow this process:

- Step 1: Claim Review Request;
- Step 2: Medicaid Review of Claim Determination;
- Step 3: Formal Appeal.

6.1 Claim Review Request

The Claim Review Request (CRR) process is available to providers who want Gainwell Technologies (GWT) to physically review their claims. CRRs must be submitted within two (2) years of the date of service, or the through date for facility claims. A CRR is used when:

- The provider disagrees with a timely filing denial.
- The provider disagrees with the application of Coordination of Benefits (COB).
- The provider disagrees with the denial or payment amount of a claim and wants a manual review.
- The claim denied for bundling issues against a denied claim line.
- The claim was inappropriately denied as a duplicate claim.
- The claim was inappropriately denied for exceeding a lifetime benefit.
- A condition on the Hospital-Acquired Conditions was not caused by a lack of appropriate care or inappropriate treatment.
- A claim for delivering a newborn is denied for a participant under the age of 13.
- A claim was submitted for organ donor costs for a deceased Medicaid participant.
- A participant lost eligibility in the middle of a covered stay and then resumed eligibility.
- A revenue code and CPT®/HCPCS combination is not in the claims processing system.

While CRRs can be used for many reasons but should not be used in these instances:

- The claim needs to be adjusted or additional documentation attached. Examples of documents include: Explanation of Benefits (EOB), invoice, sterilization/hysterectomy consent forms, NOA for timely filing, or run/trip report.
- The provider has concerns with Share of Cost (SOC).
- The provider wants more information on Health Management Systems (HMS) adjustments or recoupments.
- The provider wants to request recoupment for a claim within the two (2) year adjustment period.
- The provider is adjusting a claim after a change in the participant's eligibility.

It is best practice for providers to use the provider portal to reverse and adjust claims when necessary, to attach documentation, or reprocess the claim, especially in the instances noted above when a CRR is not used. Please reference the section titled Reverse or Adjust a Claim in the Trading Partner Account (TPA) User Guide for more information on navigating the provider portal. For overpayments, see *Adjustments*.

The CRR instructions and form are found on GWT's website under the Reference Material tab under Forms – Gainwell Technologies Forms. Check Claim Review Request on the Claim Review Request Form and complete the necessary information. The form must be completed in blue or black ink and follow all instructions for it to be processed. Attach only documents pertinent to the request. Do not attach the full medical record as this may be a HIPAA violation. Some of the information required on the form includes:

- Most current claim ID requiring review
- Provider information
- Participant information
- Comments – any explanation needed to help in review
- Attachments – any attachments pertinent to the claim and that helps support the request as well as any additional required documentation (such as a corrected or replacement claim, EOB with remark codes, timely filing, medical records, chart notes, or reports).

Medicaid does not accept CRRs via e-mail or fax. All requests must be mailed. Mail the Claim Review Request Form and attachments to:

Gainwell Technologies Provider Correspondence
P. O. Box 70082
Boise, ID 83707

Providers requesting more than five (5) CRRs to Gainwell for reconsideration are encouraged to contact a Provider Relations Consultant (PRC) first for assistance with the denial. The PRC can help the provider ensure the CRR process is the most efficient way for resolution of the claim. More information about PRCs is found in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

6.1.1 References: Claim Review Request

(a) Idaho Medicaid Publications

"Best Practices for a Claim Review Request." *MedicAide Newsletter,* March 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202024%20MedicAide.pdf.

6.2 Medicaid Review of Claim Determination

A pre-appeal process is available to providers who want someone at the Medicaid Central Office to physically review their claim. To initiate a pre-appeal, follow the procedure outlined below. Requests must be submitted within 28-days of a determination of the Claim Review Request of claim adjudication.

Check **Medicaid Review** on the **Claim Review Request** form, and complete the necessary information:

- Original claim ID requiring review
- Provider information
- Participant information
- Comments – any explanation needed to help in review
- Attachments – any attachments you feel will help support your request as well as any required documentation (such as timely filing, medical necessity, notes, or reports)
- ***You must include a copy of the* Gainwell Technologies *Claim Review Determination Letter***

Mail the Claim Review Request form and attachments to the following address.

Gainwell Technologies Provider Correspondence
P. O. Box 70082
Boise, ID 83707

6.3 Formal Appeal

A formal appeal must be submitted in writing with supporting documentation within 28 days of the date of the Medicaid Review of Claim Determination letter to:

Division of Medicaid
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036
Fax: 1 (208) 364-1811
MedicaidAppeals@dhw.idaho.gov

Submit the following information for a formal appeal:

- Cover letter detailing why the formal appeal is requested
- Copy of Medicaid Review of Claim Determination Letter
- Copy of Gainwell Technologies review letter
- Copy of claim and all attachments or new claim for possible resubmission
- Copy of the applicable Remittance Advice (RA)

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

7. Third Party Liability

This section covers the Third-Party Liability (TPL) situations applicable to providers working with Idaho Medicaid participants. It briefly describes how Gainwell Technologies (GWT) processes TPR claims. In accordance with Federal regulations 42 CFR-433.135-139, the Division of Medicaid or its designee must take all reasonable measures to determine the legal liability of third parties to pay for medical services under the plan.

A third party is any insurance company, private individual, corporation, or business that can be held legally responsible for the payment of all or part of the medical or dental costs of a participant. Third parties could include:

- Medicare;
- Group health insurance;
- Workers' compensation;
- Homeowners' or renters' insurance;
- Automobile liability insurance;
- Non-custodial parents and/or their insurance carriers; or
- An individual found legally responsible for a Medicaid participant's injury (a person who committed an assault on a participant, for instance).

Federal regulations require providers to bill all known insurance companies before submitting a claim to Medicaid. At this time, services federally excluded from TPR requirements are:

- Indian Health Services (IHS);
- Purchased or Referred Care (PRC) healthcare by IHS;
- Health insurance plans self-funded by a federally recognized tribe;
- School-based services;
- Victims of Crime Act (VOCA) or the crime victim's compensation programs;
- The Ryan White HIV/AIDS Program (RWHAP); and
- Early and periodic screening, diagnostic, and testing (EPSDT) services, when a liable third party has not made payment within 90 days after the date the provider of such services initially submitted a claim to such third party for payment for such services, in accordance with section 1902(a)(25)(E) of the Social Security Act. Screening and diagnosis program services include:
    - Age-appropriate exams, including comprehensive health and developmental history, growth, development, and nutritional status, provided in accordance with reasonable standards of medical and dental practice;
    - Medically necessary behavioral health services;
    - Immunizations;
    - Laboratory tests; and
    - Diagnosis of defects of vision, hearing, dental needs, and other health conditions for participants under the age of 21.

Based on these regulatory requirements, Idaho Medicaid is the primary payer for the following third-party insurers:

- 6243 SHASTA ADMIN SERVICES-INDIAN HEALTH
- 6233 HEALTHCARE MGT ADMIN - AN/AI

Services for treatment of individuals under the age of 21 are not excluded from TPL requirements except where noted.

The provider must accept the Medicaid allowed amount as payment in full. The provider cannot bill the participant for any balance remaining after the primary insurance and Medicaid have both paid. This also includes claims with third-party liability where Medicaid's

reimbursement methodology considers the third-party payment to have covered the claim in full and no additional amount is paid by Medicaid. See the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for when billing a participant is allowed.

7.1 References: Third Party Liability

7.1.1 CMS Guidance

"Coordination between Medicaid and Ryan White HIV/AIDS Programs." *CMCS Informational Bulletin, May 1, 2013,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-01-2013.pdf.

"Further Guidance to Medicaid Bipartisan Budget Act (BBA) of 2018 and changes to Medicaid Provisions Passed in April 2019 – Third Party Liability in Medicaid and CHIP." *CMCS Informational Bulletin, November 14, 2019,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/federal-policy-guidance/downloads/cib111419.pdf.

"Opportunities to Improve HIV Testing, Prevention, and Care Delivery for Medicaid and CHIP Beneficiaries." *CMCS Informational Bulletin, January 15, 2025,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/federal-policy-guidance/downloads/cib01152025.pdf.

7.1.2 Federal Regulations

Acceptance of State Payment as Payment in Full, 42 CFR 447.15 (2013). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-sec447-15.pdf.

"Extension of Third-party Liability Period for Child Support Services." H.R. 1839, "Medicaid Services Investment and Accountability Act of 2019," Sec. 7. Government Printing Office, https://www.congress.gov/bill/116th-congress/house-bill/1839.

Payment for Provider and Supplier Services Purchased by Indian Health Programs, 42 CFR 136.203 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol1/pdf/CFR-2019-title42-vol1-sec136-203.pdf.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(25) (2020). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

"Strengthening Medicaid Third-Party Liability." H.J.R. 59, "Bipartisan Budget Act of 2013," Sec. 202. Government Printing Office, https://www.congress.gov/113/bills/hjres59/BILLS-113hjres59enr.pdf.

Third Party Liability, 42 CFR 433 Subpart D (2013). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part433-subpartD.pdf.

"Third Party Liability in Medicaid and CHIP." H.R. 1892, "Bipartisan Budget Act of 2018," Sec. 53102. Government Printing Office, https://www.congress.gov/bill/115th-congress/house-bill/1892/text.

Victims of Crime Act Victim Compensation Grant Program, OJP(OVC)–1319 (2001). Government Printing Office, https://www.govinfo.gov/content/pkg/FR-2001-05-16/pdf/01-12256.pdf.

7.1.3 Idaho Medicaid Publications

"Coordination of Benefits." *MedicAide Newsletter,* January 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202014%20MedicAide.pdf.

"Coordination of Benefits-Updates, Changes, & Reminders." *MedicAide Newsletter,* February 2013, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202013%20MedicAide.pdf.

"Medicaid as Payer of Last Resort." *MedicAide Newsletter,* January 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202016%20MedicAide.pdf.

7.1.4 State Regulations

"Acceptance of State Payment." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 025.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

7.2 Determining Other Insurance Coverage

Call the Medicaid Automated Customer Services (MACS) line at 1 (866) 686-4272, or use the Idaho Gainwell Technologies Idaho Medicaid website, or other successfully tested vendor software to determine if a participant has other insurance coverage before billing Idaho Medicaid.

The name of the insurance company and the type of coverage is given. If there is other insurance coverage, note the information on the other insurance carrier and bill the other insurance before billing Medicaid.

Third Party Recovery (TPR) Coverage Codes	
Code	Description
0001	Full coverage
0002	Full coverage, no dental
0003	Full coverage, no dental, no drugs
0004	Full coverage, no vision
0005	Full coverage, no dental, no vision
0006	Accident only policy
0007	Hospital only policy
0008	Surgical policy
0009	Accident & hospital only
0010	Cancer only policy
0011	Dental only
0012	Drug only
0013	Vision
0014	Medicare Part A
0015	Medicare Part B
0016	Medicare supplement, no drug
0017	Full coverage with dental, no drug
0018	Medicare supplement with drug
0025	Full coverage, no dental, no vision, no drug
0027	Medicare HMO
0029	Unknown
0038	Air ambulance coverage
0039	LTC/nursing home coverage
0040	Full coverage, no vision, no drug
0041	Medicare HMO
0042	Medicare Advantage, Part A & B only
0043	Medicare Advantage, Part A & B with drug
0044	Medicare Advantage, Part A & B with dental
0045	Medicare Advantage, Part A & B with dental and drug
0046	Medicare Advantage, Part A & B with vision
0047	Medicare Advantage, Part A & B with drug and vision
0048	Medicare Advantage, Part A & B with dental and vision
0049	Medicare Advantage, Part A & B with dental, vision, and drug
0050	Medicaid/Medicaid Coordinated Plan

Third Party Recovery (TPR) Coverage Codes	
Code	Description
0051	Medicare Part C

Refer to the *TPR Carrier Codes* document for carrier codes. If you do not find the carrier on the list, please call HMS 1 (800) 873-5875 for the appropriate carrier code.

7.2.1 References: Determining Other Insurance Coverage

(a) Idaho Medicaid Publications

"Coordination of Benefits." *MedicAide Newsletter,* January 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202014%20MedicAide.pdf.

7.3 Coordination of Benefits (COB)

Coordination of Benefits (COB) is how Idaho Medicaid determines payment for claims when a third-party is liable for a portion of the charges. The COB calculation is performed at the claim level for all claims to determine the payment for claims with a third-party insurer. COB calculation is not performed line by line. COB amounts entered at the claim detail level are summed up for the claim and then the COB calculation is performed. The payment is then distributed to the claim detail lines.

The Department is not liable for penalties levied against a provider by a third-party payor. Any amount deducted from a payor's reimbursement for a penalty will not be included in the COB calculation. For example, if Medicare decreases reimbursement on a claim due to a penalty, the amount used in the COB calculation is what Medicare would have reimbursed if no penalty was applied.

Third Party Recovery claims are claims that HMS has recovered payment on from a participant's primary insurance payer, who was unknown at the time the original claim was paid. The amount HMS recovered from the other payer is reflected as a primary insurance payment amount on the Remittance Advice and provider portal. An eligibility segment will be displayed reflecting either Third Party Recovery or Casualty for participants on the portal. Claims marked as Casualty indicate a settlement has been reached in an accident case and the claim is finalized; these claims cannot be adjusted any longer. Claims marked as Third Party Recovery indicate that the Department received funds from a primary insurance carrier; these claims can be adjusted, but the recovery amount will remain with the claim for historical purposes, regardless of what is updated by the provider.

All claims are priced in one (1) of four (4) ways when determining coordination of benefits:

1. **Member Responsibility**
   Add together the primary's coinsurance, co-payment, and deductible. If no coinsurance, co-payment, and/or deductible are reported, then the payment is zero.

   Claims paid with this method:
   - Medicare Part A
   - Hospital Inpatient (Unless primary was not active the full length of the stay.)
   - QMB-Only participants

Examples of Member Responsibility calculations:

Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 Primary Ins Paid Amount: $64.00 **Primary Ins Deductible: $0.00** **Primary Ins Co-Insurance: $0.00** **Primary Co-Payment: $16.00** Medicaid Allowed Amount: $80.00	**Medicaid will pay $16**
Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** **Primary Ins Deductible: $0.00** **Primary Co-Insurance: $0.00** **Primary Co-Payment: $16.00** **Medicaid Allowed Amount: $60.00**	**Medicaid will pay $0** (Primary paid more than Medicaid allowed.) For QMB-Only **Medicaid will pay $16**

Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 Primary Ins Paid Amount: $64.00 **Primary Ins Deductible: $8.00** **Primary Co-Insurance: $0.00** **Primary Co-Payment: $8.00** Medicaid Allowed Amount: $90.00	**Medicaid will pay $16**

2. Medicaid-Allowed Minus Primary Insurance Payment
Take the Medicaid contract amount minus COB paid amount.

Claims paid with this method:
- RHC, FQHC, IHC *(benefit)*
- Long Term Care *(contract)*

Examples of Medicaid-Allowed Minus Primary Payment calculations:

Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $0.00 Primary Ins Co-Insurance: $0.00 Primary Co-Payment: $16.00 **Medicaid Allowed Amount: $70.00**	**Medicaid will pay $6** For QMB-Only **Medicaid will pay $16**
Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $0.00 Primary Co-Insurance:$0.00 Primary Co-Payment: $16.00 **Medicaid Allowed Amount: $60.00**	**Medicaid will pay $0** For QMB-Only **Medicaid will pay $16**
Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $8.00 Primary Co-Insurance: $0.00 Primary Co-Payment: $8.00 **Medicaid Allowed Amount: $90.00**	**Medicaid will pay $26** For QMB-Only **Medicaid will pay $16**

3. Lesser of Member Responsibility or Medicaid-Allowed Amount Minus Primary Insurance Payment

Whichever is the lesser of:

Add together the primary's coinsurance, co-payment, and deductible. If there is no reported coinsurance, co-payment, and/or deductible, then the payment is zero (*Member Responsibility*). For commercial claims, if there is no reported coinsurance, co-payment, and/or deductible, then the payment follows *Medicaid-Allowed Minus Primary Insurance Payment*.

OR

Subtract the COB-paid amount from the Medicaid allowed amount. When the *Medicaid-Allowed Minus Primary Insurance Payment* is less than COB paid, then the payment is zero.

Claims paid with this method:

- Medicare Part B *(including those on a denied Part A claim)*
- Professional Services
- Hospital Outpatient

Examples of Lesser of calculations:

Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 Primary Ins Paid Amount: $64.00 **Primary Ins Deductible: $0.00** **Primary Co-Insurance: $16.00** Primary Co-Payment: $0.00 Medicaid Allowed Amount: $70.00 **Member Responsibility: $16.00**	Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $0.00 Primary Co-Insurance: $0.00 **Primary Co-Payment: $16.00** **Medicaid Allowed Amount: $70.00** **Medicaid Allowed Minus Primary's Payment: $6.00**	**Medicaid will pay $6** For QMB-Only **Medicaid will pay $16**
Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 Primary Ins Paid Amount: $64.00 **Primary Ins Deductible: $0.00** Primary Co-Insurance: $0.00 **Primary Co-Payment: $16.00** Medicaid Allowed Amount: $60.00 **Member Responsibility: $16.00**	Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $0.00 Primary Co-Insurance: $0.00 Primary Co-Payment: $16.00 **Medicaid Allowed Amount: $60.00** **Medicaid Allowed Minus Primary's Payment: $0.00**	**Medicaid will pay $0** For QMB-Only **Medicaid will pay $16**
Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 Primary Ins Paid Amount: $64.00 **Primary Ins Deductible: $8.00** Primary Co-Insurance: $0.00 **Primary Co-Payment: $8.00** Medicaid Allowed Amount: $90.00 **Member Responsibility: $16.00**	Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $8.00 Primary Co-Insurance: $0.00 Primary Co-Payment: $8.00 **Medicaid Allowed Amount: $90.00** **Medicaid Allowed Minus Primary's Payment: $26.00**	**Medicaid will pay $16**

4. Lesser of Provider Charge Minus Primary Insurance Payment or Medicaid-Allowed Amount Minus Primary Insurance Payment

Whichever is the lesser of:

The provider's charge minus the primary insurances payment. The payment is zero if there is no remainder.

OR

Subtract the primary insurance's payment amount from the Medicaid allowed amount. The payment is zero if there is no remainder.

Claims paid with this method:

- Hospital Inpatient when the primary insurance is not active for the entire stay.

Examples of Lesser of calculations:

Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $0.00 Primary Co-Insurance: $16.00 Primary Co-Payment: $0.00 Medicaid Allowed Amount: $70.00 **Provider Charge Minus Primary Insurance Payment: $36.00**	Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $0.00 Primary Co-Insurance: $0.00 **Primary Co-Payment: $16.00** **Medicaid Allowed Amount: $70.00** **Medicaid Allowed Minus Primary's Payment: $6.00**	**Medicaid will pay $6** For QMB-Only **Medicaid will pay $16**
Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $0.00 Primary Co-Insurance: $0.00 Primary Co-Payment: $16.00 Medicaid Allowed Amount: $60.00 **Provider Charge Minus Primary Insurance Payment: $36.00**	Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $0.00 Primary Co-Insurance: $0.00 **Primary Co-Payment: $16.00** **Medicaid Allowed Amount: $60.00** **Medicaid Allowed Minus Primary's Payment: $0.00**	**Medicaid will pay $0** For QMB-Only **Medicaid will pay $16**
Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $8.00 Primary Co-Insurance: $0.00 Primary Co-Payment: $8.00 Medicaid Allowed Amount: $90.00 **Provider Charge Minus Primary Insurance Payment: $36.00**	Provider Billed Amount: $100.00 Primary Ins Allowed Amount: $80.00 **Primary Ins Paid Amount: $64.00** Primary Ins Deductible: $8.00 Primary Co-Insurance: $0.00 Primary Co-Payment: $8.00 **Medicaid Allowed Amount: $120.00** **Medicaid Allowed Minus Primary's Payment: $56.00**	**Medicaid will pay $36** For QMB-Only **Medicaid will pay $16**

Important note: It is necessary to report the Medicare/Other Insurance allowed, paid, deductible, coinsurance, and co-payment amounts accurately for correct payment consideration.

Professional Claims

Medicaid's payment for services will be calculated according to the *Lesser Of* methodology. The payment will be the lesser of the primary insurance's co-insurance, co-payment, and deductible, or the primary's insurance payment subtracted from the Medicaid allowed amount. When the Medicaid allowed amount is less than COB paid, the payment is zero.

Hospital Claims – Inpatient

Medicaid's payment for services are usually calculated according to the *Member Responsibility* methodology. If no co-insurance, co-payment, or deductible are reported the payment is zero. However, if the primary insurance was not active for the entire inpatient stay, the payment for services will be the lesser of the provider's charge minus the primary insurance payment, or the primary's insurance payment subtracted from the Medicaid allowed amount.

Hospital Claims – Outpatient

Medicaid's payment for services are calculated according to the *Lesser Of* methodology. When the Medicaid allowed amount is less than COB paid, the payment is zero. When Medicare reports zero for non-covered services, then DHW processes claims as Primary and pays the Medicaid allowed amount.

Professional Claims for Medicare Non-covered Service
Medicaid's payment for services are calculated according to the *Lesser Of* methodology. When the Medicaid allowed amount is less than COB paid, the payment is zero. When Medicare reports zero for non-covered services, then DHW processes claims as Primary and pays the Medicaid allowed amount.

Long Term Care Facility
Medicaid's payment for services are calculated according to the *Medicaid-Allowed Amount Minus Primary Insurance Payment* methodology. Then minus any unpaid Share of Cost (SOC) amount. When the Medicaid allowed amount is less than COB paid, the payment is zero.

FQHC/RHC/IHC
Medicaid's payment for services are calculated according to the *Medicaid-Allowed Amount Minus Primary Insurance Payment* methodology. When the Medicaid allowed amount is less than COB paid, the payment is zero.

7.3.1 References: Coordination of Benefits

(a) Idaho Medicaid Publications

All Medicaid Providers Billing Medicare Part B Crossover Claims, *Information Release MA02-11* (2002). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Coordination of Benefits Claim Processing." *MedicAide Newsletter,* January 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202016%20MedicAide.pdf.

"Coordination of Benefits (COB) Enhancements." *MedicAide Newsletter,* August 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202019%20MedicAide.pdf.

"Coordination of Benefits Reimbursement Alignment." *MedicAide Newsletter,* November 2015, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202015%20MedicAide.pdf.

(b) State Regulations

"Procedures for Medicare Cross-Over Claims." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.07. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

7.4 Submitting Third Party Liability Claims

The claim must be submitted correctly to the responsible third party before it may be submitted to Medicaid. After receiving either a partial payment or a denial from an insurance company, submit the claim to Medicaid for payment consideration along with a copy of the Explanation of Benefits (EOB) including the information for the claim and the explanation of the remark codes. Do not wait to submit claims to Medicaid if doing so would cause the claim to be denied for timely filing. See the Timely Filing Limit section for more information.

A billing or timeliness error is not considered a valid denial for the purposes of satisfying the requirement to bill all other insurances. The following are examples of denials that are not accepted for paper, online, or electronic claims:

- Claim lacks information needed for adjudication;
- Prior Authorization required;
- Patient cannot be identified as our insured;
- Claim filed past filing time limit; and
- Duplicate of a previously submitted claim.

When submitting the claim to Medicaid, verify that the dates of service, units, detail charges, and total charges are the same on the primary insurance EOB and on the claim to Medicaid. If the other insurance carrier denied the claim, submit the claim to Gainwell Technologies (GWT) for processing. A copy of the other insurance company's EOB (both detail about the claim and an explanation of the remark codes) must be attached to the claim to document the other insurance company's denial. The denial must be validated before the claim can be processed by GWT. The following types of documentation are not acceptable as EOBs:

- Screen prints of primary insurance system, or an internal system;
- Word documents;
- Eligibility inquiries;
- Claim inquiries; or
- Claim rejection notices.

A paper EOB from the other insurer is included with paper claims, including the EOB claim resolution message from the other insurance and the explanation of any remark codes. Since there are hundreds of insurers, each with their own remark coding system, Idaho Medicaid cannot process a claim unless the EOB number and message is included with the paper claim.

Fill in the other insurance paid amount in the appropriate field of the claim. If the insurance pays at zero, **0.00** must be recorded in the appropriate field or the claim will be denied. These claims must be submitted to Medicaid with the EOB attached.

When some of the services were paid by the liable third-party and others denied, the claim must be split between the paid and the denied services on separate claim forms along with the EOB.

If you receive notification or a claim rejection notice that your member has lost primary insurance coverage from the carrier please contact HMS at P.O. Box 94630, Seattle, WA 98124-6930, or by phone at 1 (800) 873-5875. A member's primary insurance record must be verified as inactive before the claims processing system can be updated and claims can be paid.

7.4.1 References: Submitting Third Party Liability Claims

(a) Idaho Medicaid Publications

"Attaching Explanation of Benefits (EOB) to Claims." *MedicAide Newsletter, November 2010*, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202010%20MedicAide.pdf.

"Claims Documentation." *MedicAide Newsletter, May 2018*, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202018%20MedicAide.pdf.

"Coordination of Benefits." *MedicAide Newsletter,* January 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202014%20MedicAide.pdf.

"Coordination of Benefits-Updates, Changes, & Reminders." *MedicAide Newsletter,* February 2013, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202013%20MedicAide.pdf.

"Do You Submit Coordination of Benefit Secondary Claims to Medicaid?" *MedicAide Newsletter,* June 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202017%20MedicAide.pdf.

"Split Billing for Private Insurance COB Claims?" *MedicAide Newsletter,* November 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202011%20MedicAide.pdf.

7.4.2 Electronic Third-Party Claims

HIPAA Remittance Advice Remark Codes (RARC) replace the third-party Explanation of Benefits (EOB) codes that were formerly used on both paper and electronic third-party claims. They explain how the claim was processed and give additional information about the payment of benefits or denial of the claim by the third-party payer.

For electronic/EDI claims, the current RARC(s) are required on all TPR transactions. For paper claims and online entry claims, attach the required EOB(s) from the other insurance(s); these EOB(s) would also use the same RARC.

The RARC are updated three times a year by CMS. A current list of the RARC codes can be found on the X12 website.

Further information can also be obtained online at the Idaho Gainwell Technologies' Medicaid website, or by contacting Provider Services at 1 (866) 686-4272.

(a) References: Electronic Third-Party Claims

(i) Idaho Medicaid Publications

"Coordination of Benefits." *MedicAide Newsletter,* January 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202014%20MedicAide.pdf.

7.4.3 Third Party Fields on Paper Claim Forms

The following table lists all the paper claim forms used by Idaho Medicaid and the fields used for Third Party Liability (TPL) by number.

Third Party Liability Fields on Paper Claim Forms					
Form	Service Line Charge	Total Charges	Other Insurance Payment	Balance Due	Comments
CMS-1500 claim form	24F	28	29	30	19
	$ Charges	Total Charge	Amount Paid	Balance Due	Reserved for local use
UB-04 claim form	(not used)	23	54	55	80
		Enter the total of all claim charges	Prior Payments	Estimated Amount Due	Remarks

(a) References: Third Party Fields on Paper Claim Forms

(i) Idaho Medicaid Publications

"Coordination of Benefits." *MedicAide Newsletter,* January 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202014%20MedicAide.pdf.

7.4.4 Split Claims

Sometimes claims are billed to other insurance companies with more lines than will fit on the Medicaid paper claim form. To create a matching claim, the claim must be split.

If the other insurance's Explanation of Benefits (EOB) has more detail lines than will fit on the claim form, divide the claim into two or more separate claims. Submit the first lines on one claim form and the remaining lines on additional claim forms. Write *Split Claim* in **Field/Box 19** of the CMS-1500 claim form, or **Field/Box 80** of the UB-04 claim form. Total each claim. Pro-rate the third-party payments to match the lines billed Attach a separate copy of the EOB to each split claim.

When billing electronically, it is not necessary to split a claim unless the provider is submitting more than the maximum number of detail lines allowed on the claim.

- Professional claims: Up to 50 details
- Institutional claims: Up to 999 details

Claims must also be split between paid and denied services.
Note: ICD-10-CM codes S00 to T88.9 are injury diagnoses. For more on using diagnosis codes in this range see section, Injury Liability*,* before submitting your claim. This helps prevent an unnecessary claim denial.

(a) References: Split Claims

(i) Idaho Medicaid Publications

"Split Billing for Private Insurance COB Claims?" *MedicAide Newsletter,* November 2011, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202011%20MedicAide.pdf.

7.5 Claims for Participants with Medicare

Providers must enroll with the Idaho Medicaid Program separately from Medicare. When the participant is dually eligible for Medicare and Medicaid, Medicare must be billed first. Claims submitted to Medicare electronically crossover to Medicaid. Claims that fail to automatically cross over from Medicare must be submitted to Medicaid with a Medicare Remittance Notice (MRN) attached. The MRN must include the Medicare payment or non-payment reason code. If the MRN does not clearly identify that it is an MRN, write on the top right margin of the claim or the MRN, "Medicare MRN" or "Medicare HMO", if applicable to help sort the claim. Medicare Excluded Services do not require a MRN to be considered by Medicaid. If the participant's coverage is handled through a private insurance carrier that is not Medicare, then the provider must submit an Explanation of Benefits (EOB) from the primary insurance.

When Medicare is the primary carrier for payment, the Idaho Medicaid authorization requirements do not apply. Medicare guidelines are followed. If Medicare denies the claim, Idaho Medicaid becomes the primary payer and Idaho Medicaid's prior authorization, documentation, processing, and payment rules apply.

Claims for Qualified Medicare Beneficiaries (QMB; rate code 68) are eligible for reimbursement as described under the Qualified Medicare Beneficiaries section.

See the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for information related to the different kinds of Medicare and Medicaid coverage a participant may have. A participant's Medicare Part A and Part B information is available by calling the Medicaid Automated Customer Services (MACS) line at 1 (866) 686-4272 and choosing the *other insurance* menu option.

7.5.1 Qualified Medicare Beneficiaries

Participants enrolled only as Qualified Medicare Beneficiaries (QMB; rate code 68) are not eligible for Medicaid benefits. Services denied or not covered by Medicare for QMB participants are denied when billed to Medicaid. Claims submitted with both Medicare covered and Medicare non-covered services on the same claim are denied. The provider must split bill both covered and non-covered services. The exception to this rule is Medicare excluded services or when the provider reports modifiers GY or GZ on a Medicare non-covered service for which they expect no payment from Idaho Medicaid. Excluded services are those that Medicare never pays for, vs. non-covered, which Medicare may pay in certain circumstances.

These claims are only eligible for the *Member Responsibility* portion across all provider types. Member Responsibility is calculated by adding together the primary payers' coinsurance, co-payment, and deductible. If no coinsurance, co-payment, and/or deductible are reported, then the Medicaid payment is zero.

Claims filed secondary to Medicare and sent electronically by Medicare are called crossover claims. On the Medicare Remittance Notice (MRN) the payment of these charges appears on the first detail line of the paid claim on the Professional Crossover Claims page. Each claim form must be submitted with an MRN attached. All claims submitted online or on paper must match the MRN exactly.

(a) References: Qualified Medicare Beneficiaries

(i) Idaho Medicaid Publications

All Medicaid Providers Billing Medicare Part B Crossover Claims, *Information Release MA02-11* (2002). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Coordination of Benefits Reimbursement Alignment." *MedicAide Newsletter,* November 2015, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202015%20MedicAide.pdf.

7.5.2 Medicare Advantage

To ensure the claim is processed correctly, claim forms must be filled out completely. If the Explanation of Benefits (EOB) does not designate Medicare Advantage, specify which plan is indicated in box 9D or 11C on the CMS-1500. On the UB-04, indicate the plan in box 50.

7.5.3 Split Claims

Claims will deny if submitted with both Medicare covered and Medicare non-covered services on the same claim. Providers must split bill these services.

An exception to this rule is when modifier GY and/or GZ are reported for Medicare non-covered services. These services can be billed on the same claim with a Medicare covered service.

Sometimes claims are billed to Medicare with more lines than will fit on the paper claim form. To create a matching paper claim, the claim must be split. When the Medicare Remittance Notice (MRN) has more detail lines than will fit on the claim form, split the claim. Submit two claims with the first lines on one claim form and the remaining lines on additional claim forms. Write *Split Claim* in **Field/Box 19** of the CMS-1500 claim form or in **Field/Box 80** of the UB-04 claim form. Leave the fields for amount paid and balance due blank. Attach a separate copy of the Explanation of Benefits (EOB) to each split claim. Total each claim.

When billing electronically, it is not necessary to split a claim unless submitting more than the maximum number of details allowed on one (1) claim.

- Professional claims: Up to 50 details
- Institutional claims: Up to 999 details

(a) References: Split Claims

(i) Idaho Medicaid Publications

"Billing Tips for Medicare Crossover – Split Claims." *MedicAide Newsletter, October 2007*.

"Claims for Medicare Covered/Non-Covered Services." *MedicAide Newsletter, August 2012*, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202012%20MedicAide.pdf .

7.5.4 Electronic Crossover Claims

Medicare Part B services billed by Idaho providers cross over electronically from the Medicare carrier to Gainwell Technologies. This process occurs automatically when the Medicare claim shows:

- Assignment was accepted
- Participant's Idaho MID number
- Provider's Medicare number

Providers may submit claims for Part B services directly to Idaho Medicaid.

7.5.5 Paper Claims for Dually Eligible Participants

Information on dually eligible fee-for-service claims submitted on paper must match the information on the MRN exactly. The dates of service and dollar amounts must be the same as those on the MRN. File a separate claim for each claim on the MRN. Participants with both Medicare and private insurance must have an Explanation of Benefits (EOB) from both carriers attached to the Medicaid claim form.

When billing paper claims for dually eligible participants:

- Use the participant's MID number.
- Use the Idaho Medicaid provider number.
- Fill in fields required on standard Medicaid claims.
- Sign and date all claims.
- Attach the MRN to the claim and ensure that the MRN is clearly identified as Medicare, Medicare HMO, or Medicare Supplement on the claim form or MRN; include any explanations of the remark code(s).
- Ensure all attachments are on 8 1/2" x 11" paper.

When the participant is not Medicaid eligible for a certain date of service, do not enter those charges on the claim. Enter a note on the front of the claim explaining that this is why the MRN does not match the claim.

7.5.6 Crossover Errors

Occasionally, a claim from Medicare does not automatically crossover to Gainwell Technologies (GWT). This occurs when the Medicare and Medicaid participant numbers on file do not match. If a claim does not appear on the Medicaid remittance advice (RA) within four weeks after Medicare payment, submit a claim to Medicaid for processing. Call GWT's Provider Enrollment at 1 (866) 686-4272 to verify that all provider numbers are on file to allow for automatic crossover.

Medicaid claims must be submitted within 6 months of the payment date of the Medicare EOB.

7.5.7 Resubmitting Crossover Claims

Claims for dually eligible in fee-for-service which are returned to the provider by Medicare for any reason must be resubmitted as a Medicaid claim. Attach the original claim and any other supporting documentation to a copy of the Medicare Remittance Notice (MRN). Include both your provider number and the participant's Medicaid identification (MID) number.

The claim dates of service, billed amounts and the MRN must match. Occasionally, Medicare combines or splits claims to expedite processing. When this happens, change the Medicaid claim form to match the MRN. The services Medicare processes as a single claim under one claim number must match exactly the service billed on the claim submitted to Medicaid, with the exception as noted in the *Hospital*, Idaho Medicaid Provider Handbook section for Emergency Department/Rooms and Observation.

Lab services are usually paid at 100% of the approved amounts. The claim total differs from the total billed on the MRN if you do not bill these charges to Medicaid. Adding a notation on a claim (**Field/Box 19** of the CMS-1500 claim form) stating that the lab charges were paid reduces the chance of a claim being returned in error.

7.5.8 Medicare/Medicaid Crossover Inquiries

For inquiries regarding Medicare/Medicaid crossover claims, write or call the related fiscal intermediary or carrier listed below.

Part A Medicare:

Noridian Administrative Services
P.O. Box 6726
Fargo, ND 58108-6726
Provider Number: 1 (866) 497-7857 or TTY Line 1 (866) 967-7902
Beneficiary Number: 1 (800) 633-4227

Part B Medicare:

Noridian Administrative Services
P.O. Box 6701
Fargo, ND 58108-6701
Provider Number: 1 (877) 908-8431 or TTY Line 1 (877) 261-4163
Beneficiary Number: 1 (800) 633-4227 or TTY/TDD Line 1 (877) 486-2048

DME Jurisdiction D:

Noridian JD DMEP.O. Box 6727
Fargo, ND 58108-6727
Provider Number: 1(877) 320-0390
Participant Number: 1(800) 633-4227

7.6 Injury Liability

All claims submitted with a diagnosis indicating an injury are reviewed for possible liability recoveries. Claims are still subject to timely filing requirements. Include all documentation regarding the injury with the claim or on the electronic claim record, even if there are several claims for the same injury. Claims are reviewed separately and each stands on its own merit.

All possible third party involvement must be investigated for injury liability. The participant should be contacted for information about the circumstances of the injury. If investigation reveals no third party liability or shows the claim is not accident related, submit the claim to Medicaid with information regarding attempts made to identify a third party or obtain accident information. The information must demonstrate that at least three attempts were made. Document the person(s) to whom the provider spoke, date and time of the contacts.

In the event that the participant receives a payout directly from a third-party to cover their medical costs, the provider may bill the participant up to the amount of the direct payout. This would be reported on a claim as being received from the primary insurer.

To prevent a claim from being denied for additional information, providers should submit letters of denial; maximums met, no liability, or other documentation, with the claim. Indicate in **Field/Box 19** of the CMS-1500 claim form, or **Field/Box 80** of the UB-04 claim form the following information:

- How the injury occurred;
- If the injury is not accident related;
- Where the injury occurred (home, someone else's home, work, commercial property, auto, etc.);
- Date the injury occurred;
- Dates, times and names of person contacted for information, if applicable; and
- Name and phone number of the attorney, if applicable.

See Coordination of Benefits for information about claims that have already had third-party liability collected.

7.6.1 References: Injury Liability

(a) State Regulations

Medical Assistance – Medical Assistance Account, Idaho Code 56-209b (2002). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-209b.

7.6.2 Injury Liability: Inpatient Coordination of Benefits

For inpatient claims with payments from a Third Party Liability payer:

- In the total allowed amount field enter the Medicaid allowed amount; and
- In the co-insurance field enter the difference between the Medicaid allowed amount and the Third Party Liability payer amount that was received in order to accurately calculate Medicaid reimbursement. For example:

Coordination of Benefits (COB)	
Total Allowed Amount	Medicaid Allowed Amount
Total Paid Amount	Payment from Third Party Liability payer
Total Deductible Amount	$0.00
Total Coinsurance Amount	Medicaid Allowed Amount – Payment from Third Party Liability payer
Total Co-payment Amount	$0.00

7.6.3 Litigation Cases

When an injury claim is in litigation or may go to litigation the provider must choose one of the following options:

Option One: Submit the claim to Medicaid
Medicaid will pay up to the allowed amount for the services billed. The provider agrees to accept what Medicaid paid as payment in full. The provider is prohibited from submitting those same charges for reimbursement in the litigation. The provider cannot later refund Medicaid and accept a payment from litigation.

Option Two: Pursue payment through litigation
The provider forgoes payment from Medicaid. The provider collects payment from the participant up to a maximum of what they received through litigation. Regardless of the litigation's outcome, the provider may not bill Medicaid or the Medicaid participant for those services.

(a) References: Litigation Cases

(i) CMS Guidance

State Medicaid Director Letter #060997. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD060997.pdf.

(ii) State Regulations

"Acceptance of State Payment." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 025.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance – Medical Assistance Account, Idaho Code 56-209b (2002). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-209b.

7.7 Third Party Recovery (TPR) Inquiries

Send direct inquiries regarding TPR and insurance information to HMS.

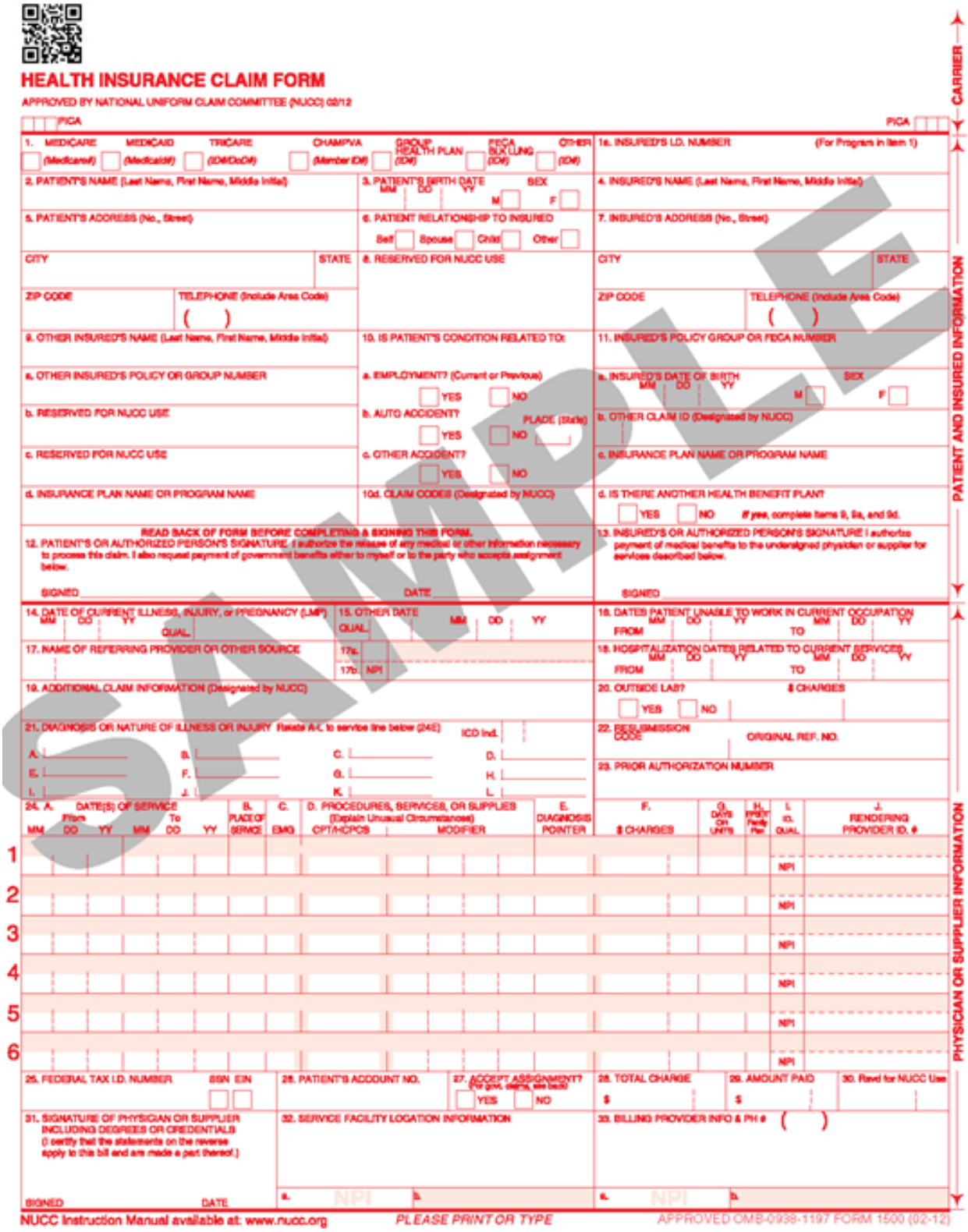
HMS
P.O. Box 94630
Seattle, WA 98124-6930
1 (800) 873-5875
IDTPLInsuranceReferrals@gainwelltechnologies.com

HMS Casualty
P.O. Box 84551
Seattle, WA 98124-5851
1 (844) 388-0652
IDCasualty@gainwelltechnologies.com

Provider representatives are available Monday through Friday from 8 A.M. – 5:30 P.M., MT, Monday – Friday excluding State holidays.

8. Appendices

Appendix A. CMS-1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

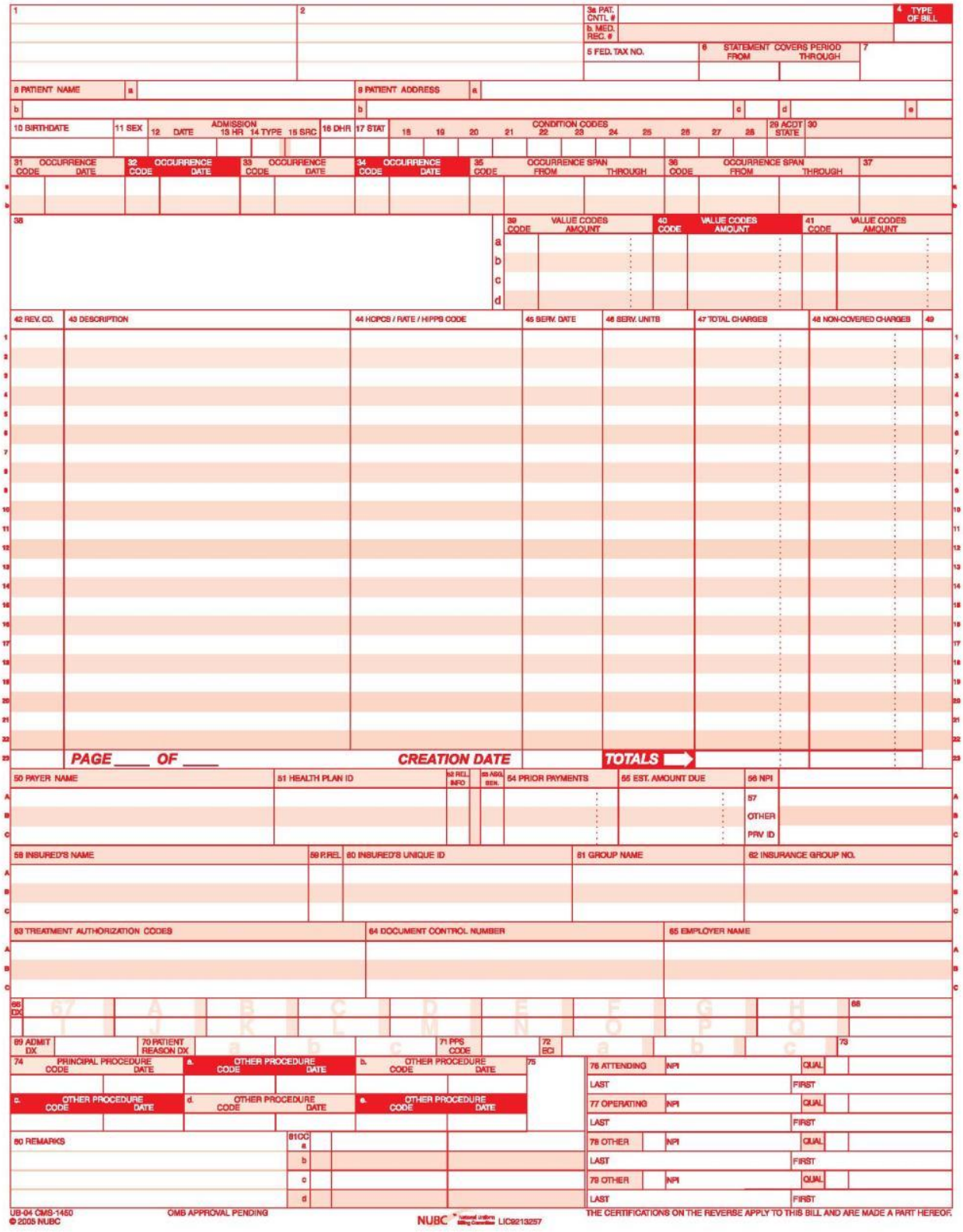
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Appendix B. UB-04 Claim Form



Appendix C. General Billing Instructions, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date. Changes to references or of a non-substantive technical nature are not captured.

General Billing Instructions, Provider Handbook Modifications				
Version	Section	Update	Publish Date	SME
85.0	All	Published version	07/01/2025	TQD
84.15	5. Adjustments	Clarified institutional time frames.	07/01/2025	W Deseron K Lolofie
84.14	3.3.10 Modifier TL	Renamed Modifier TL: Infant Toddler Services.	07/01/2025	W Deseron K Lolofie
84.13	3.3.9 Modifier TB: 340B Pharmacy Claims	New section.	07/01/2025	W Deseron K Lolofie
84.12	3.3.8 Modifier KX: Medical Policy Met	New section.	07/01/2025	W Deseron K Lolofie
84.11	3.3.7 Modifier JW: Medical Waste of Drugs and Biologicals	Added skin substitutes.	07/01/2025	W Deseron K Lolofie
84.10	3.3.6 Modifier GZ: Non-covered	New section.	07/01/2025	W Deseron K Lolofie
84.9	3.3.5 Modifier GY: Non-covered	New section.	07/01/2025	W Deseron K Lolofie
84.8	3.3.4 Modifier GX: Non-covered	New section.	07/01/2025	W Deseron K Lolofie
84.7	3.3.3. GA: Non-covered	New section.	07/01/2025	W Deseron K Lolofie
84.6	3.3.3. Modifier GY and Modifier GZ - Non-covered	Deleted section	07/01/2025	W Deseron K Lolofie
84.5	3.3.1 Modifier AS: Surgery Assistance	New section.	07/01/2025	W Deseron K Lolofie
84.4	3.3.1 Modifier 66: Surgical Team	New section.	07/01/2025	W Deseron K Lolofie
84.3	3.3.18 Modifier 62: Two Surgeons	New section.	07/01/2025	W Deseron K Lolofie
84.2	1.11 Manually Priced Goods and Services	Clarified 340B reimbursement.	07/01/2025	W Deseron K Lolofie
84.1	1.8 Place of Service	Clarified school place of service can only be used for school-based services.	07/01/2025	W Deseron K Lolofie
84.0	All	Published version	01/21/2025	TQD
83.2	1.11 Manually Priced Goods and Services	Removed allowance for purchase order. Added in error.	01/13/2025	W Deseron S Fox
83.1	7. Third Party Liability	Corrected EPSDT date allowance.	01/13/2025	W Deseron S Fox
83.0	All	Published version	12/04/2024	TQD
82.12	7. Third Party Liability	Added exception for school-based services.	11/25/2024	W Deseron E Garibovic
82.11	4.5 Claim Status	Added timeline for processing.	11/25/2024	W Deseron E Garibovic
82.10	3.3.15 Modifier TL	New section.	11/25/2024	W Deseron E Garibovic
82.9	3.3.12 Modifier EP	New section.	11/25/2024	W Deseron E Garibovic
82.8	3.3.11 Modifier 76: Repeat Procedure	New section.	11/25/2024	W Deseron E Garibovic

General Billing Instructions, Provider Handbook Modifications				
Version	Section	Update	Publish Date	SME
82.7	3.3.10 Modifier 59: Separate Encounters and Distinct Procedures	Added note about anesthesia services	11/25/2024	W Deseron E Garibovic
82.6	3. Required Coding	Reiterated use of most specific code.	11/25/2024	W Deseron E Garibovic
82.5	1.12 Timely Filing Limit	Clarified time limit for Medicare claims.	11/25/2024	W Deseron E Garibovic
82.4	1.11 Manually Priced Goods and Services	Updated documentation requirements for items and services including pharmaceuticals.	11/25/2024	W Deseron E Garibovic
82.3	1.7 340B Pharmacy Billing	Updated JG modifier effective date.	11/25/2024	W Deseron E Garibovic
82.2	1.3 Billing 15-Minute Time Codes	Clarified multiple timed codes.	11/25/2024	W Deseron E Garibovic
82.1	1. Medicaid Billing Policies	Clarified the effective date of policies.	11/25/2024	W Deseron E Garibovic
82.0	All	Published version	08/01/2024	TQD
81.16	7.5.1 Qualified Medicare Beneficiaries (QMB) Medicare/Medicaid Billing	Renamed Qualified Medicare Beneficiaries. Added information from COB section.	07/29/2024	W Deseron E Garibovic
81.15	7.5 Claims for Participants with Medicare	Added information from COB section.	07/29/2024	W Deseron E Garibovic
81.14	7.3 Coordination of Benefits (COB)	Added guidance for when insurance changes during inpatient. Move Medicare information to Medicare section.	07/29/2024	W Deseron E Garibovic
81.13	7. Third Party Liability	Added VOCA as an exception.	07/29/2024	W Deseron E Garibovic
81.12	6.3 Formal Appeal	Added timeline.	07/29/2024	W Deseron E Garibovic
81.11	6.2 Medicaid Review of Claim Determination	Added timeline.	07/29/2024	W Deseron E Garibovic
81.10	6.1 Claim Review Request	Clarify best practices and correct completion.	07/29/2024	W Deseron E Garibovic
81.9	4. Claim Submission	Clarify claim number composition.	07/29/2024	W Deseron E Garibovic
81.8	3.3.7 Modifier 52: Reduced Services	Clarify eligible providers.	07/29/2024	W Deseron E Garibovic
81.7	3.3.6 Modifier 51: Multiple Surgical Procedures	Clarify eligible providers.	07/29/2024	W Deseron E Garibovic
81.6	3.3.5 Modifier 50: Bilateral Procedure	Clarify eligible providers.	07/29/2024	W Deseron E Garibovic
81.5	2.3 UB-04 Instructions	Added reference to NUBC guidelines and use of condition codes.	07/29/2024	W Deseron E Garibovic
81.4	2.2 CMS-1500 Instructions	Clarify provider address determination.	07/29/2024	W Deseron E Garibovic
81.3	1.12 Timely Filing Limit	Added exception for inpatient stays exceeding 365 days.	07/29/2024	W Deseron E Garibovic
81.2	1.11 Manually Priced Goods and Services	Added criteria for acceptable invoices.	07/29/2024	W Deseron E Garibovic
81.1	General Billing Instructions	Provide instructions for requesting archived records.	07/29/2024	W Deseron E Garibovic
81.0	All	Published version	03/21/2024	TQD

General Billing Instructions, Provider Handbook Modifications				
Version	Section	Update	Publish Date	SME
80.18	7.7 Third Party Recovery (TPR) Inquiries	Updated HMS contact information.	03/14/2024	W Deseron T Kinne
80.17	7.4 Submitting Third Party Liability Claims	Updated HMS contact information.	03/14/2024	W Deseron T Kinne
80.16	7. Third Party Liability	Added information Indian health plans.	03/14/2024	W Deseron T Kinne
80.15	3.5.3 Medically Unlikely Edits (MUE)	Updated information on zero MUE codes.	03/14/2024	W Deseron T Kinne
80.14	3.2 HCPCS Requiring NDC for Medications	Added A codes.	03/14/2024	W Deseron T Kinne
80.13	1.11 Manually Priced Goods and Services	Clarified date after items on invoices and hospital methodology.	03/14/2024	W Deseron T Kinne
80.12	1.10. QIO Appeals	Section deleted. Moved to Telligen Reconsiderations.	03/14/2024	W Deseron T Kinne
80.11	1.9.8 Transferring a Prior Authorization	New section.	03/14/2024	W Deseron T Kinne
80.10	1.9.7 Prior Authorization Appeals	Clarified timeline and appeal avenues.	03/14/2024	W Deseron T Kinne
80.9	1.9.6.(b) Telligen Reconsiderations	New section.	03/14/2024	W Deseron T Kinne
80.8	1.9.6.(a) Department Reconsiderations	New header.	03/14/2024	W Deseron T Kinne
80.7	1.9.5 Status of a Prior Authorization	New section.	03/14/2024	W Deseron T Kinne
80.6	1.9.4 Modifying a Prior Authorization	New section.	03/14/2024	W Deseron T Kinne
80.5	1.9.3 Quality Improvement Organization Prior Authorization	Renamed Telligen Prior Authorization. Updated information.	03/14/2024	W Deseron T Kinne
80.4	1.9.2 Medicaid Prior Authorization (PA)	Renamed Medicaid Prior Authorization.	03/14/2024	W Deseron T Kinne
80.3	1.9 Prior Authorization (PA)	Renamed Prior Authorization. Updated policy.	03/14/2024	W Deseron T Kinne
80.2	1.7 340B Pharmacy Billing	Incorporated MedicAide billing instructions.	03/14/2024	W Deseron T Kinne
80.1	1.4 Electronic Visit Verification (EVV)	Incorporated MedicAide instructions.	03/14/2024	W Deseron T Kinne
80.0	All	Published version	08/16/2023	TQD
79.5	3.1.3 State Regulations	New section.	08/02/2023	W Deseron E Garibovic
79.4	3. Required Coding	Added CDT codes. Clarified that Medicaid will not code claims for providers.	08/02/2023	W Deseron E Garibovic
79.3	1.9.3(a) References: Quality Improvement Organization Prior Authorization	New section.	08/02/2023	W Deseron E Garibovic
79.2	1.9.3 Quality Improvement Organization (QIO) Prior Authorization (PA)	Renamed Quality Improvement Organization Prior Authorization. Clarified scope.	08/02/2023	W Deseron E Garibovic
79.1	1.7 340B Pharmacy Billing	Updated requirements for enrolling a 340B NPI.	08/02/2023	W Deseron E Garibovic
79.0	All	Published version	06/02/2023	TQD
78.10	8. Appendices	Added header.	05/26/2023	W Deseron K Duke

General Billing Instructions, Provider Handbook Modifications				
Version	Section	Update	Publish Date	SME
78.9	5. Adjustments	Clarification on timeline for adjusting Medicare primary claims.	05/26/2023	W Deseron K Duke
78.8	4.4 Claim Status	Clarifies denied claim status questions must use secure messaging through TPA.	05/26/2023	W Deseron K Duke
78.7	3.2 HCPCS Requiring NDC for Medications	Clarifies which codes require an NDC.	05/26/2023	W Deseron K Duke
78.6	2.3 UB-04 Instructions	Clarified field 76 does not require attending physician for ambulances if not present.	05/26/2023	W Deseron K Duke
78.5	1.11.8 Adjustments of Paid or Denied Claims	Deleted section.	05/26/2023	W Deseron K Duke
78.4	1.11 Manually Priced Goods and Services	Clarified how pharmaceuticals are priced.	05/26/2023	W Deseron K Duke
78.3	1.8 Place of Service	Created list of acceptable places of service for Idaho Medicaid.	05/26/2023	W Deseron K Duke
78.2	1.2 Billing Procedure for Date Spanning	Clarified UB-04 applicability.	05/26/2023	W Deseron K Duke
78.1	General Billing Instructions	Clarify handbook applies to services billed through Gainwell Technologies.	05/26/2023	W Deseron K Duke
78.0	All	Published version	08/10/2022	TQD
77.1	1.12.8 Adjustments of Paid or Denied Claims	Clarified that the same or lesser units must be billed	08/08/2022	M Payne C Beal E Garibovic