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General Information and Requirements for Providers

The General Information and Requirements for Providers, 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 Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies' Idaho Medicaid website.

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

- General Billing Instructions; 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 themselves 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. They are required to 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 These are included in the handbook for historical reference.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. Provider Responsibilities

Providers are required to adhere to all applicable provisions of federal law including, but not limited to, the following as amended:

- Title VI of the Civil Rights Act of 1964;
- Title IX of the Education Amendments of 1972 regarding education programs and activities;
- The Age Discrimination Act of 1975;
- Section 504 of the Rehabilitation Act of 1973;
- The Americans with Disabilities Act of 1990;
- Section 1557 of the Patient Protection and Affordable Care Act;
- Health Insurance Portability and Accountability Act (HIPAA);
- Sections 262 and 264 of Public Law 104-191;
- 42 USC Section 1320d;
- 45 CFR Subchapter C Administrative Data Standards and Related Requirements;
- False Claims Act (31USC 3729-3733);
- Section 12006(a) of the 21st Century Cures Act; and
- 42 CFR §455 Subpart B Disclosure of Information by Providers and Fiscal Agents.

Providers have the following, but not limited to, ongoing responsibilities:

- To review and abide by the contents of all Idaho Medicaid rules governing items and services under Medicaid;
- To abide by their provider agreement;
- To review and abide by the Idaho Medicaid Provider Handbook;
- To review and abide by periodic provider Information Releases and other program notifications issued by Medicaid such as the MedicAide Newsletter;
- To make records available to Medicaid upon request per the Documentation subsection;
- To abide by Provider Enrollment requirements including, but not limited to:
    - Being licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with professionally recognized standards;
    - Complying with the disclosure of Ownership and Controlling Interests;
    - Keeping Medicaid and Gainwell Technologies advised of the provider's current address and telephone number per the Maintenance of Information subsection;
- To sign every claim form submitted for payment or complete a signature-on-file form (including electronic signatures). See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information;
- To acknowledge when Medicaid is a secondary payer and agree to seek payment from other sources. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information about third party liability;
- To accept Medicaid payment for any item or service as payment in full and to make no additional charge to participants or other parties for the difference. See the Participant Financial Responsibility section for more information;
- To not bill a Medicaid participant unless the item or service is non-covered or excluded by Medicaid, and the provider complies with the Participant Financial Responsibility section. See Non-Covered and Excluded Services, which includes a list of excluded services, for more information; and
- To assure Medicaid participants are not billed for "no-show" or missed appointments nor can they enter into an agreement to be responsible for any resulting fees.

All correspondence sent to the provider's mailing address on file with the State's fiscal agent shall be deemed to be received by the Provider. Department correspondence is not forwarded

by a change of address with the U.S. Postal Service. All mail and checks are returned to Gainwell Technologies.

1.1. Employees and Contractors

Providers are responsible for the recruiting, hiring, firing, training, supervision, scheduling, and payroll for their employees, subcontractors, or agents. The Provider shall maintain general liability insurance coverage, worker's compensation, and unemployment insurance, and shall pay all FICA taxes and state and federal tax withholding for its employees. The Provider agrees to bill only for service providers who have the qualifications required for the type of service being delivered.

Furthermore, providers assume sole responsibility for the actions of their employees and contractors acting on the provider's behalf. This includes the accuracy of claims submitted as specified in the Idaho Medicaid Provider Agreement. The provider shall immediately repay the Department for any items or services determined to be improperly provided, documented, or claimed. In cases of suspected fraud, the Department may refer individual employees to the Medicaid Fraud Control Unit for further investigation and possible prosecution. Providers may also contact local law enforcement or take independent civil action against employees to recover losses caused by the employee.

1.1.1. References: Employees and Contractors

a) Idaho Medicaid Publications

"**Medicaid Program Integrity Unit:** Provider Responsibilities Regarding Overpayments." *MedicAide Newsletter,* January 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202014%20MedicAide.pdf.

1.2. Documentation

All providers are required to generate records at the time the service is delivered and to maintain documentation to fully document the extent of services submitted for Medicaid reimbursement. Services which have not been sufficiently documented are not reimbursable. The person delivering the services and any supervising providers must ensure all documentation is legible, complete, dated, time-stamped, and includes a written or electronic dated signature to attest that the records are a true and accurate account of the services delivered.

1.2.1. Additional Documentation

Additional documentation requirements may vary by provider or service type and are listed in the appropriate sections of the provider type and specialty specific Idaho Medicaid Provider Handbooks. Providers should consult the applicable handbooks on the Medicaid Provider Portal prior to delivering or billing for services.

1.2.2. Amendments or Corrections

Any records requiring amendment or corrections must be clearly and permanently identified and leave the original contents of the document legible. Amendments and corrections are intended to provide clarification and cannot be used to add new services for billing or retroactively establish medical necessity. Amendments and corrections separately require the author to be clearly identified with their credentials, a signature and the date of the changes.

1.2.3. Artificial Intelligence

Documentation generated by artificial intelligence is not acceptable.

1.2.4. Electronic Transcription

Documentation is acceptable when generated by software transcribing verbal notes to text. Providers are responsible for the accuracy of the transcription.

1.2.5. Signatures

Handwritten or electronic signatures (including those captured by Electronic Visit Verification software certified by the Department) are acceptable. All signatures must be dated. Electronic signatures must meet the requirements in the Electronic Signatures subsection. For handwritten signatures, stamped and typed signatures are only allowed for providers with proof of a physical disability that prevents their signing.

Records should be signed shortly after the service is provided with time allowed for transcription by a scribe. Signatures cannot be added to documents beyond that time frame, and scribes do not need to sign documents. Documentation signed by multiple providers is allowed, when one provider is supervising another if the rendering provider is clearly identified.

If the Department determines a handwritten signature is illegible, a provider may submit a signature log or attestation with requested records to support the identity of the signer. A signature log must include a typed list of provider names, titles and credentials followed by the corresponding handwritten signature. Signature attestations must be signed and dated by the author of the illegible signature. Attestations must include a statement of the document's validity, the name and credentials of the author, the date of service being attested to and the participant's name and Medicaid Identification Number (MID). Attestations can also be used as documentation for missing signatures.

a) Electronic Signatures

Idaho Medicaid will accept dated electronic signatures for provider orders and records to meet the requirements for documentation. The individual whose name is on the electronic signature and the provider bear the responsibility for authenticity. Each provider must develop written policies and procedures to assure complete, accurate, and authenticated records and at a minimum include:

- Security provisions to protect against the use of an electronic signature by anyone other than the person to which the electronic signature belongs;
- How the privacy and integrity of the record is protected;
- A list of which records will be maintained and signed electronically;
- How an e-signature code is assigned;
- How passwords are assigned and the frequency for which they are changed in provider software;
- Clarification on whether a digital signature, a digitized signature, or an electronic signature is being used, and the details of the signing process involved; and
- Access standards to the records for participants, the Department and others who are authorized by law.

The following are not considered acceptable electronic signatures and may not be accepted by Idaho Medicaid: (a) created by, (b) received by/for, (c) generated by/for, (d) administratively signed by, (e) dictated but not signed, (f) electronically signed to expedite delivery, or (g) proxy signature (signed via approval letter or statement).

Providers are encouraged to review and apply HIPAA guidance on the U.S. Health & Human Services site: https://www.hhs.gov/hipaa/for-professionals/index.html. As required by HIPAA-covered entities, the provider must ensure the software program used is set up so that the signer cannot deny having signed the document in the future, the signer's identity is guaranteed at the time the signature was generated, and the document has not been altered since it was signed. Providers using Electronic Visit Verification (EVV) software to verify service delivery meet these requirements when their EVV software is certified by the Department or its contractor.

1.2.6. Retention of Records

Providers are required to retain records of documented services submitted for Medicaid reimbursement for at least five (5) years from the date of service. Documentation must be made available immediately upon request from the Department, Centers for Medicare and Medicaid Services (CMS), or any Department or CMS contractor acting in their official capacity. Documentation must be sufficient to substantiate the amount, duration, scope, and medical necessity of billed services. Documentation to support claims for services includes, but is not limited to, medical records, treatment plans, medical necessity justification, assessments, appointment sheets, patient accounts, financial records, or other records regardless of its form or media. Medicaid may recoup the payment and apply a penalty if proper documentation cannot be produced by the provider.

Documentation created after a Department records request is made will not be accepted. Intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit constitutes fraud, and offending individuals will be referred for prosecution.

1.2.7. References: Documentation

a) CMS Guidance

"Chapter 3 – Verifying Potential Errors and Taking Corrective Actions (2024)." *Medicare Program Integrity Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf.

"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.

"Medical Documentation Signature Requirements. Noridian Healthcare Solutions, 4 April 2022, https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirements.

"Signature Guidelines for Medical Review Purposes (2010)" CMS Medicare Learning Network (MLN) Matters (MM)6698, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6698.pdf.

b) Federal Regulations

"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.

Failure to Grant Immediate Access, 42 CFR 1001.1301 (1992). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-sec1001-1301.pdf.

The Rehabilitation Act. H.R. 8070 (1973). U.S. 93rd Congress, https://www.congress.gov/bill/93rd-congress/house-bill/8070.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(27) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

c) Idaho Medicaid Publications

"Documentation of Services Provided – Signature Required." *MedicAide Newsletter,* October 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202018%20MedicAide.pdf.

"Documentation Requirements for Personal Care Services." MedicAide Newsletter, August 2022, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202022%20MedicAide.pdf

"Healthy Connections Referrals." MedicAide Newsletter, April 2022, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202022%20MedicAide.pdf.

"If it is not documented, it has not been done, CMS.gov." *MedicAide Newsletter,* October 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202018%20MedicAide.pdf.

"Medicaid Program Integrity Unit: Documentation Requirements." *MedicAide Newsletter,* February 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202019%20MedicAide.pdf.

"Medicaid Program Integrity: Medical Record Entries." *MedicAide Newsletter,* October 2013, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202013%20MedicAide.pdf.

"Signatures on Documentation." *MedicAide Newsletter,* May 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

d) State Regulations

Administrative Remedies, Idaho Code 56-209h (1998). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209h.

"Documentation for Audits." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 040. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Documentation of Services and Access to Records." *IDAPA 16.05.07,* "The Investigation and Enforcement of Fraud, Abuse, and Misconduct*,"* Sec. 101. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160507.pdf.

Failure to Retain Records, Idaho Code 56-209o (2007). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-209o.

Legal Recognition of Electronic Records, Electronic Signatures and Electronic Contracts – Electronic Transmittal in Lieu of Certified Mail, Idaho Code 28-50-107 (2003). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title28/t28ch50/sect28-50-107.

"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.

1.3. Ordering, Referring and Prescribing Providers

As a condition of payment, provider's claims designated in the Provider Types and Specialties, Idaho Medicaid Provider Handbook requires inclusion of an enrolled ordering, referring or prescribing (ORP) provider's name and NPI. If the claims are submitted without an enrolled provider's name and NPI, they will deny. Claims that come directly from Medicare to Idaho Medicaid will not require an enrolled ORP, but if the provider submits a manual claim it will deny without one.

The definition for ordering, prescribing, and referring includes, but is not limited to: prescribing drugs or other covered items, sending a participants specimens to a laboratory for testing, ordering imaging/diagnostic services or durable medical equipment, prosthetics, orthotics or supplies for a participant, referring a participant to another provider or certifying a participants need for covered items or services.

Based on the State of Idaho's medical licensing structure and statutes, the following individual provider types may order, refer, or prescribe healthcare services or supplies for participants of the Idaho Medicaid program. These services or supplies must be requested in accordance with the provider's scope of practice and their licensure, which includes any certifications or credentials they possess. Eligible healthcare professionals are:

- Dentists;
- Licensed midwives;
- Nurse practitioners;
- Optometrists;
- Pharmacists;
- Physicians including residents, licensed bridge year physicians and licensed international medical graduates;
- Physician assistants;
- Podiatrists; and
- Psychologists (except school-based psychologists, who are exempt).

ORP providers must:

- Enroll with Idaho Medicaid as a billing provider, a non-billing ORP, or a crossover provider;
- Complete enrollment application;
- Complete Idaho Medicaid Provider Agreement; and
- Retain all documentation to support services ordered including the establishment of medical necessity for the services, equipment or supplies.

Billing providers must:

- Ensure all ORP providers are enrolled with Idaho Medicaid;
- Obtain the name and the NPI of the ORP provider and include it on claims; and
- Retain all documentation to support services billed

Interns and students (except first-year physician residents) are not eligible to enroll as ORP providers. The teaching, admitting or supervising eligible healthcare professional, however, can review their documentation and perform the order or referral on their behalf.

1.3.1. References: Ordering, Referring and Prescribing Providers

a) CMS Guidance

"1.5.1.B. Ordering or Referring Physicians or Other Professionals (ORP)." *Medicaid Provider Enrollment Compendium (MPEC) (2025).* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/media/123411.

"1.5.2. When Screening is Required (2025)." *Medicaid Provider Enrollment Compendium (MPEC).* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/media/123411.

b) Federal Regulations

Enrollment and Screening of Providers, 42 CFR 455.410 (2011). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf.

c) Idaho Medicaid Publications

"Edits Will Change from Warn to Deny on October 1, 2017." *MedicAide Newsletter,* September 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202017%20MedicAide.pdf.

"Policy Update: Ordering, Referring, and Prescribing (ORP) Providers." *MedicAide Newsletter,* April 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202023%20MedicAide.pdf.

d) State Regulations

"Ordering, Referring and Prescribing Providers." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

1.4. Background Checks

Fingerprint-based background checks through Idaho's Background Check Unit are required for certain provider types and services. Substitutions are not permitted for services provided in-state or for high-risk providers except Residential Assisted Living Facilities, which may have alternative background checks. The following require background check clearances, those with an asterisk require enhanced clearances:

- Adult Day Health providers who provide direct care or services;
- Adult Residential Care providers who provide direct care or services;
- Attendant Care providers who provide direct care or services;
- Behavior Consultation or Crisis Management providers;
- Certified Family Homes including all adults in home, staff and substitute caregivers*;
- Children's Residential Care Facilities*;
- Children's Therapeutic Outdoor Programs*;
- Chore Services Providers who provide direct care or services;
- Community-Based Support Services;
- Companion Services providers;
- Contracted Non-Emergency Medical Transportation providers;
- Day Habilitation providers who provide direct care or services;
- Department employees, contractors, and volunteers who provide direct care services, work at state institutions, or who have access to children or vulnerable adults;
- Department Fraud Investigators, Utilization Review Analysts, and staff in the Background Check Unit;
- Developmental Disability Agencies;
- Durable Medical Equipment (DME) Suppliers new to Idaho Medicaid;
- Emergency Medical Services (EMS);
- Fiscal Intermediary Services;
- High Risk Providers including individuals with 5% or more direct or indirect ownership interest in the agency or facility;
- Home and Community-Based Services (HCBS) providers;
- Home Health Agencies;
- Homemaker Service providers who provide direct care or services;
- Hospice Agencies;
- Idaho Behavioral Health Plan (IBHP)* providers;
- Independent Children's Habilitation Intervention Service Providers;
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID);
- Mental Health Services*;
- Non-Medical Transportation providers;
- Personal Assistance Agencies (PAA), including PAAs acting as Fiscal Intermediaries;
- Personal Care Service Providers including, but not limited to, service coordinators, registered nurse supervisors, qualified intellectual disability professional (QIDP) supervisors and direct care workers;
- Providers enrolling within six (6) months of the date of the lifting of a temporary moratorium that at the time would have barred the provider's enrollment;
- Providers excluded within the last ten (10) years by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) or any state Medicaid agency;
- Providers that have had a payment suspension based on a credible allegation of fraud occurring within the past ten (10) years;
- Providers with a qualifying Medicaid overpayment;
- Residential Assisted Living Facilities;
- Residential Habilitation administrators and staff who provide direct care or services;
- Respite Care providers providing direct care or services;
- Service Coordinators and Paraprofessional providers;
- Skilled Nursing providers providing direct care or services;

- Skilled Nursing Facilities;
- Substance Use Disorder Services*;
- Support Brokers and Community Support Workers;
- Supported Employment providers who provide direct care or services;
- Therapeutic Consultant providers; and
- Transition Managers.

Provider agencies are required to register with the Background Check Unit before submitting background check applications. Providers must update their address, contact information and name within thirty (30) days of any change. The agency must complete a new registration thirty (30) days before new ownership takes control of the agency. New ownership is evidenced by a new Federal Employer Identification Number (FEIN) with the Internal Revenue Service (IRS). Additionally, when there is new ownership, the agency must complete new background checks on everyone required to have a clearance.

The Department obtains information for background checks from:

- The Federal Bureau of Investigation
- The Idaho State Police Bureau of Criminal Identification
- Any state or federal Child Protection Registry
- Any state or federal Adult Protection Registry
- Any state Sexual Offender Registry
- Office of Inspector General List of Excluded Individuals and Entities
- Idaho Department of Transportation Driving Records
- Nurse Aide Registry
- Other states and jurisdictions' records and findings.

1.4.1. References: Background Checks

a) Federal Regulations

Criminal Background Checks, 42 CFR 455.434 (2023). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-sec455-434.pdf.

b) State Regulations

"Subsequent Convictions, Charges, or Investigations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 003.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Agencies Approved Through National Accreditation." *IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA),"* Sec. 119.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

"Agency Responsibilities." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 060. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Applicants Receiving a Department Enhanced Clearance." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 126. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

Application for Certification, Idaho Code 39-3520 (2024). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title39/t39ch35/sect39-3520.

"Background Check." *IDAPA 16.03.03, "Skilled Nursing Facilities,"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160302.pdf.

"Background Check Compliance." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 003.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Causes for Denial." *IDAPA 16.03.19, "Certified Family Homes,"* Sec. 112.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160319.pdf.

"Criminal History and Background Check." *IDAPA 16.07.17, "Substance Use Disorders Services,"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160717.pdf.

"Criminal History and Background Check Requirements." *IDAPA 16.01.17, "Emergency Medical Services (EMS) – Personnel Licensing Requirements,"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160107.pdf.

"Criminal History and Background Check Requirements." *IDAPA 16.03.19, "Certified Family Homes,"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160319.pdf.

"Criminal History and Background Check Requirements." *IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA),"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

"Criminal History and Background Check Requirements." *IDAPA 16.03.22, "Residential Assisted Living Facilities,"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160322.pdf.

"Criminal History and Background Check Requirements." *IDAPA 16.07.33, "Adult Mental Health Services,"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160733.pdf.

"Criminal History and Background Check Requirements." *IDAPA 16.07.37, "Children's Mental Health Services,"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160319.pdf.

Criminal History and Background Checks, Idaho Code 56-1004A (2022). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH10/SECT56-1004A.

"Department Individuals Subject to a Background Check." *IDAPA 16.05.06, "Criminal History and Background Checks,"* Sec. 101. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Individuals Subject to Background Check Requirements." *IDAPA 16.04.18, "Children's Agencies and Residential Licensing,"* Sec. 009. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160418.pdf.

"Personnel Records." *IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA),"* Sec. 301.04.c. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160321.pdf.

"Policy." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 001. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Providers Subject to Background Check Requirements." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 003.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Standards for Children's Residential Care Facilities, Idaho Code 39-1210 (2015). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH12/SECT39-1210.

Standards for Children's Therapeutic Outdoor Programs, Idaho Code 39-1208 (2002). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH12/SECT39-1208.

"Substitute Care." *IDAPA 16.03.19, "Certified Family Homes,"* Sec. 300.02.d.ii. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160319.pdf.

1.4.2. Availability to Provide Services

An agency may allow an employee to provide care or services on a provisional basis when certain criteria are met. The individual must complete and have notarized the Background Check Unit's application. The agency must review the application for disqualifying incidents. Individuals with a disqualifying incident cannot provide services. Individuals failing to disclose information receive an unconditional denial and may be prosecuted. Agencies that prompt the individual to refrain from fully disclosing their history are subject to penalties including up to, but not limited to, recoupment, disenrollment from the Idaho Medicaid program, or prosecution. Individuals seeking licensure or certification are not eligible to provide services until a background check clearance is received.

When the application contains no disqualifying incidents, the agency must decide based on the information provided if the individual is safe to provide services to participants. Services may be provided when there are no disqualifying incidents and the agency determines the individual is safe to provide services. Fingerprints must be submitted within twenty-one (21) days of application submission and the results of the background check must be reviewed by the agency within fourteen (14) days of a determination. Failure to do either or withdrawal of the application makes the individual no longer eligible to provide services. The Department may allow an extension for fingerprint submission at its discretion.

Individuals without a clearance are only eligible to provide services to an agency for twenty-one (21) days in a rolling year. They cannot submit subsequent applications within that year to continue to work beyond the twenty-one (21) day period. If fingerprints are not received within sixty (60) days, the application is no longer valid, and the individual must begin a new application.

When an individual receives a background check clearance, the agency must assess if they are fit for employment based on the results. When an agency becomes aware of any subsequent criminal convictions or child or adult protection issues, they must report the information immediately to the Background Check Unit.

The agency may use the results of a previously completed background check at their discretion in some circumstances. The clearance from the background check must be within three (3) years of its determination. An individual is not eligible to provide services until the

agency has linked the clearance to their profile on the Department's website and completed a state-only background check through the Idaho State Police with no disqualifying incidents being returned.

Individuals receiving unconditional denials or inability to proceed are immediately unable to work. The Department may allow background check variances for clearance requirements at its discretion on a case-by-case basis with consideration of the underlying facts and circumstances.

The Department may require a new background check at any time. If requested, the individual must provide a completed application and fingerprints within fourteen (14) days to maintain their eligibility to provide services. The Department may revoke a background check clearance when the individual fails to submit a new background check upon request, a subsequent background check finds a disqualifying incident, or fees are not paid in full.

All background check applications, clearances, denials, and results from an Idaho State Policy background check must be retained by the agency and available upon request for five (5) years from separation of employment.

a) References: Availability to Provide Services

(i) State Regulations

"Agency Responsibilities." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 060. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Application for a Background Check." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 120. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Availability to Provide Services Pending Completion of the Background Check." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 170. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Time Frame." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 150. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Use of Previously Completed Background Checks." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 195. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Use of Previously Completed Background Checks." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 195. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Withdrawal of Application." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 160. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

1.4.3. Denials or Inability to Proceed

An individual who receives an unconditional denial or inability finding may not provide services, have access to participants, or be licensed or certified by the Department. Disqualifying incidents, or any substantially conforming foreign incident, results in issuance of an unconditional denial. When the individual has a pending incident for a disqualifying event, the Department may issue a finding of inability to proceed. Documentation can be submitted by the individual for reconsideration within 120-days of an inability to proceed finding.

The Department considers the underlying facts and circumstances of felony or misdemeanor conduct, including a guilty plea or admission when determining whether to issue a clearance, regardless of whether the individual received one (1) of the following:

- A withheld judgement,
- A dismissal, suspension, deferral, commutation, or a plea agreement where probation or restitution was or was not required, or
- An order under Section 19-2604, Idaho Code, or other equivalent state law
- A sealed record.

Incidents resulting in indefinite unconditional denials are:

- Crimes against vulnerable adults,
- Abuse, neglect, or exploitation of a vulnerable adult, as defined in Section 18-1505, Idaho Code,
- Abandoning a vulnerable adult, as defined in Section 18-1505A, Idaho Code,
- Sexual abuse and exploitation of a vulnerable adult, as defined in Section 18-1505B, Idaho Code,
- Aggravated, first-degree and second-degree arson, as defined in Sections 18-801 through 18-803, and 18-805, Idaho Code,
- Forcible sexual penetration by use of a foreign object, as defined in Section 18-6604, Idaho Code,
- Hiring, employing, or using a minor to engage in certain acts, as defined in Section 18-1517A,
- Human trafficking, as defined in Sections 18-8602 and 18-8603, Idaho Code,
- Incest, as defined in Section 18-6601, Idaho Code,
- Injury to a child, felony or misdemeanor, as defined in Section 18-1501, Idaho Code,
- Kidnapping, as defined in Sections 18-4501 through 18-4503, Idaho Code,
- Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code,
- Mayhem, as defined in Section 18-5001, Idaho Code,
- Manslaughter:
    - Voluntary manslaughter, as defined in Section 18-4006(1) Idaho Code
    - Involuntary manslaughter, as defined in Section 18-4006(2), Idaho Code
    - Felony vehicular manslaughter, as defined in Section 18-4006(3)(a) and (b), Idaho Code,
- Murder (Homicide) in any degree or assault with intent to commit murder, as defined in Sections 18-4001, 18-4003, and 18-4015, Idaho Code,
- Poisoning, as defined in Sections 18-4014 and 18-5501, Idaho Code,
- Rape, as defined in Section 18-6101, Idaho Code,
- Robbery, as defined in Section 18-6501, Idaho Code,
- Felony stalking, as defined in Section 18-7905, Idaho Code,
- Sale or barter of a child, as defined in Section 18-1511, Idaho Code,
- Ritualized abuse of a child, as defined in Section 18-1506A, Idaho Code,
- Female genital mutilation, as defined in Section 18-1506B, Idaho Code,
- Sexual abuse of a child, as defined in Sections 18-1506, Idaho Code,
- Felony sexual exploitation of a child, as defined in Section 18-1507, Idaho Code,

- Sexual battery of a minor child under sixteen (16) or seventeen (17) years of age, as defined in Section 18-1508A, Idaho Code,
- Video voyeurism, as defined in Section 18-6605, Idaho Code,
- Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code,
- Inducing individuals under eighteen (18) years of age into prostitution or patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code,
- Any felony punishable by death or life imprisonment,
- Attempted strangulation, as defined in Section 18-923, Idaho Code,
- Felony domestic violence, as defined in Section 18-918, Idaho Code,
- Battery with intent to commit a serious felony, as defined in Section 18-911, Idaho Code,
- Assault with intent to commit a serious felony, as defined in Section 18-909, Idaho Code,
- Aggravated sexual battery, as defined in Section 18-925, Idaho Code,
- Sexual abuse of an animal, as defined in Section 18-6602, Idaho Code,
- Sexual abuse of human remains, as defined in Section 18-6603, Idaho Code, or
- Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-304, 18-305, 18-306, 18-307, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes.

The Department issues an unconditional denial for five (5) years from the date of conviction for an individual convicted of the following:

- Any felony not described as an indefinite or three-year unconditional denial,
- Misdemeanor domestic violence, as defined in Section 18-918, Idaho Code,
- Failure to report abuse, abandonment, or neglect of a child, as defined in Section 16-1605, Idaho Code,
- Misdemeanor forgery of and fraudulent use of a financial transaction card, as defined in Sections 18-3123 through 18-3128, Idaho Code,
- Misdemeanor forgery and counterfeiting, as defined in Sections 18-3601 through 18-3620, Idaho Code,
- Misdemeanor identity theft, as defined in Section 18-3126 and 18-3126A, Idaho Code,
- Misdemeanor insurance fraud, as defined in Sections 41-293 and 41-294, Idaho Code
- Public assistance fraud, as defined in Sections 56-227, 56-227A, 56-227E and 56-227F, Idaho Code,
- Sexual exploitation of a child by electronic means, felony or misdemeanor, as defined in Section 18-1507A, Idaho Code,
- Stalking in the second degree, as defined in Section 18-7906, Idaho Code,
- Misdemeanor vehicular manslaughter, as defined in Section 18-4006(3)(c), Idaho Code,
- Sexual exploitation by a medical care provider, as defined in Section 18-919, Idaho Code,
- Sexual battery, as defined in Section 18-924, Idaho Code,
- Operating a certified family home without certification, as defined in Section 39-3528, Idaho Code, or
- Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-204, 18-205, 18-304, 18-306, 18-307, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying five (5) year crimes.

The Department issues an unconditional denial for an individual convicted of the following crimes for three (3) years from the date of conviction:

- A controlled substance manufacture, delivery, or possession with intent to deliver or manufacture offense, as defined in Section 37-2732, Idaho Code, felony,
- A controlled substance paraphernalia offense, as defined in Section 37-2734B, Idaho Code, felony, or

- Operating a motor vehicle under the influence of alcohol, drugs, or any other intoxicating substance offense, as defined in Section 18-8004, Idaho Code, felony.

The Department issues an unconditional denial for an individual with:

- A relevant record on any Child Protection Registry for anyone requiring an enhanced clearance,
- A relevant record on the Idaho Child Protection Central Registry with a Level one (1) or Level two (2) designation,
- A relevant record on the Nurse Aide Registry,
- A relevant record on either the state or federal sex offender registries,
- A relevant record on the U.S. Health and Human Services, Office of the Inspector General List of Excluded Individuals and Entities (LEIE),
- A relevant record on the state Medicaid Exclusion List, or
- A materially false statement made knowingly in connection to the Department's background check application for those requiring an enhanced clearance results in a five-year disqualification period for the applicant.

Individuals can challenge an unconditional denial within twenty-eight (28) days from the determination date. The challenge must be made to the Background Check Unit in writing with records that demonstrate the finding is incorrect. The Department makes a ruling within thirty (30) days of receipt. The Department ruling may be appealed under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." The request to appeal an unconditional denial does not allow the individual to continue working.

The individual can challenge the validity of records provided by the Federal Bureau of Investigation (FBI) within fifteen (15) days of receiving results. Challenges should be sent to:

FBI, Criminal Justice Information Services (CJIS) Division
ATTN: SCU, Mod. D–2
1000 Custer Hollow Road
Clarksburg, WV 26306

a) References: Denials or Inability to Proceed

(i) Federal Regulations

Exchange of FBI Identification Records, 28 CFR 50.12 (2024). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2024-title28-vol2/pdf/CFR-2024-title28-vol2-sec50-12.pdf.

Procedure to Obtain Change, Correction or Updating of Identification Records, 28 CFR 16.34 (2024). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2024-title28-vol1/pdf/CFR-2024-title28-vol1-sec16-34.pdf.

(ii) State Regulations

"Criminal or Relevant Record – Action Pending." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 270. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Disqualifying Crimes Resulting in an Unconditional Denial." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 210. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Unconditional Denial." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 200. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

"Use and Dissemination Restrictions for FBI Criminal Identification Records." *IDAPA 16.05.06, "Criminal History & Background Checks,"* Sec. 300.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160506.pdf.

1.4.4. Background Check Variances

Variances allow an individual to provide specific services when ineligible for a clearance. The Department may allow a variance for clearance requirements at its discretion on a case-by-case basis with consideration of the underlying facts and circumstances. Variances are not considered clearances and may be revoked at any time if a health or safety risk is identified. A granted variance does not set a precedent for future reviews. Medicaid peer support and recovery coaching providers can apply for a variance if their background check results in a denial due to prior convictions for drug and alcohol-related offenses. Factors for consideration include, but are not limited to the:

- Severity or nature of the crime or finding;
- Time period since the incidents occurred;
- Number and pattern of incidents;
- Circumstances that may determine risk of recidivism;
- Relationship between the incidents and the position applied for;
- Evidence of activities demonstrating rehabilitation;
- Pardons by a state governor or the President of the United States; and
- Falsification or omission of information during the application process.

a) References: Background Check Variances

(i) State Regulations

"Department-Issued Variances." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 003. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2. Participant Financial Responsibility

Providers rendering items or services to a participant must bill any third-party liable payor and Idaho Medicaid. Any payment made by Idaho Medicaid must be accepted as payment in full. 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. Providers cannot refuse to provide covered services because of potential third-party liability.

Unless stated otherwise by the Department (e.g. Idaho Medicaid co-pays and share of cost) no additional payment may be collected from the participant either before or after Medicaid payment, regardless of a separate contract between the participant and the provider for assumption of liability. This includes, but is not limited to:

- No-show or missed appointment fees;
- Other insurer's co-pays;
- Failure on the part of the provider to submit a complete and correct claim to the Department or other payor;
- Failure by the provider to submit a complete and correct request for prior authorization from the Department or other payor;
- Claims voided by the provider;
- Failure of the provider to follow any payor's policy or procedure; or
- Any recoupment or penalties the provider receives as a result of their action or inaction.

Providers may bill a participant when a third-party payment (e.g. automotive insurance adjustment) was made to the participant instead of the provider, in which case the participant may be billed for an amount equal to that payment.

Providers can only bill participants for non-covered or excluded items and services, if prior to rendering such services or providing such items, the provider informed the participant through a written notice that what they are receiving is not covered under Medicaid. Idaho Medicaid does not have an official format, but the notice must specify the non-covered/excluded service or item, the cost of each service or item, and be signed by the participant. If the participant chooses to obtain services not covered or excluded by Medicaid, it is the participant's responsibility to pay for the services. See the Non-Covered and Excluded Services section for more information.

Providers are exempt from the requirement to notify the participant in writing for services provided during any period where the participant was later found retroactively eligible for Medicaid coverage. However, providers must adhere to all other requirements of being a Medicaid provider. If the provider previously collected a payment that would not be allowed by Idaho Medicaid from a participant later found eligible, the payment must be refunded.

See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information about billing non-covered services under GA, GX, GY and GZ modifiers, third-party liability, co-payments, share of cost and reimbursement methodologies.

2.1. References: Participant Financial Responsibility

2.1.1. 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-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec447-15.pdf.

Provider Restrictions: State Plan Requirements, 42 CFR 447.20(b) (2013). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2012-title42-vol4/pdf/CFR-2012-title42-vol4-sec447-20.pdf.

2.1.2. 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.

"Services Normally Billed Directly to the Patient." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

2.2. Co-payments

Some participants may be subject to a co-payment. When a provider verifies a participant's eligibility for the service, a co-payment indicator of "Exempt" or $3.65 displays. Participants may only be charged a co-payment as specified by the provider handbook and when the reimbursement amount for the service is more than $36.50 in the Medicaid Fee Schedule.

Services for wellness including preventive exams, and all medically necessary immunizations or family planning services are excluded from co-pay.

These services are subject to a co-payment:

- Ambulance services for a non-emergency;
- Chiropractic;
- Emergency room services for a non-emergency;
- Podiatric;
- Eye and vision services provided by an optometrist;
- Therapy Services;
- Medical Services; and
- IHS, FQHC and RHC Services.

The provider is responsible for collection of the copayment. Routinely waiving co-payments could be a violation of the anti-kickback statute. When the co-payment is applicable, the provider's reimbursement is reduced by the amount of the co-payment regardless of whether or not the co-payment was charged or collected by the provider. If a participant subject to a co-payment is unable to make a payment, the provider may:

- Bill the participant for the co-payment;
- Refuse to provide services at that time for participants with incomes above 100% of the federal poverty level (FPL); or
- Waive the co-payment on a case-by-case basis when the provider has a written policy describing the criteria for waiving and enforcing collection of co-payments.

2.2.1. References: Co-payments

a) Federal Regulations

"Criminal Penalties for Acts Involving Federal Health Care Programs." Social Security Act, Sec. 1128B(b)(3)(D) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm.

Civil Monetary Penalties, 42 U.S. 1320a-7a (2023). Government Printing Office, https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap7-subchapXI-partA-sec1320a-7a.pdf.

Premiums and Cost Sharing: Basis and Purpose, 42 CFR 447.50—447.90 (2013). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-part447-subpartA.pdf.

"State Option for Alternative Premiums and Cost Sharing." Social Security Act, Sec. 1916A (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916A.htm.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(14) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

"Use Of Enrollment Fees, Premiums, Deductions, Cost Sharing, And Similar Charges." Social Security Act, Sec. 1916 (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916.htm.

b) Idaho Medicaid Publications

Co-payment for Non-Emergency Use of Ambulance Transportation Services, Information Release MA07-04 (1/08/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA07-04.pdf.

Co-payment for Non-Emergency Use of an Emergency Room, Information Release MA07-03 (1/05/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=26571&dbid=0&repo=PUBLIC-DOCUMENTS.

Co-payments, Information Release MA11-26 (10/24/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho.

Co-payments (Co-pays), Information Release MA11-29 (11/22/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho.

Idaho Medicaid Public Schedule of Premiums and Cost Sharing Requirements. Idaho Department of Health and Welfare, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=19934&dbid=0&repo=PUBLIC-DOCUMENTS.

c) State Regulations

Co-payments, Idaho Code 56-257 (2011). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-257.

Legislative Intent, Idaho Code 56-251 (2007). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-251.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

2.3. Share of Cost (SOC)

Share of Cost (SOC) is a financial arrangement for a participant to pay a specific portion of the monthly costs associated with a service. Share of Cost is associated to participants eligible for the Adult Developmental Disabilities (DD) Waiver, Aged and Disabled Waiver (A&D), or residing in Skilled Nursing (SNF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Facilities (i.e., Long Term Care).

There are three (3) eligibility categories (referred to as Rate Codes):

- Rate Code 14: Developmental Disability Waiver;
- Rate Code 15: Aged and Disabled Waiver; and
- Rate Code 17: Skilled Nursing Facilities (Long Term Care) or ICF/IID Facilities.

It is the provider's responsibility to verify the participant's SOC each month and collect this from the participant. The provider's allowable reimbursement is reduced by the amount of the applicable SOC on a first claim in basis until the full amount of the SOC has been offset. Refer to Verifying Participant Eligibility and the *Eligibility Verification* section of the Trading Partner Account (TPA) User Guide.

Claims submitted with an applicable SOC must not span over multiple months. They must be billed within a single month on a claim.

2.3.1. Discrepancy Contact Information

If the participant or provider believes that the SOC amount is based on outdated or incomplete information, the participant or participant's personal representative should contact Self Reliance at 1 (877) 456-1233 to review the information used in the SOC calculation.

If there is a variance between the SOC identified in the participant's notification letter and what was reported on the participants SOC eligibility verification, send an e-mail to SOCdiscrepancies@dhw.idaho.gov, or fax to 1 (208) 334-5571 using the Fax Cover Sheet found on the Idaho Gainwell Technologies Medicaid website, under Gainwell Technologies Forms.

2.3.2. Paid Claim Discrepancies

If there is a variance between the amount of SOC offset on a claim and the amount reported during the SOC participant eligibility verification, the provider can complete the Nursing Home and Waiver Share of Cost (SOC) Review Request form e-mailed to idnursinghomes@gainwelltechnologies.com. This form is available online under Gainwell Technologies Forms. The instructions to fill out the form are in the same location. All fields in the forms are ***required***.

2.3.3. References: Share of Cost

a) 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-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec447-15.pdf.

b) State Regulations

"Participant Responsibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 012. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3. Fraud, Waste and Abuse

3.1. Reporting Provider Fraud

The Medicaid Program Integrity Unit (MPIU) conducts reviews and investigations to determine whether or not a provider is incorrectly billing Medicaid. The MPIU also conducts random studies of provider payment histories to detect billing errors and over-utilization. They perform on-site visits and obtain records to verify that services billed correspond to services rendered to participants. Once services are reviewed, issues may be resolved by provider education or policy revision, recovery of funds from the provider, and/or assessment of civil monetary penalties. In more serious cases, the Department can take any or all of the following actions:

- Suspend payment pending further investigation;
- Terminate provider numbers;
- Exclude entities/individuals;
- Refer individuals/providers for criminal prosecution.

If you believe that a particular Medicaid provider is abusing the program, you may contact:

Medicaid Program Integrity Unit
PO Box 83720
Boise, Idaho 83720-0036
prvfraud@dhw.idaho.gov
Phone 1 (208) 334-5754
Fax 1 (208) 334-2026
https://healthandwelfare.idaho.gov/report-provider-fraud

3.2. Self-Reporting Overpayments

Providers aware of an overpayment by the Department must immediately repay the improper amount. If an overpayment is identified within the time frame allowed for a claim adjustment, providers should adjust their claims per the General Billing Instructions, Idaho Medicaid Provider Handbook. If the overpayment is identified after the allowed adjustment period, providers can submit the Overpayment Form to Gainwell Technologies for claim adjustments.

Providers who want to self-report overpayments and send a lump sum payment or enter into a repayment agreement to pay back the overpayment over time, should fill out and submit the Medicaid Program Integrity Unit's online Health Care Provider Self Report form. Providers who submit the online Health Care Provider Self-Report forms are contacted by the Medicaid Program Integrity Unit within five (5) working days to discuss repayment.

Incentives are extended to providers who responsibly self-report including:

- Extended repayment terms;
- Waiver of civil monetary penalties;
    - Civil monetary penalties cannot be waived for background check compliance cases, but an audit would not include all employees; and
- Quick resolution of overpayments.

Situations that could cause an overpayment include, but are not limited to:

- Incorrect coding or billing;
- Services provided by an unlicensed or excluded individual; and
- Claims submitted for services that were billed but not provided.

3.2.1. References: Self-Reporting Overpayments

a) Idaho Medicaid Publications

"**Medicaid Program Integrity Unit:** Provider Self-Report of Overpayments." MedicAide Newsletter, June 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf.

3.3. Prevention Requirements

Providers are responsible to establish, disseminate, and enforce written policies that detect and prevent waste, fraud, and abuse to their employees, contractors, and subcontractors. The provider's employee handbooks must include references to the laws in the written policies, protections for whistleblowers, and specific discussion of policies and procedures in compliance with the False Claims Act of 1863 and Deficit Reduction Act of 2005. These handbooks must be available to all employees, contractors, and agents.

Additionally, entities receiving payments totaling $5,000,000 or more per year must provide the Department with an annual written affidavit attesting to their compliance with these laws. Each year the Division of Medicaid sends reminder letters to entities determined to meet this requirement.

Compliance with these laws is a condition of payment. Failure to comply results in termination of the provider contract, and potential recoupment and penalties. Providers are encouraged to use the Office of Inspector General's Compliance Resource Portal for best practices and complimentary trainings.

3.3.1. References: Prevention Requirements

a) Federal Regulations

Deficit Reduction Act of 2005. S. 1932 (2006). Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-109s1932enr/pdf/BILLS-109s1932enr.pdf.

The False Claims Act. 12 Stat. 696 (1863). The Library of Congress, https://www.loc.gov/law/help/statutes-at-large/37th-congress/session-3/c37s3ch67.pdf.

False Claims Amendments Act of 1986. 100 Stat. 3153 (1986). Government Printing Office, https://www.govinfo.gov/content/pkg/STATUTE-100/pdf/STATUTE-100-Pg3153.pdf#page=1.

Fraud Enforcement and Recovery Act of 2009. 123 Stat. 1617 (2009). Government Printing Office, https://www.govinfo.gov/content/pkg/STATUTE-123/pdf/STATUTE-123-Pg1617.pdf#page=1.

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.

b) Idaho Medicaid Publications

Changes in Federal Legislation Affecting Medicaid Providers, Information Release MA07-01 (01/05/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13183&dbid=0&repo=PUBLIC-DOCUMENTS.

Federal Anti-Kickback Statute, Information Release MA07-24 (12/13/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13199&dbid=0&repo=PUBLIC-DOCUMENTS.

"Provider Responsibilities for the Prevention of Waste, Fraud and Abuse." *MedicAide Newsletter,* January 2019,

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

3.4. Payment Error Rate Measurement Audits

The Centers for Medicare and Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) by reviewing claim payments and participant eligibility determinations every three (3) years. CMS uses a Review Contractor (RC) to perform medical records collection, statistical calculations, medical data, and a processing review of fee-for-service (FFS) claims. The RC selects a sample of claims and calls affected providers to explain the process to establish a point of contact for the audit. The RC then sends each provider a written request by fax or mail detailing the documents needed.

Documentation must be submitted per the RC's instructions including the PERM coversheet and within seventy-five (75) calendar days. If the documentation submitted is insufficient to support the claim, additional documentation is requested. Providers only have fourteen (14) days to comply with any additional requests. It is important that providers cooperate by submitting all requested documentation within the designated timeframe. Failure to provide the requested documentation in the designated time frame is a violation of Idaho Code Section 56-209h and the Idaho Medicaid Provider Agreement, which may result in disenrollment, investigation, recoupment and/or civil monetary penalties.

Medical staff and certified coders review the claims and documentation provided to the RC ensuring payment was appropriate based on the Department's policy, state and federal regulations. Non-compliant claims are recouped by the Department, and to avoid future issues, the provider may be required to submit a corrective action plan. Additionally, the Medicaid Fraud Control Unit or the Medicaid Program Integrity Unit may investigate providers suspected of fraud or abuse. Providers are still entitled to their normal appeal rights with the Department.

The Department monitors PERM audits and follows up with providers and the RC as necessary. This includes reviewing audit results and providing the RC additional information when findings are incorrect. Providers may email their State PERM contact at permaudit@dhw.idaho.gov or CMS at PERMProviders@cms.hhs.gov for any provider specific questions.

3.4.1. References: Payment Error Rate Measurement Audits

a) CMS Guidance

Payment Error Rate Measurement (PERM) (2024). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index?redirect=/PERM.

HHS Agency Financial Reports (2024). Department of Health and Human Services, https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html.

b) Federal Regulations

Improper Payments Elimination and Recovery Act of 2010. P.L. 111-204 (2010). Government Printing Office, https://www.govinfo.gov/content/pkg/PLAW-111publ204/pdf/PLAW-111publ204.pdf.

Improper Payments Information Act of 2002. P.L. 107-300 (2002). Government Printing Office, https://www.govinfo.gov/content/pkg/PLAW-107publ300/pdf/PLAW-107publ300.pdf.

c) State Regulations

Administrative Remedies, Idaho Code 56-209h (2016). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209h.

3.5. Retrospective Review

A retrospective review is a determination of coverage after a claim has been submitted. It may even occur after payment has been made. Should a review find that payment for a claim was inappropriate, it may be recouped. The review checks for appropriate documentation, medical necessity, and adherence to all applicable rules, regulations, and statutes. Receipt of documentation and claim payment is not certification that the Department has conducted a review or verified the appropriateness of a claim.

Providers may appeal a finding on a retrospective review by Medicaid or its designee by requesting a reconsideration. If the provider disagrees with the result of the reconsideration, they may file a formal appeal.

3.5.1. Reconsideration Request

Prepare a written Request for Reconsideration including additional documentation to support the validity of your claim. Documentation may include medical records, guidance from the Centers for Medicare & Medicaid Services, Idaho Provider Handbooks, Idaho statute, or Idaho Administrative Procedure Acts (IDAPA). Resubmit to the reviewing agent within 28 days from the mailing date of the Notice of Decision.

Upon completion of the reconsideration review, Medicaid will issue a second Notice of Decision. If the provider or participant disagrees with the reconsideration decision made by 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 to submit a formal appeal.

3.5.2. Appeal Request

A formal appeal must be submitted in writing with supporting documentation within 28 days of the date of the Medicaid Review of Claim Determination 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 a cover letter detailing the reason a formal appeal is requested along with copies of the flowing information:

- Medicaid Review of claim Determination Letter
- Gainwell Technologies review letter
- Claim and all attachments or new claim for possible resubmission
- Any applicable Remittance Advice (RA)

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

3.6. Services for Immediate Family or Household Member

The Department reimburses providers based on the lesser of reasonable costs or customary charges for services and items. The definition for customary charges includes the provision for Medicare rates, which considers items and services furnished to an immediate family or household member to be without charge or no charge due to the relationship between the participant and the provider. Unless otherwise stated providers cannot be reimbursed for services provided to a participant within their immediate family or household.

For physicians and non-physician practitioners this also includes services that are incidental to their care. This section does not apply to a non-professional corporation regardless of the relationship with any employee, stockholder, officer or director. It does apply to a professional corporation, which is any corporation owned by healthcare professionals for the purpose of practicing medicine, midwifery, dentistry, podiatry, optometry, or chiropractic care.

Providers are encouraged to consult their professional organization's stance on these services as many organizations such as the American Medical Association consider the treatment of self or an individual with a close personal relationship in violation of their ethical standards.

3.6.1. Immediate Family Definition

An immediate family member is:

- A spouse;
- A natural, step, in-law, or adopted child;
- A natural, step, in-law, or adopted parent;
- A person acting in loco parentis;
- A natural, step, in-law, or adopted sibling;
- A natural, step, in-law, or adopted grandchild; or
- A natural, step, in-law, or adopted grandparent.

The spouse of a brother-in-law or sister-in-law is not considered an immediate family member. Familial bonds remain in effect in the event of the death of one of the parties.

3.6.2. Household Member Definition

A household member is anyone living in the provider's residence with a relationship based on blood, adoption, marriage, or employment. Roommates and renters are not considered a member of the provider's household. However, services provided for a roommate or renter are still excluded from reimbursement when they are an immediate family member.

3.6.3. References: Services for Immediate Family or Household Member

a) CMS Guidance

"Chapter 16 – General Exclusions from Coverage (2014)." *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/bp102c16.pdf.

b) Idaho Medicaid Publications

"Providers of Medical, Surgical, and DMEPOS, Medicaid Does not Pay for Services Rendered or Performed by Spouses and Legally Responsible Parents of Minors." MedicAide Newsletter, January 2019,

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

c) Professional Organizations

American College of Physicians Ethics Manual: Seventh Edition (2019), Lois Snyder Sulmasy, Thomas A. Bledsoe, American College of Physicians Ethics, Professionalism and Human Rights Committee, https://annals.org/aim/fullarticle/2720883/american-college-physicians-ethics-manual-seventh-edition.

"Treating Self or Family: Opinion 1.2.1." *Code of Medical Ethics: Patient-physician Relationships,* American Medical Association, https://www.ama-assn.org/delivering-care/ethics/treating-self-or-family.

d) 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.

3.7. Prohibition on Gifts to Participants

Providers are prohibited from offering gifts or incentives to participants and may be liable for a civil monetary penalty up to $10,000 per occurrence as well as exclusion from Federal programs for a period not to exceed ten (10) years. This includes waivers of co-payments and the transfer of items or services for free or below the fair market value. There are some allowances such as:

- Nominal gifts other than cash and valued up to $15 per item, but not more than $75 annually;
- Items or services offered on equal terms to the general public, regardless of insurance status;
- Payments between an employer and employee;
- Waivers of cost-sharing payments not advertised and based on financial need;
- Incentives to promote the delivery of preventive care services to any participant, or services in the Guide to Clinical Preventive Services by the United States Preventive Services Task Force (USPSTF);
- Drug manufacturers that do not file claims with Medicaid; and
- Independent provider funded entities furnishing services to the financially needy that do not require participants receive services from a particular provider.

3.7.1. References: Prohibition on Gifts to Participants

a) Idaho Medicaid Publications

Federal Anti-Kickback Statute, Information Release MA07-24 (12/13/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=13013&dbid=0&repo=PUBLIC-DOCUMENTS.

b) Federal Regulations

"Civil Monetary Penalties." Social Security Act, Sec. 1128A(a)(5) (1996). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm.

CMPs, Assessments, and Exclusions for Beneficiary Inducement Violations, 42 CFR 1003 Subpart J (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-part1003-subpartJ.pdf.

Definitions, 42 CFR 1003.110 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-sec1003-110.pdf.

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

Permissive Exclusions, 42 CFR 1001 Subpart C (2017). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-part1001-subpartC.pdf.

c) Office of the Inspector General Publications

Offering Gifts and Other Inducements to Beneficiaries (08/2002). Office of Inspector General, Department of Health and Human Services, https://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf.

Office of Inspector General Policy Statement Regarding Gifts of Nominal Value to Medicare and Medicaid Beneficiaries (12/07/2016). Office of Inspector General, Department of Health and Human Services, https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf.

3.8. Reporting Participant Fraud

The Welfare Fraud Unit conducts reviews and investigations to determine whether or not a participant is fraudulently using Medicaid services. If you believe that a Medicaid participant is abusing the program, you may contact:

Welfare Fraud Unit
PO Box 83720
Boise, Idaho 83720-0036
welfraud@dhw.idaho.gov
Phone 1 (866) 635-7515
https://healthandwelfare.idaho.gov/report-welfare-fraud

4. Services for Providers

Gainwell Technologies is the fiscal agent for the Idaho Medicaid Program. The primary objective for Gainwell Technologies is to process Medicaid claims efficiently and accurately for Idaho Medicaid providers. The Gainwell Technologies Provider Enrollment Department enrolls providers into the Idaho Medicaid Program and responds to providers' requests for information not currently available through Idaho's Medicaid Automated Customer Service (MACS). The Gainwell Technologies Provider Services Department helps to keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid and to answer any questions regarding claims and eligibility.

4.1. Idaho Medicaid Automated Customer Service (MACS)

Medicaid Automated Customer Service (MACS) is the interactive voice response system (IVR) that allows a computer to recognize voice and telephone keypad inputs. MACS will allow users to access a database via a telephone touchtone keypad or by speech recognition, after which they can service their own inquiries by following the instructions. MACS will respond with pre-recorded audio to further direct users on how to proceed. MACS can be used to control almost any function where the system can be broken down into a series of simple menu choices.

The following table shows the information available through MACS. The phone number for MACS is 1 (866) 686-4272.

Information Available in MACS				
Claims Information	**Last Payment Amount**	**Mailing Addresses**	**Participant Information**	**Security Code**
Claim status	Amount and date of payment	Paper claims	Copay/Deductible	Create a new code
Procedure code coverage	Number of claims paid	ResHab/PCS PA	Eligibility	Change an existing code
PA required for procedure code	Warrant/EFT number	Medical or Surgical PA	HC enrollment and referrals	
Units remaining		Dental PA	Lock-In	
Revenue code coverage		DME PA	Other Insurance/TPLs	
PA required for revenue code		Inpatient or Outpatient PA	Prior Authorizations	
Diagnosis code coverage		Transportation PA	Service Limits	
		All other PAs		
		Web Portal address		

4.2. Benefit Eligibility Checks

Providers must verify and document participant eligibility and Healthy Connections enrollment status on the date of service and prior to rendering services to qualify for reimbursement. More information about checking participant eligibility is in the Verifying Participant Eligibility section of the handbook. Gainwell Technologies provides the ability for providers to verify billing code coverage as well. Due to system limitations, the system shows all codes residing in a single benefit category. It does not show benefits specific to the participant. Gainwell does try to name the benefits that apply to a particular age group. Providers should be aware of this system limitation when determining whether a participant is eligible for a service. Furthermore, providers must abide by the Idaho Medicaid Provider Handbook. When a limitation is stated in the handbook, the provider is responsible for ensuring they do not exceed that limitation regardless of the system check.

4.2.1. References: Benefit Eligibility Checks

a) Medicaid Publications

"Handbook and the Eligibility System." *MedicAide Newsletter,* January 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf.

4.3. Information Releases

Information releases (IR) are issued to update providers on policy, billing, and claims processing changes. An IR can be published to the provider portal at any time and are republished in the next MedicAide Newsletter. Providers are required to adhere to information communicated by an IR as part of the Compliance section of their provider agreement. The Department maintains IRs from 2018 to the present on the Information Releases webpage. IRs from before 2018 can be requested by fax or letter to:

Information Release Coordinator
Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0036
Fax: 208-364-1811

4.3.1. References: Information Releases

a) State Regulations

"General." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 022.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.4. MedicAide Newsletter

The MedicAide newsletter is a monthly publication that communicates information to Medicaid Providers and other interested parties. The newsletter contains policy, program and billing changes as well as Information Releases published since the last edition. Providers are required to adhere to information in newsletter articles as part of the Compliance section of their provider agreement.

The newsletter is published electronically by the 5th business day of the month at Gainwell Technologies Idaho Medicaid website under MedicAide Newsletters. Issues are only available for newsletters published May 2010 and forward. Paper copies may be requested by calling 1 (866) 686-4272. Subscriptions are unavailable at this time.

4.4.1. References: MedicAide Newsletter

a) State Regulations

"General." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 022.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.5. Provider Handbooks and Guides

The *Idaho Medicaid Provider Handbook* is the primary repository for policy and billing instructions. The handbook is updated periodically with program changes and to incorporate information communicated in Information Releases or the MedicAide Newsletter. Providers are required to adhere to information in the handbook as part of the Compliance section of their provider agreement. Should the handbook ever appear to contradict relevant provisions of state or federal regulations, the regulations prevail.

The Trading Partner Account (TPA) User Guide helps providers navigate their TPA accounts including how to check Medicaid coverage, eligibility for goods and services, submitting claims and other useful information. Additional user guides for enrollment and maintenance of information can be found in the Reference Material section of www.idmedicaid.com.

Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies Idaho Medicaid website.

4.5.1. References: Provider Handbooks and Guides

a) State Regulations

"Comply with the Idaho Medicaid Provider Handbook." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 025.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

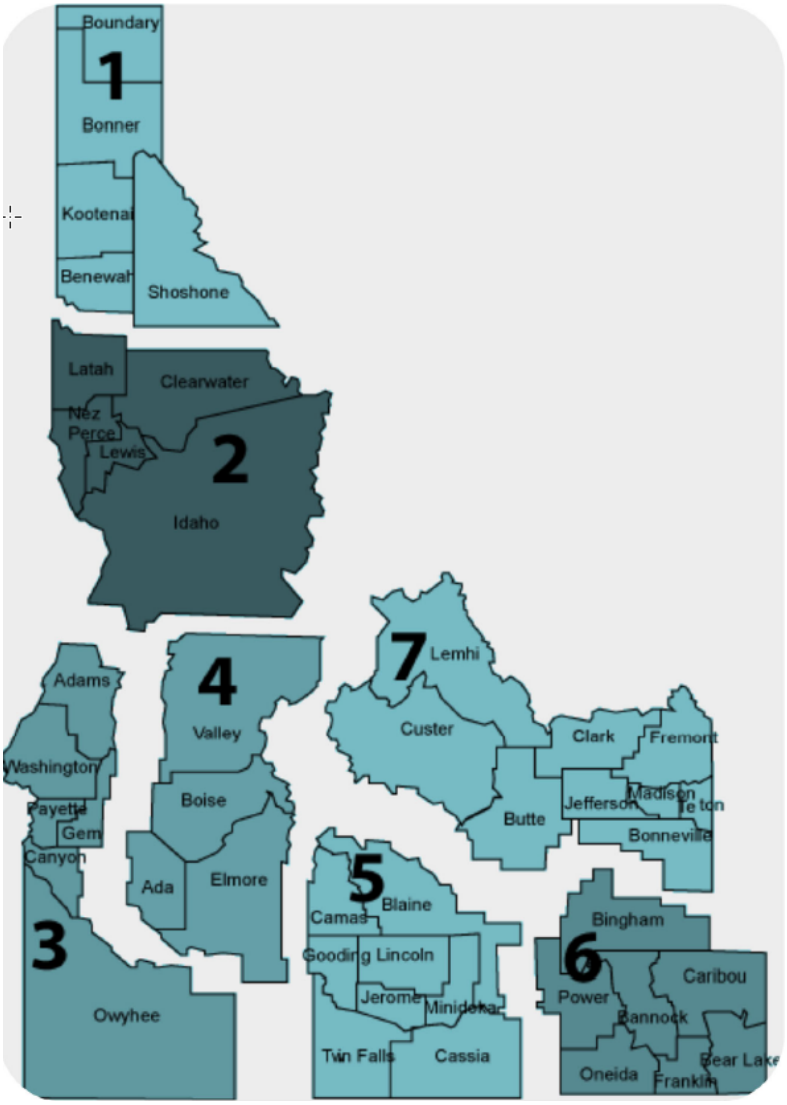
"Idaho Medicaid Provider Handbook." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 006.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"General." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 022.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.6. Provider Relations Consultants (PRC)

Gainwell Technologies Provider Relations Consultants help keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid. Provider Relations Consultants accomplish this by:

- Conducting provider workshops;
- Conducting live meetings for training;
- Visiting a provider's site to conduct training; and
- Assisting providers with electronic claims submission.



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

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

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

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

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

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

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

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

4.7. Provider Service Representatives (PSRs)

Provider service representatives are available Monday through Friday from 7 A.M. to 7 P.M. Mountain Time by calling MACS at 1 (208) 373-1424 or 1 (866) 686-4272, and saying representative or rep. Gainwell Technologies provider service representatives are trained to promptly and accurately respond to requests for information on:

- Adjustments;
- Billing instructions;
- Claim status;
- Participant benefit information;
- Participant eligibility information;
- Form requests;
- Payment information;
- Provider participation status information;
- Recoupments; and
- Third party recovery information.

When calling with questions about claim status, please have the following information ready:

- Billing provider's Idaho Medicaid provider number;
- Participant's Medicaid identification number; and
- Date(s) of service.

When calling for questions about participant eligibility, have the following information ready:

- Billing provider's Idaho Medicaid provider number;
- Participant's first and last name; and
- Participant's Medicaid identification number, date of birth, and/or Social Security number.

4.8. Secure Messaging

The Trading Partner Account on Gainwell Technology's website includes a secure and convenient messaging tool with a high level of security to allow better provider communication. Providers do not need to use third-party secure messaging systems to send sensitive information. Messages and attachments can be sent between providers and specific teams for assistance. The system includes e-mail features such as archiving, searching, and printing messages. Gainwell strives to provide a two (2) day business turnaround time.

To access secure messaging, sign into your provider portal Trading Partner Account (TPA). Choose File Exchange, then the Messages/Alerts link. The inbox is immediately displayed; new messages can be sent by selecting New Message, then choosing the relevant topic. We encourage providers to check out the section titled Secure Messaging Interface for detailed instructions.

Inquiries involving the following are more expediently processed when the Pay-to or billing NPI, name of the provider, the participant's Medicaid ID number and name are attached along with:

- Claims:
  - Claim number; and
  - The date of service and billed amount.
- Eligibility:
  - The date of service(s); and
  - Service codes (CPT, HCPCS, and/or Revenue).
- Prior Authorization (PA):
  - the PA request date;
  - Date of service(s) the PA was requested for; and
  - Service codes.
- EDI:
  - Claim submission date;
  - Claim number(s) (if on file);
  - The date of service; and
  - Billed amount.

Providers requesting to update the administrator on their Trading Partner Account must submit a signed letter on company letterhead with the following:

- NPI/Provider ID for account;
- Explanation of Administrator change;
- First and last name of previous administrator or their username;
- Current e-mail on file; and
- First and last name of new administrator.

4.8.1. References: Secure Messaging

a) Medicaid Publications

"Secure Message Inquiries." *MedicAide Newsletter,* November 2021, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202021%20MedicAide.pdf.

"Simple, Secure, and Clean – Secure Messaging." *MedicAide Newsletter,* February 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202024%20MedicAide.pdf.

5. Provider Enrollment

Providers must be enrolled before billing or providing services except in emergency circumstances or as detailed in the provider handbook. Idaho Medicaid enrolls four types of providers:

- Providers with full billing privileges
- Crossover only providers
- Managed care organization/ordering, referring and prescribing only providers (MCO/ORP)
- Non-billing ordering, referring and prescribing (ORP) providers

All providers wishing to participate in the Idaho Medicaid program must first register for a Trading Partner Account (TPA) at https://www.idmedicaid.com and then follow the link for the Provider Enrollment Application upon logging in. A complete application includes a Medicaid Provider Agreement and a W-9, which must be signed by the provider and submitted with the enrollment application along with other attachments to Gainwell Technologies through their website. The date of enrollment is considered the date a complete application is submitted. Enrollment can be backdated up to a year from the date of application in some circumstances.

Individual providers enrolling must disclose information, including, but not limited to:

- Date of birth (DOB);
- Social Security Number (SSN);
- Licensure;
- National Provider Identifier (if applicable); and
- Convictions of any criminal offense related to the person's involvement in any program under Medicare, Medicaid, or CHIP since those programs began.

All owners, corporate officers, directors, or shareholders of legal entities to include the following: general or limited corporations; partnerships; professional corporations or associations; limited liability companies with a direct, indirect or control interest; managed care organizations AND managing employees or fiscal agents who exercise day-to-day operational or managerial control or operations must also disclose information upon enrollment in Medicaid. A disclosing entity is defined as "a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent." Both individuals and entities must disclose family relationships between persons with ownership or control interests in the disclosing entity. Disclosing entities must also disclose:

- Names and addresses of any person with an ownership or control interest in the disclosing entity;
- Names, addresses, DOBs, and SSNs of any managing employee or fiscal agent of the disclosing entity;
- Whether a person with an ownership interest is related to another person with an ownership or control interest;
- Names of other disclosing entities in which the owner, managing employee or fiscal agent has ownership or control interest regardless of the percentage of ownership;
- Convictions of persons who have ownership or control interests in the provider entity;
- Convictions of persons who are managing employees or fiscal agents of the provider entity; and
- Whether any person with an ownership or control interest, a managing employee or a fiscal agent has voluntarily revoked, terminated or been subject to a revocation or termination action of a Medicare, Medicaid or CHIP enrollment as defined by 42 CFR 455.107.

Provider Enrollment can be contacted by e-mail at idproviderenrollment@gainwelltechnologies.com or by phone at 1 (866) 686-4272. Additional information about Idaho administrative rules is available on Idaho.gov at the Legislative Branch link under the Government heading. See the Provider Agreement Example for provisions that apply to all providers.

5.1. References: Provider Enrollment

a) Federal Regulations

Disclosure of Information by Providers and Fiscal Agents, 42 CFR 455, Subpart B (2023). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-part455-subpartB.pdf.

b) State Regulations

"Provider Agreements." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 022. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Application Process." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 021. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.2. Crossover Only Providers

Healthcare professionals and facilities that do not wish to be Medicaid providers can instead choose to enroll as crossover only providers to receive coinsurance and deductible payments for participants dually eligible for Medicare and Medicaid. Enrollment as a crossover only provider also allows the professional to be an Ordering, Referring and Prescribing Providers when they meet all other requirements. This enrollment option *is not* for providers wanting to submit claims to Idaho Medicaid for reimbursement for non-Medicare services or participants with Medicaid only.

Providers wishing to enroll as a crossover only provider must complete an enrollment application with their Medicare certification, sign the Idaho Medicaid Provider Agreement, and retain all documentation to support services ordered including the establishment of medical necessity. This enrollment is for professional services only. If an enrolled provider later chooses to start billing Idaho Medicaid for these services, they can contact Provider Enrollment for instructions on converting their account.

See General Billing Instructions, Idaho Medicaid Provider Handbook for more information about reimbursement for participants dually eligible for Medicare and Medicaid.

5.2.1. Mental Health Clinics

Idaho Medicaid's behavioral health and substance use disorder services are usually covered under the Idaho Behavioral Health Plan (IBHP) with benefits administered under contract by Magellan Healthcare, Inc. However, participants with only Medicare Savings Plan eligibility or dual eligible participants enrolled in the Idaho Medicaid Plus or Medicare Medicaid Coordinated Plan (MMCP), do not receive benefits under the IBHP. Mental Health Clinics providing services to these participants when eligible are reimbursed through Fee-For-Service Medicaid or under the dual health plan in which they are enrolled. The clinic must enroll as a crossover only provider with a group NPI or service location with all Medicare certified staff as rendering providers (e.g. Licensed Clinical Social Workers).

5.3. Managed Care Organization/Ordering, Referring and Prescribing Providers

Healthcare professionals and facilities providing services to a Medicaid managed care organization are required to enroll with Idaho Medicaid. Providers that do not wish to be fee-for-service Medicaid providers can instead choose to enroll as non-billing entities. This enrollment also allows for the provider to order, refer, or prescribe services and items, allowing participants enrolled in fee-for-service Medicaid to fill prescriptions or another Idaho Medicaid provider to accept a referral. Providers wishing to enroll as managed care organization/non-billing ordering, referring and prescribing (MCO/ORP) providers must complete an enrollment application, sign the MCO/ORP Idaho Medicaid Provider Agreement, and retain all documentation to support services ordered including the establishment of medical necessity. The Department has established a streamlined process to enroll non-billing individuals. This enrollment method *is not* for providers who want to submit claims directly to Idaho Medicaid for reimbursement for their services. If an enrolled non-billing provider later chooses to start billing fee-for-service Idaho Medicaid, they can contact Provider Enrollment for instructions on converting their account.

5.4. Non-billing Ordering, Referring and Prescribing Providers

Healthcare professionals that do not wish to be Medicaid providers can instead choose to enroll as non-billing entities for the sole purpose of ordering, referring, or prescribing services and items. This allows participants to fill prescriptions or an Idaho Medicaid provider to accept a referral. Providers wishing to enroll as non-billing ordering, referring and prescribing providers must complete an enrollment application, sign the Idaho Medicaid Provider Agreement, and retain all documentation to support services ordered including the establishment of medical necessity. The Department established a streamlined process to enroll non-billing individuals whose only relationship with the Idaho Medicaid program is to refer for specialized care or order items or services. This enrollment is for individuals only, not facilities or provider group entities. Call Idaho Medicaid Provider Enrollment toll free at 1 (866) 686-4272 for a non-billing provider enrollment form. This enrollment method *is not* for individuals who want to submit claims to Idaho Medicaid for reimbursement for their services. If an enrolled non-billing provider later chooses to start billing Idaho Medicaid, they can contact Provider Enrollment for instructions on converting their account.

5.4.1. References: Non-billing Ordering, Referring and Prescribing Providers

a) CMS Guidance

"1.5.1.B. Ordering or Referring Physicians or Other Professionals (ORP) (2025)." *Medicaid Provider Enrollment Compendium (MPEC).* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/media/123411.

"1.5.2. When Screening is Required (2025)." *Medicaid Provider Enrollment Compendium (MPEC).* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/media/123411.

b) Federal Regulations

Enrollment and Screening of Providers, 42 CFR 455.410 (2011). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf.

c) Idaho Medicaid Publications

"Edits Will Change from Warn to Deny on October 1, 2017." *MedicAide Newsletter,* September 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202017%20MedicAide.pdf.

"Ordering, Referring and Prescribing Providers." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.5. Medicaid Provider Identification Numbers

5.5.1. Individual Provider Numbers

The National Provider Identifier (NPI) is a requirement of HIPAA. The NPI must be used on all electronic claims and identifies healthcare providers to health plans with a unique 10-digit numeric provider identifier. An NPI can only be associated to one Tax ID, but a Tax ID can be associated to many NPI numbers or Idaho Medicaid Provider numbers. Providers who registered in the MMIS with an NPI will use that NPI on all paper or electronic transactions. Reimbursement for providers with an NPI is sent to the pay-to address associated with the NPI. Providers without an NPI can apply for one online at https://nppes.cms.hhs.gov/#/ or by calling 1 (800) 465-3203 for a paper application.

Provider-types that do not meet the HIPAA definition of a healthcare provider are considered atypical provider types. Atypical providers are generally not eligible to receive an NPI. Instead a unique 8-digit Idaho Medicaid Provider Number is assigned during enrollment. Claim reimbursement is sent to the pay-to address associated with the Medicaid provider number. The types of providers Idaho Medicaid recognizes as atypical provider types are listed below:

- Adult day health facility;
- Behavior consultation/crisis management;
- Certified family homes;
- Chore service providers;
- Community support workers;
- Home delivered meal providers;
- Home modification contractors;
- Non-medical transportation agency and individual providers;
- Non-emergency and/or non-medical commercial transportation;
- Personal Assistance Agency (PCS/aged and disabled (A&D) agency);
- Personal Care Services (PCS) Family Alternate Care Home (FACH);
- Personal emergency response system (PERS) providers;
- Residential Assisted Living Facility (RALF);
- Residential habilitation agency;
- Respite care providers;
- Self-determination fiscal employer agent;
- Supported employment agency;
- Transition mangers; and
- Transportation providers.

5.5.2. Multiple Service Locations

Providers with multiple service locations must identify where the service took place. A service location is considered separate from the primary location when one of the following applies:

- The location is off-campus from the primary demonstrated by:
  - The site is not immediately adjacent to the main building.
  - The site is more than 250 yards from the main building.
- The site is on-campus but presents itself separately from the primary location.
- The Department determines the site to be a separate service location.

When billing claims, providers with multiple service locations must enter a three-digit site number (i.e. 001, 002) to identify the specific location, in addition to their NPI/Medicaid ID. The three-digit location code is identified on the provider enrollment approval letter. Providers can also obtain this number by logging into their Trading Partner Account to view the information.

Enter this information in the following fields:

- Paper UB04, enter in field 2;
- Paper CMS-1500, enter in field 32a; or
- Electronic claims refer to 837 Professional/837 Institutional companion guide.

5.5.3. Group Practice

The Centers for Medicare and Medicaid Services (CMS) requires the identification of the individual who actually performs a service when billing under a group number. The performing provider's individual NPI/Medicaid provider number must be on the claim as well as the provider's group NPI/Medicaid number.

5.6. Provider Qualifications

Idaho Medicaid providers must meet all qualification requirements to be eligible for payment. Providers are required where appropriate to be licensed, certified, or registered with the appropriate state and federal authorities. Continued provider participation is contingent on the ongoing maintenance of required credentials. The claims processing system verifies the effective dates of the provider's credentials against the date of service. Provider credentials must be up to date or claims are denied. Providers are required to split claims for covered and non-covered dates of service, or update their credentials with Gainwell Technologies and resubmit the claim. The loss of, or failure to renew, required credentials or insurance is cause to terminate a provider's participation in the Idaho Medicaid Program.

Providers are also required to carry any insurance mandated by state or federal regulations, or Idaho Medicaid. Additional provider qualifications are listed throughout the Idaho Medicaid Provider Handbook based on provider type or service requirements. Payment of a claim does not verify that a provider meets qualifications to provide the service. It is the provider's responsibility to ensure they meet the qualifications for a service. Providers that do not meet the qualifications for a paid service may be subject to recoupment and civil or monetary penalties.

5.6.1. References: Provider Qualifications

a) State Regulations

"Individual Providers: Requirements." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 007.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5.7. Ownership and Controlling Interests

Providers with any type of partnership, corporation or nonprofit entity with an executed Idaho Department of Health and Welfare Medicaid Provider Agreement agree that the entity and the partners, directors, officers, members, or individuals with an ownership interest of five-percent (5%) or greater, are jointly and severally liable for any breach of this Provider Agreement, and that action by the Department against the Provider may result in action against all such individuals in the entity.

The agreement also stipulates that providers furnish the Department or the U.S. Department of Health and Human Services, within thirty-five (35) days of the request, full and complete information related to certain business transactions, specifically about:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Providers are also required in their Provider Agreement to comply with the disclosure of ownership requirements in 42 CFR Part 455, Subpart B, and 42 CFR 411.361, when as applicable, and to notify the Department thirty (30) days prior to any change of ownership. The Provider Agreement is not transferable to the new owner.

5.8. Provider Risk Levels

Medicaid agencies must assign a categorical risk level for each provider type enrolling in the program. The screening level determines the processes the state must use for enrollment of new providers and revalidation of existing providers. Whenever appropriate, states are required to use the same risk level assigned by Medicare or assign a higher risk level. The screening requirements listed below are in addition to all other provider enrollment requirements already established.

Screening Required by the Affordable Care Act by Provider Risk Level			
Type of Screening Required	**Limited**	**Moderate**	**High**
Verification of any provider/supplier-specific requirements established by Medicare	X	X	X
Conduct license verifications (may include licensure checks across States)	X	X	X
Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	X	X	X
Pre and post enrollment Site Visits (Unscheduled/Unannounced)		X	X
Background Checks with fingerprinting			X

5.8.1. Limited Risk Providers

Idaho Limited Risk Provider Types
Adult Day Health
Ambulatory Surgical Center (ASC)
Assistive Tech Supplier (Specialized Medical Equipment and Supplies)
Audiologist
Behavior Consultation/Crisis Management
Certified Family Home (CFH)
Children's Service Coordination (CSC)
Chiropractor
Chore Services
Classic Optical
Clinic/Center - Hearing & Speech
Clinic/Center - Rehab, SA – Division of Behavioral Health
Cochlear Implant Suppliers
Critical Access Hospital (CAH)
Developmental Disability (DD) Case Management
Developmental Disability (DD) Child Independent Crisis Interventional/Professional
Developmental Disability (DD) Independent Therapeutic Consultation
Developmental Disability Agency (DDA)
Developmental Disability Agency (DDA) – Support Only Child Services
Diabetes Educator

Idaho Limited Risk Provider Types
Diagnostic Services
Dialysis Unit
Dietician
End-stage Renal Disease (ESRD) Facilities
Federally Qualified Health Clinic (FQHC)
Groups (Idaho has groups of physicians, non-physician practitioners, and therapists)
Home Modifications (Environmental Accessibility Adaptations)
Home-Delivered Meals
Hospital
Indian Health Service (IHS)
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – private
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – state
Mental Health Case Management
Mental Health Clinic
Nurse Non-Physician Practitioner
Occupational Therapist
Optician
Optometrist
Personal Care Services (PCS) Aged and Disabled (A&D) Agency
Personal Care Services (PCS) Family Alternate Care Home (FACH)
Personal Care Services (PCS) Homes - DD children
Personal Emergency Response System (PERS)
PHA – Weight Management Dietician
PHA – Weight Management
Pharmacy (clinic, retail, institution, specialty, mail, unit dose)
Pharmacist
Pharmacy Infusion Therapy
Physician
Physician Assistant
Podiatrist
Pregnant Women Clinic (PWC) – CLIA
Private Duty Nursing (PDN) Agency
Public Health
Radiology/Other Techs
Rehab Mental Health
Residential Assisted Living Facility (RALF)
Residential Habilitation Agency
Respite Care
Rural Health Clinic (RHC)
School Based Services (SBS)
Social Worker
Speech Language Pathologist (SLP)
Supported Employment Services
Support Brokerage-Fiscal Employer Agent (FEA)
Swing Bed Units
Translators

Idaho Limited Risk Provider Types
Transportation

5.8.2. Moderate Risk Providers

Idaho Moderate Risk Provider Types
Ambulance
Clinic/Center – Mobile Radiology
Clinic/Center – Physical Therapy (PT)
Durable Medical Equipment (DME) (Existing Idaho Providers)
Hearing Aid Vendor
Home Health (Existing Idaho Providers)
Lab CLIA
Pharmacy – Durable Medical Equipment (DME)
Physical Therapist
Portable X-ray
Prosthetics & Orthotics–existing

5.8.3. High Risk Providers

In addition to the provider types below, any provider is individually considered high risk when the provider:

- Has a payment suspension based on a credible allegation of fraud occurring within the past ten (10) years;
- Was excluded within the last ten (10) years by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) or any state Medicaid agency;
- Has a qualifying Medicaid overpayment; or
- Is enrolling within six (6) months of the date of the lifting of a temporary moratorium that at the time would have barred the provider's enrollment.

Idaho High Risk Provider Types
Durable Medical Equipment (DME) (New to Idaho Medicaid)
Home Health (New to Idaho Medicaid)
Hospice
Skilled Nursing Facility

5.8.4. References: Provider Risk Levels

a) Federal Regulations

Screening Levels for Medicaid Providers, 42 CFR. 455.450 (2011). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf.

b) Idaho Medicaid Publications

"Medicaid Provider Enrollment Requirements." *MedicAide Newsletter,* October 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf.

5.9. Provider Enrollment Moratoria

At its discretion, the Department may request from CMS a temporary prohibition on provider enrollment for a provider type when necessary to prevent or combat fraud, waste and abuse. The moratorium lasts for a six-month increment initially and may be repeatedly extended for the same. Any providers requesting enrollment under such a provider type during a moratorium must be denied by the Department. At this time Idaho Medicaid does not have a moratorium in place.

5.9.1. References: Provider Enrollment Moratoria

a) Federal Regulations

Temporary Moratoria, 42 CFR 455.470 (2011). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf.

b) Idaho Medicaid Publications

"Medicaid Provider Enrollment Requirements." *MedicAide Newsletter,* October 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf.

5.10. Maintenance of Information

Providers shall notify the Department of any changes to the information contained in the Enrollment Application, including but not limited to their mailing address and service locations, within 30 days of the date of the change. The Department is required by Federal regulations to terminate a provider's enrollment for failure to submit timely and correct information, which may also affect the provider's enrollment in other states' Medicaid programs. The Department may allow a provider to keep their enrollment if it documents in writing that termination would not be in the best interests of the Medicaid program. Failure to keep information current may also result in recoupment and civil or monetary penalties.

After enrolling, any updates needed to the provider file can be done through the online portal at the Idaho Gainwell Technologies Medicaid website. Once logged into your Trading Partner Account (TPA), select the **Provider Enrollment Application** link to electronically maintain your provider record.

Provider record changes include, but are not limited to:

- Change in address
- New phone number
- Name change (individual, group practice, etc.)
- Change in ownership or tax identification information
- Change in provider status (voluntary inactive, retired, etc.)
- Add/update/end date of rendering provider
- Add/update/end date of service locations

All correspondence sent to the provider's mailing address on file with the State's fiscal agent is deemed to be received by the Provider. Department correspondence is not forwarded by a change of address with the U.S. Postal Service. All mail and checks are returned to Gainwell Technologies.

To update or enroll additional provider records, visit the Provider Enrollment User Guides.

5.10.1. References: Maintenance of Information

a) Federal Regulations

Provider Screening and Enrollment, 42 CFR. 455 Subpart E (2011). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf.

b) Idaho Medicaid Publications

"Reminder to All Providers." *MedicAide Newsletter,* November 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202016%20MedicAide.pdf.

5.11. Change in Ownership or Tax Identification Information

Please be advised that a change in ownership or tax identification information requires a NEW provider enrollment application. The Idaho Medicaid provider agreement IS NOT transferable. Notification of a change must be made to the Department timely, within 35-days.

The following are examples of changes of ownership. This list is not exhaustive. In all the examples below, a new provider enrollment IS required and the existing record must be termed. Providers who are unsure of whether a transaction constitutes a change of ownership should contact the Division of Medicaid.
Examples include:

1. The provider is purchased or leased by another organization resulting in the transfer of the provider's identification number.
2. Changes to type of organization (e.g. Partnerships to limited liability company, or sole proprietorship to organization), which result in an asset or liability change.
3. An acquisition or merger where one entity purchases another. The purchasing entity typically uses their provider number in place of the selling provider's.
4. Consolidations, when a new corporate entity is formed, and the merging companies are non-surviving.
5. Changes in composition of a partnership (i.e. removal, addition, or substitution of one or more individuals as partners).
6. Transfers, creations or changes in the control of government owned institutions between different levels of government, such as city to county, state to county, etc..
7. Transfer of title or property to another party.
8. Leasing of all or part of a provider facility.
9. Bankruptcy proceedings filing.
10. Changes to a facility that require a change in licensure or certification.

Providers are not required to get a new NPI after a change in ownership, however, providers are encouraged to do so. This allows for a smooth billing transition and tracking of receivables, along with avoiding NPI crosswalk issues.

5.11.1. References: Change in Ownership or Tax Identification Information

a) Federal Regulations

Change of Ownership or Leasing: Effect on Provider Agreement, 42 CFR. 489.18 (1994). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2021-title42-vol5/pdf/CFR-2021-title42-vol5-sec489-18.pdf.

Disclosure by Medicaid Providers and Fiscal Agents: Information on Ownership and Control, 42 CFR. 455.104 (2011). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-sec455-104.pdf.

5.12. Provider Termination

Idaho Medicaid is required to deny applications for provider status or terminate the Medicaid Provider Agreement of any provider suspended from the Medicare Program or another state's Medicaid program. A provider's Medicaid status may also be terminated when the provider fails to comply with any term or provision of the Medicaid Provider Agreement. This includes failing to notify Idaho Medicaid or Gainwell Technologies in writing of any changes in address or ownership.

Continued provider participation is contingent on the ongoing maintenance of current licensure, certification, or insurance. Failure to renew required licenses, certifications, or insurance is cause to terminate a provider's participation in the Idaho Medicaid program.

5.12.1. References: Provider Termination

a) CMS Guidance

Medicaid Provider Enrollment Compendium (MPEC) (2025). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/media/123411.

b) Federal Regulations

Disclosure of Information by Providers and Fiscal Agents, 42 CFR 455 Subpart B (1979). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartB.pdf.

Provider Screening and Enrollment, 42 CFR 455 Subpart E (2011). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf.

Reporting Requirements, 42 CFR 411.361 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol2/pdf/CFR-2018-title42-vol2-sec411-361.pdf.

c) Idaho Medicaid Publications

"Medicaid Provider Enrollment Requirements." *MedicAide Newsletter,* October 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf.

"Reminder to All Providers." *MedicAide Newsletter,* November 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202016%20MedicAide.pdf.

6. Participant Eligibility and Benefit Plan Coverage

Medicaid is a medical assistance program that is jointly funded by the federal and state governments to assist in providing medical care to individuals. Applicants must meet each of the financial and non-financial requirements of a program to participate in its benefit plan, which may include a review of income, resources and other assets. The Division of Self-Reliance determines Medicaid eligibility and enrolls eligible applicants in the appropriate benefit package.

General information for participants on services covered under the Idaho Medicaid Program are listed in the booklet, *Idaho Health Plan,* which is available in English and Spanish from the Division of Medicaid, Department Regional Offices, or online. All services fall under either the Medicaid Basic Plan or Medicaid Enhanced Plan. However, some participants' eligibility to receive those services may provide additional restrictions, limitations or benefits not otherwise available as described below.

See the Provider Handbooks under Provider Guidelines for specific service coverage and billing details for individual programs and specialties.

6.1. References: Participant Eligibility and Benefit Plan Coverage

6.1.1. State Regulations

Eligibility for Medical Assistance, Idaho Code 56-254 (2021). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-254.

Legislative Intent, Idaho Code 56-251 (2021). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-251.

Powers of State Department, Idaho Code 56-203 (2022). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-203.

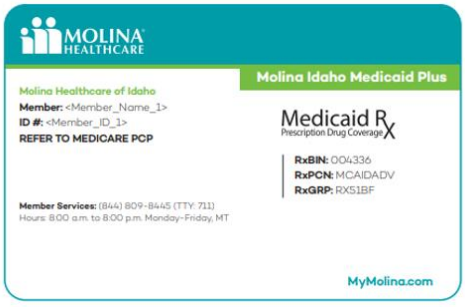
6.2. Medicaid Identification Card

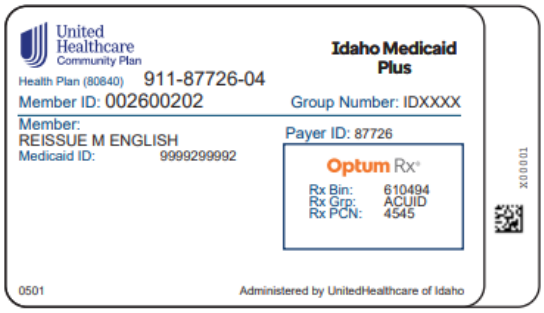
An identification card is issued to participants determined eligible for Medicaid benefits. All Medicaid participants, except otherwise ineligible non-citizens or presumptive eligibility (PE) participants, receive an identification card. Possession of a Medicaid ID card does not guarantee Medicaid eligibility or provider payment. Providers should request the Medicaid ID card with additional picture identification and retain copies of this documentation for their records.

The participant's Medicaid identification (MID) number is on the card. Cards issued after June 1, 2010 are a 10-digit number with no letters or symbols. Cards issued prior to June 1, 2010 are seven digits. Providers should convert the older versions by adding three zeroes on the front of the MID number.

Participants enrolled in the Idaho Medicaid Plus (IMPlus) plan or Medicare Medicaid Coordinated Plan (MMCP) are issued an alternative Medicaid card by their chosen or assigned health plan.

IMPlus Health Cards





MMCP Health Cards

Molina Medicare Complete Care (HMO D-SNP) and Molina Medicare Complete Care Select (HMO D-SNP):

6.2.1. References: Medicaid Identification Card

a) State Regulations

"Medical Assistance Procedures." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 010. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.3. Verifying Participant Eligibility

Self-Reliance determines participant eligibility annually and as needed based on reported changes. Any participant's eligibility may change from month-to-month. Providers are required to verify and document participant eligibility and Healthy Connections enrollment status on the date of service and before providing services to qualify for reimbursement. Medicaid only reimburses for services rendered to participants eligible for Medicaid benefits at the time of service. Deceased participants are not eligible for services or items. Providers are not reimbursed for services or items provided after the participant's date of death.

Example

A participant is eligible and has Medicaid coverage during the months of April and June. The participant was found ineligible and didn't have coverage during May.

Eligibility information can be accessed three (3) different ways:

- Trading Partner Account (TPA) on Gainwell Technologies Idaho Medicaid website;
- MACS 1 (866) 686-4272; or
- HIPAA compliant vendor software (tested with Gainwell Technologies).

To obtain eligibility information from one of these systems, submit two (2) participant identifiers from the following list:

- MID number;
- Social Security number (SSN);
- Last name, first name; or
- Date of birth.

Available participant eligibility information includes eligibility dates and Healthy Connections (HC) enrollment data, Medicaid special program limitations, certain service limitations, procedure code inquiries, third party recovery (TPR), Medicare coverage information, co-payments, and lock-in data. When viewing participant eligibility on a trading partner account Healthy Connections information is listed on the "Network" tab. If no information is available, then the participant is not enrolled with Healthy Connections, and a referral for services is not required.

6.3.1. References: Verifying Participant Eligibility

a) Idaho Medicaid Publications

"Importance of Verifying Participant Eligibility." *MedicAide Newsletter,* January 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf.

b) State Regulations

"Medical Assistance Procedures." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 010. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

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

6.3.2. Medicaid Automated Customer Service (MACS)

Providers can use MACS to check participant eligibility. Eligibility information is available on:

- Healthy Connections Program;
- Eligibility with special programs;
- Service limits;
- Prior authorization (PA);
- Co-payments; and
- Other health coverage.

MACS informs providers of the type of Medicaid benefits a participant is eligible for on the dates of service. More information about MACS is found in the Idaho Medicaid Automated Customer Service (Idaho MACS) section of this handbook.

Participants eligible for the full range of Medicaid services have their benefit plans communicated as eligible for Medicaid benefits. Participants, such as those on hospice, who are not eligible for the full range of Medicaid services have their restrictions reported according to their benefit plan.

Example

A participant eligible for the Medicaid Basic Plan has their eligibility communicated as eligible for basic Medicaid benefits, and only benefits restricted to the basic plan are communicated.

The benefit plan parameters for Presumptive Eligibility (PE), Lock-in, and Co-pay remain unchanged and any restrictions or requirements for participants are communicated accordingly.

6.3.3. Trading Partner Account (TPA)

Information regarding online billing and eligibility verification can be found in the Trading Partner Account (TPA) User Guide. When verifying eligibility, the following information is provided for participants enrolled in Healthy Connections:

- Network of HC clinic:
  - Healthy Connections;
  - Healthy Connections Care Management;
  - Healthy Connections Medical Home; and
  - Exempt from Healthy Connections.
- Demographics of the HC clinic:
  - Name of HC clinic;
  - Address of HC clinic;
  - Phone number of HC clinic; and
  - Hours of operation of HC clinic.

6.3.4. Vendor Supplied Software

Providers may contract with a software vendor and use software supplied by the vendor. Software specifications can be found on the Idaho Gainwell Technologies Medicaid website by selecting Companion Guides under the *Reference Material* menu. The specifications assist the vendor in duplicating the program requirements and allows providers to obtain the same information available as the Idaho Gainwell Technologies Medicaid website. All vendor software must successfully test transactions with Gainwell Technologies before use. Providers can check eligibility using vendor software, if the software is modified to meet the

requirements of the HIPAA ASC X12 270/271, version 5010 format, and if the vendor successfully tests the transactions with Gainwell Technologies.

a) Electronic Visit Verification (EVV) Software

Providers required to submit EVV data through the Sandata EVV Aggregator may contract with any EVV software vendor of their choice as long as the software is certified as compatible by Sandata. EVV software specifications (OpenEVV-AltEVV) can be found on the Idaho Gainwell Technologies Medicaid website by selecting Companion Guides under the *Reference Material* menu. The specifications assist the vendor in duplicating the EVV program requirements and allows providers to obtain the same information available as Sandata. All providers must successfully test and certify their EVV software with Sandata to verify compatibility with the EVV Aggregator in order to be eligible for payment. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information.

6.4. Participant Program Abuse/Lock-In Program

Medicaid reviews participant utilization to determine if services are being used at a frequency or amount that may be delivered at a level harmful to the participant and to identify services that are not medically necessary. Abuse can include frequent use of emergency room facilities for non-emergent conditions, frequent use of multiple controlled substances, use of multiple prescribing physicians and/or pharmacies, excessive provider visits, overlapping prescription drugs in the same drug class, and drug seeking behavior as identified by a medical professional.

To prevent abuse, Medicaid has implemented the participant lock-in program. Participants identified as abusing or over-utilizing the program may be limited to emergency services only, or the use of one physician/provider and one pharmacy. Services outside of documented emergencies by other providers will not be reimbursed. This prevents these participants from going from doctor to doctor, or from pharmacy to pharmacy, to obtain excessive services.

Participants entered in the Lock-in program will be notified by the Department in writing and have thirty-five (35) days to designate a physician/provider and pharmacy or twenty-eight (28) days to file an appeal. If a participant does not make a selection or file an appeal, they will be restricted to services for documented emergencies only and may be suspended from receiving Medicaid if abuse continues.

If a provider suspects a Medicaid participant is demonstrating utilization patterns, which may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or drug seeking behavior in obtaining prescription drugs, they should notify Medicaid of their concerns. Medicaid will review the participant's medical history to determine whether the participant is a candidate for the lock-in program.

6.4.1. References: Participant Abuse/Lock-in Program

a) State Regulations

"Appeal of Lock-in." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 997. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Criteria for Lock-in." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 993. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Department Evaluation for Lock-in." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 992. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Lock-in Defined." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 991. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Lock-in Participant Notification." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 994. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Lock-in Procedures." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 995. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Utilization Control Program." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 990. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Penalties for Lock-in Noncompliance." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 996. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

6.4.2. Primary Care Physician

The primary care physician (PCP) for lock-in participants is responsible for coordination of routine medical care and making referrals to specialists as necessary. The PCP educates the lock-in participant on procedures to follow when the office is closed, or there is an urgent or emergency situation. This coordination of care and the participant's knowledge of office procedures should help reduce non-emergent use of the emergency room.

If the participant needs to see a physician other than the PCP, the PCP gives the participant a referral to another physician or clinic to ensure payment. See the Referrals section for more information.

If a PCP no longer wishes to provide services to the lock-in participant, the PCP must send a written notice to the participant stating the reasons for dismissal with a copy of the letter sent to the Healthy Connections Representative for that region.

6.4.3. Designated Pharmacy

A designated pharmacy must monitor the participant's pattern of drug use. The pharmacy should only fill prescriptions from the participant's primary care physician (PCP), or from referred physicians as confirmed by the pharmacy with the PCP.

6.5. Idaho Medicaid State Plans

Idaho Medicaid offers three (3) State Plan benefit packages for participants based on various eligibility criteria.

6.5.1. Medicaid Basic Plan

The Medicaid Basic Plan is designed to achieve and maintain participant wellness by emphasizing prevention and proactively managing health. It is the default plan for Medicaid participants.

Under some circumstances, participants in the Medicaid Basic Plan with a medical necessity for enhanced services may be eligible for enrollment in the Medicaid Enhanced Plan. This determination is made jointly by Self Reliance in the Division of Welfare and the appropriate bureau in the Division of Medicaid.

6.5.2. Medicaid Enhanced Plan

The Medicaid Enhanced Plan includes all of the benefits found in the Medicaid Basic Plan, and additional benefits designed to cover needs of participants with disabilities and/or other special healthcare needs. Participants enrolled in this plan are eligible for the full range of Medicaid covered services.

6.5.3. Medicare Medicaid Coordinated Plan (MMCP)

The MMCP includes all of the benefits found in the Medicaid Basic Plan and the Medicaid Enhanced Plan. Participants enrolled in this plan are eligible for the full range of Medicaid covered services in coordination with their Medicare covered benefits. Participants in this plan may receive Medicaid benefits under fee-for-service or may be enrolled in either the Idaho Medicaid Plus or MMCP health plan under a contracted Managed Care Organization (MCO).

6.6. Idaho Medicaid Waivers

Idaho Medicaid has two (2) home and community-based services (HCBS) waivers to offer additional benefit packages for participants based on level of care needs. The participant must require services due to their disability that impairs their mental or physical function or independence. They must also be capable of being safely and effectively maintained in a non-institutional setting that in the absence of would require residence in an intermediate care facility for people with intellectual disabilities (ICF/IID) or nursing facility.

6.6.1. Aged and Disabled Waiver

Participants on the Medicaid Enhanced Plan and MMCP Plan are eligible for the Aged and Disabled (A&D) Waiver when they meet nursing facility level of care as determined by the Bureau of Long Term Care (BLTC). The waiver provides additional benefits designed to cover the needs of elderly and disabled adult participants to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. These services are intended to encourage the involvement of natural supports such as family, friends, neighbors, volunteers, religious community, and others.

6.6.2. Developmental Disability Waiver

Participants on the Medicaid Enhanced Plan and MMCP Plan are eligible for the Developmental Disability (DD) Waiver. The waiver provides additional benefits designed to cover the needs of participants with disabilities and/or other special healthcare needs. The participant must be eighteen (18) years of age or older and meet the intermediate care facility for people with intellectual disabilities (ICF/IID) level of care requirements. The participant must have a diagnosis of being intellectually disabled or a condition defined in section 66-402, Idaho Code. A functional assessment, maladaptive behavior or medical condition is used to qualify.

6.7. Presumptive Eligibility (PE)

Presumptive Eligibility (PE) assists Idaho residents not currently receiving medical assistance from the state or county and who do not have sufficient resources for private medical coverage. PE provides immediate, presumed coverage for qualified candidates. The maximum coverage period is 45 days while the participant applies for full coverage. A Medicaid enrolled hospital with a current Memorandum of Understanding (MOU) with the Department for PE may provide assistance to individuals completing and submitting applications for health coverage. Staff must receive Department approved training in PE before they can complete an application and make a PE determination. A record of this training must be maintained and available to the Department upon request. For more information on the training process, please contact your local DHW eligibility office or visit the Presumptive Eligibility Providers webpage.

PE is only available for the groups below when they meet all other eligibility criteria:

- Children up to age nineteen (19);
- Parents or caretaker relatives of eligible children;
- Pregnant women (See the Presumptive Eligibility for Pregnant Women (PW) section for restrictions);
- Adults age eighteen (18) to twenty-six (26) who were in foster care in any state on their 18th birthday; and
- Individuals twenty-one (21) through sixty-five (65) years of age requiring treatment for breast and cervical cancer diagnosed under the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) (See the Breast and Cervical Cancer (BCC) Program section for more information).

PE determinations are reimbursable using HCPC T1023 (Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter). Claims must include the participant's full name, MID number and date of birth.

6.7.1. References: Presumptive Eligibility (PE)

a) Federal Regulations

Options for Coverage of Special Groups under Presumptive Eligibility, 42 CFR 435 Subpart L (2001). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part435-subpartL.pdf.

"Presumptive Eligibility for Certain Breast or Cervical Cancer Patients." Social Security Act, Sec. 1920B (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1920B.htm.

"Presumptive Eligibility for Children." Social Security Act, Sec. 1920A (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1920A.htm.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(47) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

b) State Regulations

"Presumptive Eligibility for Children and Adults." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 545—546. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160301.pdf.

"Women Diagnosed with Breast or Cervical Cancer." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD),"* Sec. 802. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160305.pdf.

6.8. Breast and Cervical Cancer (BCC) Program

The Breast and Cervical Cancer (BCC) program allows the state to provide Medicaid benefits to uninsured participants, who are not otherwise eligible for Medicaid, when they need treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. In order to be eligible, an applicant must be initially screened and diagnosed through a local Women's Health Check Office (usually the district health department) participating in the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Medicaid coverage lasts for the duration of their cancer treatment, and ends when a participant's plan of care reflects a status of surveillance, follow-up or maintenance. Additionally, coverage ends if a participant's treatment relies on an unproven procedure in lieu of primary or adjuvant treatment methods.

The applicant can be presumed eligible as described in Presumptive Eligibility (PE) before a formal Medicaid determination. Although Medicaid resource limits do not apply, the applicant must:

- Have an income between 138% and 250% of the federal poverty level;
- Be diagnosed with breast or cervical cancer through the Women's Health Check Program;
- Be at least twenty-one (21) years old and under the age of sixty-five (65);
- Have no creditable health insurance (if insured, the plan does not cover the same type of cancer);
- Be an Idaho resident;
- Be a U.S. citizen or meet requirements for legal noncitizen;
- Not reside in an ineligible institution; and
- Not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole.

6.8.1. References: Breast and Cervical Cancer (BCC) Program

a) Federal Regulations

Breast and Cervical Cancer Mortality Prevention Act of 1990. H.R. 4790 (1990). Government Printing Office, https://www.govinfo.gov/app/details/STATUTE-104/STATUTE-104-Pg409.

Breast and Cervical Cancer Prevention Act of 2000. H.R. 4386 (2000). Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-106hr4386enr/pdf/BILLS-106hr4386enr.pdf.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Centers for Disease Control and Prevention. https://www.cdc.gov/breast-cervical-cancer-screening.

Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001. S. 1741 (2001). Government Printing Office, https://www.govinfo.gov/app/details/CREC-2001-12-19/CREC-2001-12-19-pt2-PgH10904.

b) State Regulations

"Woman Diagnosed with Breast or Cervical Cancer." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, & Disabled (AABD),"* Sec. 802. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160305.pdf.

6.9. Early & Periodic Screening, Diagnostic & Treatment

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit was designed to help ensure that all Medicaid-eligible participants under the age of twenty-one (21) receive preventive health care and early intervention services needed to maximize each participant's potential for healthy growth and development. The benefit allows participants to receive additional services not typically covered for adults and increase access to services with limitations on amount, duration, frequency and location (e.g., hourly and/or location limits on Personal Care Services). Services not typically allowed due to duplication, overlap and/or multiple services at the same time and/or date of service may be considered when the services are medically necessary. Idaho Medicaid does not have an expenditure cap or wait list for services covered under EPSDT, however, providers may have a waitlist for appointments or scheduling procedures.

Providers of EPSDT services have all of the same requirements as other providers of their type and specialty.

Services can only be covered under EPSDT when the service is:

- Determined to be medical in nature;
- Safe, effective and generally recognized as an accepted method of medical practice or treatment;
- Not determined to be experimental, investigational or cosmetic in nature;
- Under a category of service listed in 1905(a) of the Social Security Act;
- Medically necessary to correct or ameliorate (needed to sustain or support) an illness or a health condition;
- For an illness or health condition diagnosed by a physician, therapist, or other licensed practitioner operating within the scope of their licensure;
- Supported as medically necessary by the utilization of other services to treat the illness or health condition; and
- Represented by an appropriate diagnosis and CPT® or HCPCS code.

All claims for services approved under EPSDT must have the EP modifier on the claim line.

6.9.1. EPSDT and Waiver Services

Adult participants under the age of twenty-one (21) on a waiver have the same access to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services as a non-waiver participant. Some waiver services are covered under the State Plan for these participants with increased access under EPSDT as described in the service description on the waiver. Services are considered for coverage under both EPSDT and their waiver when authorized by the Department. Support type services are not covered under EPSDT as they fail to meet the requirement for a 1905(a) service. Any service provided under EPSDT will not impact a participant's budget or share of cost.

6.9.2. EPSDT Request Procedure

See the subsection below for the request procedure for services under State Plan, outside of State Plan, outpatient behavioral health and dental services. The parent, guardian or participant receives a Notice of Decision from the Department or their designee informing them whether the request was approved or denied. The Notice of Decision may also list alternative services that are available. If the request is denied, the parent, guardian or participant, if over eighteen (18), may appeal the decision. Instructions for appeals are on the Notice of Decision.

a) Request Procedure: Services Under State Plan

Services that require a prior authorization are considered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) during the prior authorization process. However, if a service does not usually require a prior authorization, a request can be submitted with a note on the coversheet requesting a review under EPSDT and the reason for the request (e.g., for not meeting criteria, over limitations, etc.). Prior authorization requests without a legitimate cause are returned unreviewed. Services covered under the State Plan should be requested through the service's normal request channel with all regularly required documentation (e.g., durable medical equipment through the Medical Care Unit). Requests are usually completed in fifteen (15) business days or less.

b) Request Procedure: Services Not in State Plan

When a participant requires services not covered under the State Plan, an EPSDT Request Form must be submitted to the Department for prior authorization. All services under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) must fall into a category of service listed in 1905(a) of the Social Security Act, be considered safe, effective, and meet acceptable standards of medical practice.

The EPSDT Request Form must be completed and signed by a competent participant over age eighteen (18) or by their parent or guardian. All requests must be submitted with supporting documentation and an order from a physician or non-physician practitioner which may require coordination with other providers to obtain. Services not under State Plan may take longer to review when:

- A new provider must be secured to perform the treatment;
- Additional documentation is needed to determine medical necessity;
- Providers fail to submit requested materials in a timely manner;
- Research is necessary to determine impacts to care; or
- The case is particularly complex and requires coordination between multiple agencies and providers to guarantee appropriate care.

For other questions, or general information, please email requests to EPSDTrequest@dhw.idaho.gov.

c) Request Procedure: Outpatient Behavioral Health

Community-based mental health services are provided under the Idaho Behavioral Health Plan by Magellan Healthcare Inc's provider network. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requests for community-based mental health services must be completed on the Magellan Healthcare Inc's Idaho EPSDT Form. For more information contact Magellan Healthcare, Inc. by calling 1-855-202-0973 or visit the Magellan website.

d) Request Procedure: Dental Services

Preventive and restorative dental services are provided under the Idaho Smiles plan by Managed Care of North America's (MCNA) provider network. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requests for dental services must be designated on the MCNA prior authorization form. For more information or the prior authorization form contact Idaho Smiles by calling 1-855-233-6262 or visit MCNA Dental's website.

6.9.3. References: Early & Periodic Screening, Diagnostic & Treatment

a) CMS Guidance

"Chapter 5 – Early and Periodic Screening." *The State Medicaid Manual,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

Early and Periodic Screening, Diagnostic, and Treatment. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment.

EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (2014). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf.

b) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(r) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

EPSDT and Other Required Benefits, 42 CFR 440.345 (2013). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-345.pdf.

State Plans for Medical Assistance, 42 U.S.C. Sec. 1396a (1984). Government Printing Office, https://www.govinfo.gov/content/pkg/USCODE-2017-title42/pdf/USCODE-2017-title42-chap7-subchapXIX-sec1396a.pdf.

c) State Regulations

"EPSDT Services: Coverage and Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 352. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 005.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"EPSDT Services: Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 351. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

6.10. Incarcerated Persons

Medicaid reimbursement is not available for inmates of government jails, tribal jails or prison facilities, unless the inmate, the medical institution and the services rendered meet all the provisions for reimbursement as provided within the "Reimbursement Policy Change for Individuals who are Incarcerated (Residents) of Correctional Facilities (Public Institutions) within Idaho".

Inmates of a public institution operated under the authority of the State of Idaho, or its political subdivision, may be eligible for select Medicaid benefits in a hospital, freestanding psychiatric hospital, or institution for mental disease enrolled with Idaho Medicaid and open to the public. Inmates must otherwise be eligible for Medicaid and have an inpatient status of a minimum of twenty-four (24) hours. Healthcare services provided to residents of Idaho eligible for Idaho Medicaid and who are residing in Public Institutions outside of the territorial boundaries of the State of Idaho are excluded from reimbursement under this policy and are the responsibility of the Public Institution with authority over that individual.

When all provisions are met, the applicant's incarceration status no longer disqualifies providers from receiving Medicaid reimbursement. Applicants without Medicaid may be evaluated for eligibility as if they were not incarcerated. Providers should come to an agreement with the Public Institution responsible for the individual to determine which entity will apply for Medicaid on the applicant's behalf when they meet these requirements.

Eligibility for incarcerated participants is available retroactively. Medicaid coverage begins the day the inmate is admitted into the medical institution and ends the day of discharge. However, incarcerated participants do not have the same benefits as other participants. Only these services are covered for inmates, and only when all other Idaho Medicaid requirements for the service are fulfilled:

- Inpatient room and board;
- Ancillary services directly related to the inpatient stay; and
- Emergency transportation services for transfers occurring after inpatient status has been determined and only when directly between hospitals, freestanding psychiatric hospitals and institutions for mental diseases providing continued inpatient treatment.

6.10.1. Incarcerated Persons: Third-Party Liability

In addition to all regular third-party liability requirements in the General Billing Instructions, Idaho Medicaid Provider Handbook, healthcare services related to the negligent acts of a third-party, including correctional institutions or law enforcement agencies, are their responsibility. Non-covered and excluded services are the responsibility of the Public Institution with custody of the inmate. This includes any service not mentioned in the section above and expenses related to law enforcement personnel or security.

6.10.2. References: Incarcerated Persons

a) CMS Guidance

"Patients in Custody Under a Penal Authority." *MLN Fact Sheet MLN 908084, February 2025,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/mln-publications-items/icn908084.

"Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity Exclusion." *MLN Matters MM6880, July 2016,* Centers for Medicare and Medicaid Services,

Department of Health and Human Services, https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2010-transmittals-items/cms1234566.

"Updated Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals." *Survey and Certification Letter# 16-21-ALL (2016).* Center for Medicaid and State Operations, Department of Health and Human Services, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-21.pdf.

"To Facilitate successful re-entry for individuals transitioning from incarceration to their communities (2016)." *State Health Official Letter# 016-007.* Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf.

b) Federal Regulations

Definitions relating to institutional status, 42 CFR 435.1010 (1986). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec435-1010.pdf.

"Definitions." Social Security Act, Sec. 1905(a)(29)(A) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

c) Idaho Medicaid Publications

"Medicaid Program Integrity Unit: Billing for Incarcerated Clients." *MedicAide Newsletter,* November 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf.

Reimbursement Policy Change for Individuals who are Incarcerated (Residents) of Correctional Facilities (Public Institutions) within Idaho, Information Release MA19-15 (12/18/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3368&dbid=0&repo=PUBLIC-DOCUMENTS&cr.

d) State Regulations

"Medical Exception for Inmates." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 281. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160301.pdf.

State Charitable Institutions, Idaho Code Title 66. Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title66.

6.11. Katie Beckett Medicaid Eligibility

Katie Beckett Medicaid, also known as Home Care for Certain Disabled Children (HCCDC), enables children under the age of nineteen (19) with special health care needs and/or disabilities to receive care at home instead of in an institution. Eligibility for Medicaid is based on the disabled child's income and assets excluding the income of their parents or guardians. The cost of care at home is compared to the cost of institutionalization when determining eligibility. Once approved for Medicaid, participants are eligible to receive all the benefits on the Enhanced Plan. In the event that a participant becomes institutionalized, the family should contact Self Reliance to update their eligibility.

Katie Beckett participants are subject to copayments and premiums as these are based on the household's income, which is above 133% of the federal poverty limit (FPL). Participants with a household income under 133% are eligible for other Medicaid eligibility.

6.11.1. References: Katie Beckett Medicaid Eligibility

a) Federal Regulations

Individuals Under Age 19 Who Would Be Eligible For Medicaid If They Were In A Medical Institution, 42 CFR 435.225 (1990). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2022-title42-vol4/pdf/CFR-2022-title42-vol4-sec435-225.pdf.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(e)(3) (2020). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

b) Idaho State Plan

"Optional Groups Other Than the Medically Needy." Idaho Medicaid State Plan, Attachment 2.2. Division of Medicaid, Department of Health and Welfare, State of Idaho.

c) State Regulations

"Certain Disabled Children." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, & Disabled (AABD),"* Sec. 785. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160305.pdf.

6.12. Managed Care Programs for Dual Eligible Participants

The Idaho Medicaid Plus (IMPlus) plan and Medicare Medicaid Coordinated Plan (MMCP) are managed care service delivery program options for dual eligible participants. The purpose of these plans is to integrate care for individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. These programs are designed to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports.

Participants continue to use their Medicaid ID (MID) numbers as established under the Participant Eligibility and Benefit Plan Coverage section. Participating Medicare Advantage Plans offering MMCP programs also issue a plan identification number specific to their company and a provide participants an identification card incorporating their Medicare and Medicaid benefits.

6.12.1. Idaho Medicaid Plus (IMPlus)

Participants who are 21 years old or older, enrolled in both Medicare Part A and Part B, eligible for full Medicaid, who reside in an IMPlus coverage area, who do not voluntarily enroll in MMCP, and who are not in an excluded or exempt population are required to enroll in IMPlus. Participants who do not make an active selection of a health plan to administer their IMPlus coverage are automatically enrolled in IMPlus and auto-assigned to a participating health plan.

6.12.2. Medicare-Medicaid Coordinated Plan (MMCP)

Participants who are 21 years old or older, enrolled in Medicare Part A and Part B, eligible for full Medicaid, and reside in an MMCP coverage area are eligible to voluntarily enroll in MMCP through an MMCP health plan.

6.12.3. Billing Procedures for Managed Care Dual Plan Participants

Services with Medicare coverage limits must be billed to the health plan in which the participant is enrolled using their health plan-specific identification number and their Medicare identification number if enrolled under IMPlus:

- Hospital services;
- Medical services;
- Prescription drug services; and
- Nursing Home (NH).

Medicaid only services must be billed to the health plan in which the participant is enrolled using their health plan-specific identification number:

- Behavioral health services;
- Aged & Disabled (A&D) Waiver Services;
- Personal Care Services (PCS);
- Community-Based Rehabilitation Services; and
- Transition Management and Transition Services.

Providers may bill fee-for-service Medicaid for services listed below using the Medicaid ID (MID) number assigned to the participant for either managed care program.

Adult Developmental Disabilities (DD) Waiver:

- Non-Medical Transportation (NMT) provided by an Agency;
- Non-Medical Transportation (NMT) provided by an Individual;
- Non-Medical Transportation (NMT) provided through a Bus Pass;
- Specialized Medical Equipment and Supplies;

- Residential Habilitation including:
    - Certified Family Home;
    - Individual Supported Living;
    - Group Supported Living;
    - Daily Supported Living Services Intense Support;
    - Daily Supported Living Services Intense Support School Based, School Days;
    - Daily Supported Living Services High Support; and
    - Daily Supported Living Services High Support School Based, School Days;
- Behavioral Consultation/Crisis Management by a Qualified Intellectual Disabilities Professional (QIDP)/Clinician;
- Behavioral Consultation/Crisis Management by a Psychiatrist;
- Behavioral Consultation/Crisis Management Emergency Intervention Technician;
- Supported Employment;
- Adult Day Health;
- Chore Services (Skilled);
- Personal Emergency Response System (PERS) Installation and first month's rent;
- Personal Emergency Response System (PERS) monthly rent;
- Environmental Accessibility Adaptations;
- Home Delivered Meals;
- Skilled Nursing Services, Independent RN;
- Skilled Nursing Services, Agency LPN or RN;
- Nursing Oversight Services of LPN;
- Nursing Oversight Services of Agency RN;
- Nursing Oversight Services of Independent RN;
- Respite Care hourly;
- Respite Care Daily; and
- Transition Services.

Adult DD State Plan HCBS:

- Developmental Therapy Evaluation;
- Home/Community Individual and/or Group Developmental Therapy for Adults;
- Center Based Individual and/or Group Developmental Therapy for Adults;
- Community Crisis Supports;
- Interpretive Services, oral (to assist Enrollees to receive DD services); and
- Interpretive Services, sign language (to assist Enrollees to receive DD services).

Consumer Directed Services:

- Financial Management Services (FMS) provided by a Fiscal Employer Agent (FEA); and
- Community Support Services (to include Support Broker services).

6.13. Medicare Coinsurance & Deductible

These are participants with eligibility under Qualified Medicare Beneficiary (QMB)/Medicare Coinsurance. This coverage pays for the participant's Medicare Part B Premium, and any coinsurance and deductible amounts for Medicare-covered services. These participants are not eligible for Medicaid benefits, only Medicare coverage. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on third-party liability and Medicaid participants with Medicare.

6.13.1. References: Medicare Coinsurance & Deductible

a) Idaho Medicaid Publications

"Clarification on Dual Eligible Participants." *MedicAide Newsletter,* April 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf.

6.14. Medicare Part B Premium Coverage

When the participant only has Part B Premium Coverage, they have eligibility under Specified Low-Income Beneficiary (SLMB)/Part B Premium. This coverage pays for the participant's Medicare Part B Premium only. These participants are not eligible to receive Medicaid benefits and should be considered a Medicare only member. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on third-party liability and Medicaid participants with Medicare.

6.14.1. References: Medicare Part B Premium Coverage

a) Idaho Medicaid Publications

"Clarification on Dual Eligible Participants." *MedicAide Newsletter,* April 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf.

6.15. Medicare Part B Premium Coverage/Enhanced Coverage

These are participants with dual eligibility under Medicaid and Medicare. The Department pays their Medicare premium up to the lowest allowed amount for coinsurance and deductible. These participants are also eligible to receive Medicaid benefits for services that are not covered by Medicare. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on third-party liability and Medicaid participants with Medicare.

6.15.1. References: Medicare Part B Premium Coverage/Enhanced Coverage

a) Idaho Medicaid Publications

"Clarification on Dual Eligible Participants." *MedicAide Newsletter,* April 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf.

6.16. Medicare Savings Program

The Department has agreements with the Social Security Administration and Centers for Medicare and Medicaid Services (CMS), which allows the state to enroll people in the Premium Hospital Insurance Program (also referred to as Premium HI or Medicare Part A) and Supplementary Medical Insurance (also referred to as SMI or Medicare Part B). The agreements allow Medicaid participants entitled to Medicare to have their Part A and/or Part B Medicare premiums paid by Medicaid. Participants do not have to be 65 years old or older to be eligible for Medicare. See the subsections below for the different kinds of Part A and Part B Medicare Savings Programs.

See the "Qualified Medicare Beneficiaries (QMB) Medicare/Medicaid Billing Information" subsection of the General Billing Instructions, Idaho Medicaid Provider Handbook, for more information.

6.16.1. Part A Medicare Savings Programs

There are two types of Part A Medicare Savings Programs:

- Regular Type Part A; and
- Qualified Disabled Working Individual (QDWI) Part A

The Regular Type Part A Medicare Savings Program is for individuals not entitled to premium-free Medicare Part A benefits. These individuals must apply for Medicare with the Social Security Administration and be determined eligible for self-pay type Medicare. These individuals have a Medicare claim number with a Beneficiary Identification Code (BIC) of *M*. This code is found at the end of the Medicare claim number.

The Qualified Disabled Working Individual (QDWI) Part A Medicare Savings Program is for individuals that have lost Medicare Part A (HI) entitlement solely because of work and are entitled to enroll in Part A Medicare under §1818A of the Social Security Act. The Qualified Disabled Working Individual Program does not include state payment of Part B Medicare premiums.

6.16.2. Part B Medicare Savings Programs

The various types of Part B Medicare Savings Programs are listed in the table below.

Part B Medicare Savings Program				
Part B Medicare Savings Program	**Individual is entitled to Medicare** **Medicaid Pays the Medicare Premium**	**Individual is entitled to Medicaid** **Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.**	**Medicaid Prior Authorization Rules Apply for Medicare Covered Services**	**Medicaid Claim Editing Applies**
Qualified Medicare Beneficiary (QMB-Only)	Y	**N**	**N**	**N**
Qualified Medicare Beneficiary with Medicaid QMB + (QMB Plus)	Y	Y	**N**	Y

Part B Medicare Savings Program				
Part B Medicare Savings Program	**Individual is entitled to Medicare** **Medicaid Pays the Medicare Premium**	**Individual is entitled to Medicaid** **Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.**	**Medicaid Prior Authorization Rules Apply for Medicare Covered Services**	**Medicaid Claim Editing Applies**
Specified Low Income Medicare Beneficiary (SLMB)	Y	**N**	**N**	**N**
Specified Low Income Medicare Beneficiary with Medicaid eligibility SLMB + (SLMB Plus)	Y	Y	**N**	Y
Medicaid (with deemed Cash Assistance Recipient)	Y	Y	**N**	Y
Medicaid – Non-Cash (also known as Medical Assistance Only) (MAO)	Y	Y	**N**	Y
Qualified Individual 1 (QI1)	Y	**N**	**N**	**N**

6.16.3. Dually Eligible Medicare Beneficiaries

Individuals that are enrolled in Medicare, and eligible for Medicaid benefits, are considered dually eligible participants. Dually eligible participants receive Medicare Part A and/or Part B premium coverage, and coinsurance and deductible reimbursement consideration for Medicare covered services. Pharmacy items or other services not covered by the dually eligible participant's Medicare benefits may be covered under the participant's Medicaid benefits.

6.16.4. Medicare Part D

Under the Medicare Modernization Act, dually eligible individuals no longer receive their drug coverage from Medicaid and instead select or are automatically enrolled into private Medicare prescription drug plans. Medicaid may still cover certain essential drugs excluded by law from the Medicare Part D, Prescription Drug Program. Medicare must be billed prior to submitting drug claims to Medicaid. If the Medicare Explanation of Benefits (EOB) indicates that the requested medication is one of the medications not covered by law, then Medicaid may reimburse.

6.16.5. References: Medicare Savings Program

a) Federal Regulations

Medicare Catastrophic Coverage Act of 1988. H.R. 2470 (1988). Government Printing Office, https://www.congress.gov/bill/100th-congress/house-bill/2470.

"State Agreements for Coverage of Eligible Individuals Who are Receiving Money Payments Under Public Assistance Programs or are Eligible for Medical Assistance." Social Security Act,

Sec. 1843 (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1843.htm.

6.17. Otherwise Ineligible Non-citizens

Individuals who do not meet the citizenship or qualified non-citizen requirements may be eligible for medical services necessary to treat an emergency medical condition. An emergency medical condition exists when the condition could reasonably be expected to seriously harm the person's health, cause serious impairment to bodily functions, or cause serious dysfunction to any body part or organ, without immediate medical attention. Childbirth qualifies as an emergency, but ante and postpartum services do not. Medicaid eligibility for otherwise ineligible non-citizens (OINC) begins no earlier than the date the participant experiences the medical emergency and ends the date the emergency condition stops. The Quality Improvement Organization, Telligen, makes determinations on the appropriate length of stay during the eligibility review process.

6.17.1. Applying for Eligibility

The general application used to apply for Medicaid is also used for OINC applicants. Applications should be submitted after the emergency condition has ended. Hospitals may attach medical records with applications if they are helping the applicant apply for assistance. Completed applications are submitted to:

Self-Reliance Program
PO Box 83720
Boise, ID 83720-0026

Phone: 1 (877) 456-1233
Fax: 1 (866) 434-8278

The Quality Improvement Organization, Telligen, Inc., determines whether the services are necessary for the treatment of an emergency medical condition or qualify as services for pregnant women.

6.17.2. Prior Authorizations: Otherwise Ineligible Non-Citizens

Services requiring a prior authorization should be submitted to the designated reviewer for that service after the participant is approved for eligibility. Providers should note on the prior authorization request that a retrospective review is being requested for a participant with retroactive eligibility. A prior authorization for length of stay is not necessary.

6.17.3. References: Otherwise Ineligible Non-Citizens

a) Idaho Medicaid Publications

"Non-Citizen Emergency Medical." *MedicAide Newsletter,* June 2009.

b) Federal Regulations

Limited Services Available to Certain Aliens, 42 CFR 440.255 (1991). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-sec440-255.pdf.

c) State Regulations

"Emergency Medical Condition." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 250. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160301.pdf.

"The U.S. Citizenship and Qualified Non-Citizen Requirements." *IDAPA 16.03.01, "Health Care Assistance for Families & Children,"* Sec. 221.14. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160301.pdf.

"Ineligible Non-Citizen with Emergency Medical Condition." *IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind & Disabled (AABD),"* Sec. 801. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160305.pdf.

"Non-Citizen." *IDAPA 16.03.01, "Health Care Assistance for Families & Children,"* Sec. 11.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160301.pdf.

6.18. The Pregnant Women Program

The Pregnant Women (PW) program was developed to provide medical assistance to encourage women to seek prenatal care early in a pregnancy and preserve the health of both mother and infant. The program assists Idaho residents with a verified pregnancy not currently receiving medical assistance from the state or county, and without sufficient resources for private medical coverage. Women found eligible under the PW program have the same coverage as participants on the Medicaid Basic Plan. Coverage through the program continues for twelve (12) months after the end of the pregnancy, and extends until the last day of the twelfth (12th) month. Women on the PW program are evaluated for other Medicaid eligibility at the end of their coverage.

6.18.1. Presumptive Eligibility for Pregnant Women

Presumptive eligibility (PE) for pregnant women is designed to provide participants prenatal care between being diagnosed pregnant and receiving an eligibility determination. PE for pregnant women only covers outpatient prenatal care and not deliveries, miscarriages, or abortions. Medical coverage for the PW Program during the PE period is restricted to ambulatory outpatient, pregnancy-related services only. Pregnancy-related services may be rendered by any qualified Medicaid provider.

Routine prenatal services are covered, as well as some additional services such as nutrition counseling, risk-reduction follow-up, and social service counseling. Providers are not required to bill another insurance resource, if it exists, before billing Medicaid for prenatal services during the PE period.

The PE Program does not cover PW inpatient services. Medicaid does not pay for any type of abortion for women on the PE Program. Also, women with PE are not covered for any delivery services. Services not covered under Medicaid are the participant's responsibility. If the woman with PE has applied for the PW Program or any other Medicaid program, and is determined eligible, hospital inpatient services may be covered.

6.18.2. References: The Pregnant Women Program

a) Federal Regulations

Medicare Catastrophic Coverage Act of 1988. H.R. 2470 (1988). Government Printing Office, https://www.congress.gov/bill/100th-congress/house-bill/2470.

"Presumptive Eligibility for Pregnant Women." Social Security Act, Sec. 1920 (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1920.htm.

Required Services for the Categorically Needy, 42 CFR 440.210 (1995). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-210.pdf.

b) State Regulations

"Presumptive Eligibility for Children and Adults." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 545. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160301.pdf.

State Plan Amendment – Postpartum Medicaid Coverage, Idaho Code 56-270 (2024). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-270.

6.19. Refugee Medical Assistance Program

The Refugee Medical Assistance Program provides eligibility to certain refugees who are not otherwise eligible for Medicaid or CHIP. Coverage is limited to eight months, beginning when the refugee arrives in the United States. Children born to the refugee during that time period are also eligible for the Refugee Medical Assistance Program, but only as long as their parent's coverage remains in effect. At the conclusion of the program's coverage, participants will be evaluated for coverage under other eligibility programs.

In order to qualify for Medicaid eligibility through the Refugee Medical Assistance Program, the applicant must:

- Meet the federal definition of refugee for the purposes of the program;
- Not be otherwise eligible for Medicaid or CHIP; and
- Have an income under 150% of the federal poverty level (FPL).

Refugees whose income exceeds 150% of the FPL may still be eligible under a special "spend down" consideration if the remainder of their income after medical expenses are deducted drops their income below 150% of the FPL.

Coverage under the Refugee Medical Assistance Program is contingent on Idaho's receipt of federal funding. In the event that funds are not received, this program will be suspended without advance notice.

6.19.1. References: Refugee Medical Assistance Program

a) Federal Regulations

Cuban/Haitian Entrant Program, 45 CFR 401 (1982). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title45-vol3/pdf/CFR-2019-title45-vol3-part401.pdf.

Office of Refugee Resettlement; establishment; appointment of Director; functions. 8 U.S.C. 1521 (1979). Government Printing Office, https://www.govinfo.gov/content/pkg/USCODE-2018-title8/pdf/USCODE-2018-title8-chap12-subchapIV-sec1521.pdf.

Refugee Medical Assistance, 45 CFR 400 Subpart G (1989). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title45-vol3/pdf/CFR-2019-title45-vol3-part400-subpartG.pdf.

b) State Regulations

IDAPA 16.03.06, "Refugee Medical Assistance." Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160306.pdf.

6.20. Youth Empowerment Services (YES)

The Medicaid Youth Empowerment Services (YES) Program provides a doorway to Medicaid eligibility for children under the age of eighteen (18) with a serious emotional disturbance (SED). Once approved for Medicaid, participants are eligible for all benefits on the Enhanced Plan, plus respite care through the Idaho Behavioral Health Plan (IBHP) and person-centered service planning. The participant must complete an assessment and update the person-centered service plan at least every 12 months, and utilize Medicaid-paid respite services through the Idaho Behavioral Health Plan to maintain eligibility under the program.

In order to qualify for Medicaid eligibility through the Medicaid YES Program, the applicant must:

- Have a verified SED and functional impairment;
- Have an income under 300% of the federal poverty level (FPL);
- Be under the age of eighteen (18);
- Be an Idaho resident;
- Be a U.S. citizen or meet requirements for legal noncitizen;
- Cooperate with obtaining a medical support order for a non-custodial parent unless good cause can be established;
- Not reside in an ineligible institution; and
- Not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole.

A serious emotional disturbance is defined as a diagnosable mental health, emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability and which causes a functional impairment. The diagnosis must be made in alignment with the Diagnostic and Statistical Manual of Mental Disorders (DSM). A disability caused by the diagnosis is considered serious if it causes a substantial impairment of thought, perception, affect or behavior in family, school or community settings, and requires sustained treatment interventions. A substance use disorder does not, by itself, constitute a serious emotional disturbance, although it may coexist with serious emotional disturbance.

The SED must be verified by Medicaid's Independent Assessment contractor (Liberty Healthcare) using a Comprehensive Diagnostic Assessment (CDA) and the Child and Adolescent Needs and Strengths (CANS) functional assessment tool. Liberty Healthcare completes the CDA and CANS in the applicant's home and contact them within one business day with the results and next steps. These assessments are provided at no cost to the family or applicant seeking eligibility. A CDA completed by another provider may be used if it was completed in the last six (6) months.
Providers can direct potential applicants to contact Liberty Healthcare at 1 (877) 305-3469 for the free assessment. Other services may be available for children with an SED who do not meet the additional requirements for Medicaid eligibility; e.g., family income exceeding 300% FPL. See the Youth Empowerment Services website or contact Magellan Healthcare for more information on getting services for youth without Medicaid.

6.20.1. References: Youth Empowerment Services

a) Idaho Medicaid Publications

"New Independent Assessment Contractor for Children's Mental Health Services." *MedicAide Newsletter,* March 2018,
https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf.

"YES Project Update for Healthy Connections and the September MedicAide Issue." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

b) State Regulations

Children's Mental Health Services: Definitions, Idaho Code 16-2403 (2019). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title16/t16ch24/sect16-2403.

Eligibility for Medical Assistance, Idaho Code 56-254 (2017). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-254.

Idaho Medicaid Public Schedule of Premiums and Cost-sharing Requirements. Idaho Department of Health and Welfare. https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2085&dbid=0&repo=PUBLIC-DOCUMENTS&cr.

"Youth Empowerment Services (YES) HCBS State Plan Option." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 640 – 649. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Youth Empowerment Services (YES) Program Children." *IDAPA 16.03.01, "Health Care Assistance for Families & Children,"* Sec. 540. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160301.pdf.

c) Settlement Agreement

Idaho Implementation Plan (2016). Jeff D., et al. v. Clement Leroy Otter, et al., https://yes.idaho.gov/wp-content/uploads/2021/04/YESImplementationPlan.pdf.

Jeff D., et al. v. Clement Leroy Otter, et al. (2015). Case No. 4:80-CV-04091-BLW, https://yes.idaho.gov/wp-content/uploads/2021/04/JeffDOfficialAgreement.pdf.

7. Healthy Connections (HC)

Healthy Connections (HC) is the Idaho Medicaid primary care program in which a primary care provider or team provides comprehensive and continuous medical care to a participant with the goal of improving health outcomes. Our mission is to ensure Medicaid participants receive the care they need, when they need it, and in the appropriate setting. The Healthy Connections program is structured to incentivize HC providers to transform to the Patient Centered Medical Home (PCMH) model of care whereby a participant's treatment is coordinated through their primary care provider and their team, which can include organizations, hospitals or other entities.

The goals of HC are to:

- Ensure access to healthcare;
- Improve the quality of healthcare and overall well-being of Medicaid participants;
- Emphasize care coordination and continuity of care;
- Encourage participants to be involved in their healthcare decisions; and
- Achieve cost efficiencies for the Idaho Medicaid Program.

Medicaid participant enrollment into HC is required in the majority of counties statewide. Individuals qualifying for Idaho Medicaid will receive correspondence requesting they identify their current Primary Care Provider (PCP) or choose an HC clinic.

7.1. Healthy Connections Provider Enrollment

Idaho Medicaid primary care providers participate in Healthy Connections by signing a Coordinated Care Provider Agreement in addition to the Idaho Medicaid Provider Agreement. Coordinated Care Provider Agreements are available from the Regional Healthy Connections Representatives. Addresses and telephone numbers for the regional HC offices are listed in the Directory, Idaho Medicaid Provider Handbook, and at the Manage my Medicaid with Healthy Connections website.

What is a primary care provider? An MD, DO, PA, Nurse Practitioner, etc., who participates in the Healthy Connections program with a contracted organization to coordinate and monitor primary care services.

What are primary care services? Services including preventive services, diagnosis and treatment of acute injury and sickness, and management of long-term conditions.

In the Healthy Connections (HC) Program, Primary Care Providers qualify for tiers and are incentivized to implement a Patient Centered Medical Home (PCMH) model of care and improve participant outcomes. HC service locations offering enhanced participant care and PCMH characteristics may qualify for higher tier placement. Upon approval of tier placement, the HC service location is issued an HC Coordinated Care Agreement Addendum which outlines requirements to maintain tier status and monthly primary care case management fee.

Providers are required to keep their record current and notify Gainwell Technologies of any changes in their record to ensure accurate participant enrollment in Healthy Connections, including:

- Enroll all rendering PCPs and each HC service location in the MMIS system for the purposes of assigning participants at the location where they receive primary care services.
- Keep all of the provider enrollment information current in the MMIS system by completing any maintenance items within 28 days of the change as required in the Idaho Medicaid Provider Agreement.
- Updated provider record information will be acted on once submitted and approved through the provider enrollment application in HealthPAS.

The HC Service Location information (i.e. name and demographics) entered in the Gainwell Technology system will appear on the following:

- HC Network Directory (HC website)
- HC Rosters (Gainwell system)
    - Online dynamic roster (PCP Roster)
    - HC monthly Case Management report (Gainwell system - file exchange)
- Verifying participant eligibility (Gainwell system)
    - Includes clinic name and office hours
- HC Referral lookup (Gainwell system)
- HC enrollment participant letters
    - Clinic name and demographics

TERMING HEALTHY CONNECTIONS (HC) CONTRACT FOR VALUE CARE ORGANIZATION (VCO) COMPLIANCE

Existing HC Clinics/Organizations that have their HC contract termed, or New HC Clinics/Organizations that do not affiliate with a VCO will be restricted from re-contracting with the HC program until the Clinic/Organization's contract with a VCO is in effect for the next performance year.

7.1.1. Healthy Connections Primary Care Provider Network Directory

A directory of Healthy Connections (HC) clinics is made available on the HC webpage. Changes to the network directory will be posted to the webpage daily. Failure to keep the clinic's records up-to-date in the Gainwell Technologies system could result in inaccurate information populating in the HC Network Directory.

Some common changes or provider record updates submitted to Gainwell Technologies could include:

- Change of ownership;
- Change of address or phone number;
- Adding or closing a service location;
- Office hours;
- Panel Limitations (see the HC Clinic Panel Limits sections)
- Adding or removing rendering providers; and
- Provider contact information.

7.1.2. Healthy Connections Clinic Panel Limit Entry

The HC Primary Care Providers are required to keep the information in the following table entered in the Provider Enrollment Application on Health Pas.

HealthPas Portal Question/Entry	Explanation
This practice will accept patients both new to your practice and established patients new to Medicaid. Is your practice open to new Medicaid patients?	If answered **YES**, your practice will accept any patient who is ***new*** to your practice, as well as established patients new to Idaho Medicaid. HC Network directory will show "Accepting New Medicaid."
Is your practice open to new Medicaid patients? *If answered no, the following 2 questions appear:* Is your clinic limited to existing patients only? Does this clinic accept family members of existing patients?	If answered **NO**, your practice will NOT accept any ***new*** Idaho Medicaid patients. Any patient requesting enrollment to your clinic will be directed to contact you for approval. You will then need to contact Healthy Connections giving your approval. HC Network directory will show "NOT Accepting New Medicaid."
Does this clinic provide OB services? Is this clinic limited to Pregnant Women?	**IMPORTANT CHANGE:** If YES to "does this clinic provide OB services" your practice provides OB care as well as Primary Care. Answer NO to the "is this clinic limited to Pregnant Women" Yes is no longer allowed per policy.
Will this clinic allow HC staff to enroll and/or assign patients who have not identified a PCP?	If **YES**, HC will assign Idaho Medicaid patients who have not notified HC of their choice and may not be a current patient with your clinic. (mandatory assignments)
After Hours Coverage (must choose one)	How do you provide After Hours Coverage? • Answering machine directs patients to call the covering medical professional. • Answering service contacts the covering medical professional. • Phones forwarded to on-call medical professional • After hours nurse.

HealthPas Portal Question/Entry	Explanation
	• Alternate coverage arrangement (must verify with HC rep if meets Coordinated Care Agreement).
Clinic Contact Information	The following clinic contacts (if applicable) (Name, email and Phone Number): Office Manager; Biller; and Credentialer.
PCMH Information	PCMH Contact; PCMH Physician Champion; PCMH Care Coordinator; and EMR Name.
PCMH Accreditation	If you are quality certified, indicate the recognition you have achieved, effective date, and name of the Electronic Health Record you use: NCQA; AAAHC; Joint Commission; URAC; or Other.
Office Hours	Hours you are open to see patients for primary care. May enter multiple time segments for one day (example – closed for lunch).
HC rendering primary care providers	HC Organizations are required to keep the status of PCP information current in HealthPAS to populate on HC Network Directory. Checking the "PCP" box on each service location the rendering provider is affiliated with will result with that rendering provider showing as a PCP at that location on the HC Network Directory.

INFORMATION TO REPORT TO HC REPRESENTATIVE	
Information Needed	**Explanation**
Age limitations/restrictions	Any limitations you may have for age. Example: under a certain age/over a certain age.
Type of Practice	The type of practice you are. Example: Family Practice, RHC, FQHC, Indian Health, Pediatrics, etc.
Clinic Contacts	Additional contacts needed for Healthy Connections: Referral coordinator, Other office contacts.

7.1.3. Healthy Connections Clinic Panel Limit Guidelines

The following are the guidelines to determine some of the panel limitations:

- **Accepting New Medicaid**: Clinic must have the capacity for members to establish care within two (2) months of enrollment. If clinic does not have the capacity for members to establish within this timeframe, clinic must set their panel to Not Accepting New Medicaid.
    - If a participant has not established care, and has an urgent medical need, clinic is required to provide "timely access to care" either by seeing the participant

or providing a one-time referral and working with participant to schedule an appointment.

- **Accepting Mandatory Assignment:** The assignments will occur when the participant doesn't choose a PCP, and they are within the panel limits (i.e. age limits, etc.). The clinic requirements for assignments are as follows:
    - When a participant is assigned to clinic, the clinic is required to allow assigned participant(s) to establish care, even if the panel subsequently has closed to accepting mandatory assignments; and
    - If a participant has not established care, and has an urgent medical need, clinic is required to provide "timely access to care" either by seeing the participant or providing a one-time referral and work with patient to schedule an appointment.

7.1.4. Healthy Connections Tier Requirements

The following are the requirements for each of the three Healthy Connections tiers. If applying or advancing to Tier II or Tier III, please see those applications on our website for more specifics about the following requirements.

TIER I – HEALTHY CONNECTIONS

In order to qualify for Tier I of the Healthy Connections program, the provider must:

- Provide primary care services;
- Monitor and coordinate the participant's care;
- Provide timely referrals for medically necessary services;
- Provide twenty-four (24) hour, 7-days a week availability of information, referral and treatment for emergency medical conditions; and
- Participate as a partner in a Healthy Connections Value Care Organization (VCO):
    - This can be accomplished by contracting directly with the Department as a Healthy Connections VCO or partnering with a Healthy Connections VCO.
    - Healthy Connections Tribal, IHS, state-owned or Public Health District clinics are exempt from this requirement.

TIER II - HEALTHY CONNECTIONS CARE MANAGEMENT

In addition to Tier I requirements listed above, the HC clinic must provide the following:

- Clinic must meet a minimum of 30 hours of patient access to care.
- Enhanced patient access to care – must meet one of the following:
    - 46 hours of access to care for patients;
    - Nearby Service Location with extended hours and shared EMR within same organization;
    - Patient portal to enhance access to care;
    - Virtual Care - remote healthcare services; or
    - Other as approved by the Department.
- Demonstrate enrollee outreach and education activities to establish and maintain the patient/provider relationship. At a minimum to include:
    - Outreach to non-engaged enrollees; and
    - Provide patient/family education and self-management support.
- Demonstrate a continuous quality improvement program directed at increased performance in quality measures.
- Demonstrate dedicated care coordinator staff or equivalent support for coordination of patient care.
- Demonstrate a referral tracking and follow-up system is in place for purposes of care coordination.

- Demonstrate interoperability by timely exchange of patient-level data with local, regional or state-wide healthcare systems to support improved coordination of patient care.

TIER III - HEALTHY CONNECTIONS MEDICAL HOME
In addition to the requirements in Tiers I & II, the HC clinic must maintain PCMH recognition, including NCQA Patient Centered Medical Home recognition, Utilization Review Accreditation Commission (URAC), Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC) or other Patient Centered Medical Home national recognition.

HC Clinic Tier Movement Process

- HC clinics must complete a Tier Application for the higher tier they wish to apply for. The tier application can be found at the Manage my Medicaid with Healthy Connections website.
- Completed tier applications, along with required documentation, should be faxed to the Healthy Connections Consolidated Unit at 1 (888) 532-0014, or scanned and e-mailed to HCCR7@dhw.idaho.gov.
- Tier applications must be received with all required documentation **and approved by the 15th of the month** for the change and case management payment to be effective the first of the following month.
- HC clinics will receive official notice of action taken on tier applications.
- Applications will be processed in the order received.

7.1.5. Healthy Connections Coordinated Care Agreement and Tier Compliance by Tier

In addition to the Idaho Medicaid Provider Agreement, every Healthy Connections clinic/organization, at the Tax ID level, is required to sign an HC Coordinated Care Agreement. Providers may be subject to sanctions for being deemed out of compliance as per the HC Coordinated Care Agreement.

HC Staff will conduct periodic reviews of HC organization's ability to maintain compliance with the HC Coordinated Care Agreement and specific tier requirements. Clinics will be responsible for providing proof of meeting Tier requirements at a minimum annually (unless otherwise specified). As part of this review, HC Staff may ask for documentation that provides proof of meeting specific requirements. Compliance specific information including, but not limited to, the following table:

HC Tier Compliance Process				
Tier	**Requirement**	**Compliance Verification**	**Frequency**	**Compliance Level**
I, II & III	Provide 24 hour, 7-days a week availability of information, referral and treatment for emergency medical conditions	After hours phone call to service location resulting in reaching an after-hours medical professional	Annually	Service Location
I, II & III	Affiliate with a Healthy Connections VCO	Verified by the Department	Annually	Organization Tax ID
II & III*	Outreach to non-engaged patients done annually	Proof of communication to non-engaged patients, randomly selected by the Department	Annually, at a minimum	Organization

HC Tier Compliance Process				
Tier	**Requirement**	**Compliance Verification**	**Frequency**	**Compliance Level**
II & III*	Patient/family education and self-management support for chronic conditions done annually	Examples of educational material given to patients	Annually	Organization
II & III*	Quality improvement activities meant to improve 1 or more quality measures.	Written description of current quality measure improvement activities or PDSA including outcome	Bi-annually	Service Location or Organization
II & III*	Referral tracking and follow-up system for care coordination	Screen shot of current log or electronic system used that demonstrates: Tracking referral reports, flag and follow up on over-due reports Flag abnormal results and notification of family of all results and Follow up of patient accessing urgent care, ED and hospitalizations	Annually	Service Location or Organization
II & III	Clinic must provide a minimum of 30 hours of patient access to primary care each week	Service location posted hours must reflect accurately in on-line provider record	Annually, at a minimum.	Service Location
II & III	Enhanced access to care met by ONE of the following: 46 hours of access to primary care. Nearby service location with expanded patient access and shared EMR Patient portal with required features. Virtual Care Other as approved by Department.	Department will verify enhanced access met as indicated on tier application and may require documentation of any updates	Annually, at a minimum	Service Location
II & III	Designated Care Coordinator on staff OR Equivalent staff providing coordination of patient care	Department will verify care coordination met as indicated on tier application and may require documentation of any updates	Annually	Service Location or Organization
II & III	Demonstrate interoperability through the timely exchange of patient-level data with local, regional or state-wide healthcare systems to support improved coordination of patient care.	Department will verify interoperability met as indicated on tier application and may require documentation of any updates	Annually	Organization
III	National PCMH recognition	Copy of certification	Annually	Service Location

*Tier III clinics will potentially meet these requirements depending on their PCMH national recognition obtained.

7.1.6. Healthy Connections Corrective Action Process (CAP)

When Idaho Medicaid becomes aware that a clinic is out of compliance for one of the Tier requirements, the corrective action process will begin. If compliance is not met within the timeframe outlined below, the outcome could include one of the following: Regression of tier, Case management suspension, or Termination as a Healthy Connections provider.

Corrective action steps:
Step One: Clinic will be contacted verbally to discuss the non-compliance and possible solution. Clinic will be given fifteen (15) business days to correct the non-compliance issue.

Step Two: At day sixteen (16), if compliance is not met, a formal corrective action letter will be emailed to the clinic contact that has been established at first contact. Clinic will have an additional fifteen (15) business days to correct the non-compliance issue.

Step Three: At day thirty-one (31), if compliance is not met, a second formal corrective action letter will be emailed and mailed certified, return receipt. Clinic will have an additional fifteen (15) days to correct the non-compliance issue.

Step Four: After the forty-five (45) days have expired:

- If non-compliance is for 24/7 requirement, clinic will be termed as a Healthy Connections provider, and a letter will be mailed, certified, return receipt.
- If non-compliance is for other Tier requirements, clinic will be regressed to appropriate tier (example Tier 3 to Tier 2). A formal letter will be mailed, certified, return receipt.

If regression occurs, clinic can apply for higher Tier once compliance has been met.

7.1.7. Healthy Connections Case Management Payment

In addition to payment for services rendered, Healthy Connections (HC) clinics are paid a monthly case management fee. The monthly case management fee is paid for every participant enrolled with the HC clinic on the first day of each month. The case management payment is based on the tier level of the HC clinic as of the first of the month.

The case management payment is generally processed on the Tuesday of the first full week of the month. The monthly Healthy Connections roster reports are then available following the processing of the case management payment.

HC clinics qualify for one of the following three tiers of reimbursement for all enrolled participants:

Medicaid Plan	Healthy Connections Tier I	Healthy Connections Care Management Tier II	Healthy Connections Medical Home Tier III
All Enrolled participants	$3.00	$7.00	$9.50

7.1.8. Healthy Connections Participant Rosters

The following two Primary Care rosters are available to PCPs.

- An online, dynamic Primary Care Roster is available on the Gainwell Technologies Medicaid website through your Trading Partner Account and is called the PCP Roster. This is a list of currently enrolled HC participants and the PCP is able to verify eligibility or issue a referral from this roster. This roster can be exported to either Excel format or in PDF form. The contact information on the exportable report can be used to contact participants and encourage them to be engaged in their healthcare.
    - To further support HC providers in coordinating their patient care, the following are some of the fields included on the exportable Excel or PDF list of participants:
        - Participant name;
        - Phone Number;
        - Address;
        - Head of Household; and
        - Enrollment Indicator (Mandatory or Voluntary enrollment).
- The Monthly Healthy Connections Roster report is a list of participants enrolled to a Healthy Connections service location effective the first day of the month, and includes case management payment information. The report is divided in to four sections: new enrollees, ongoing enrollees, lost eligibility, and dis-enrollees. This serves as the HC Case Management Payment report. This monthly roster is uploaded to the Organization's secure portal under the File Exchange 'Reports' section and is available in both PDF and Excel formats.

An announcement will be posted to the Gainwell Technologies Health PAS website when the rosters become available.

7.2. Participant Enrollment

Medicaid providers should always verify participant eligibility and Healthy Connections (HC) enrollment prior to rendering services, as described in the Verifying Participant Eligibility section. For participants enrolled in Healthy Connections, the PCP information will be provided through the automated and/or online system. If an HC PCP is not indicated, an HC referral is not required.

Enrollment in HC is mandatory for most Medicaid participants and required in the majority of counties statewide. Participants not enrolled in HC are mailed an enrollment form and given up to 90 days to inform us of their choice of PCP. When a Medicaid participant does not choose a PCP and they live in a mandatory county, the participant is assigned to an HC PCP.

HC clinics are required to absorb any participant enrolled to their clinic even if a specific provider is no longer with that HC clinic. If the clinic does not have the capacity to absorb those participants, they must change their panel to "Not Accepting New Medicaid".

7.2.1. Voluntary Participant Enrollment in Healthy Connections

Participants not enrolled in Healthy Connections (HC) and without an exception, can complete an enrollment form at an HC clinic and fax it to 1 (888) 532-0014 or e-mail to HCCR7@dhw.idaho.gov. Assisting participants to enroll to an HC clinic will help avoid the possibility of assignment to a different HC clinic.

7.2.2. Participant Enrollment Guidelines

- Enrollment in HC is mandatory for most Medicaid participants.
- Enrollment requests must be submitted by the participant or an authorized representative.
- Enrollment to the HC clinic will be effective the date the enrollment request is approved.
- Each enrolled participant is sent a written notice listing the name, phone number, and address of their HC clinic. This notice is generated and mailed the day after the participant's enrollment is entered.
- Family participants are not required to choose the same HC clinic.
- Medicaid participants may enroll to an HC clinic in one of the following ways.
    - Preferred method – Enroll online on the Manage my Medicaid with Healthy Connections website, choosing the blue link "Find a Healthy Connections PCP".
    - Complete and return an HC Enrollment form received in the mail;
    - Complete enrollment form at clinic and have it faxed to the Healthy Connections Consolidated Unit at 1 (888) 532-0014; or
    - Call the HC Consolidated Unit at 1 (888) 528-5861 to enroll over the phone
- Clinic is required to absorb any participants enrolled to their clinic even if a specific provider is no longer with the HC clinic.
- The HC Network Directory can be found on the Find a Healthy Connections Primary Care Provider website.

7.2.3. Enrollment to clinic with panel limitations

Healthy Connections (HC) clinics have the option to request a closed panel and not accept new Medicaid participants or request panel limitations for enrollment. Limited or closed panel clinics may arrange with HC to process enrollments without prior approval when any of the following conditions are met:

- Participants are currently established as shown by claims within last 12 months.
- Participants have an upcoming scheduled appointment or recent appointment.

- Participants with family members currently established.

If the above conditions are not met, or the clinic is closed to new Medicaid, participants will be directed to the clinic for enrollment approval. The clinic must contact Healthy Connections with the approval for the participant to be enrolled in one of the following ways:

- Enrollment form from the clinic, signed by the participant or their authorized representative.
- Phone call from clinic validating enrollment request received from participant.

It is the responsibility of the organization to communicate panel limitations to all locations participating in Healthy Connections.

7.2.4. Mandatory Participant Enrollment in Healthy Connections

If a primary care provider (PCP)/clinic chooses to accept mandatory assignment participants, the assignments will occur within the panel limits the PCP/clinic has provided to Healthy Connections (HC) (i.e., accepting new Medicaid, age limits, etc.).
The requirements for assignments are as follows:

- When a participant is assigned to PCP/clinic, the clinic is required to allow assigned participant(s) to establish care, even if the panel subsequently has closed to accepting mandatory assignments; and
- If a participant has not established care, and has an urgent medical need, PCP/clinic is required to provide "timely access to care" either by seeing the participant or providing a one-time referral.
- If the clinic cannot absorb patients due to a provider leaving the location, or assigned participants cannot access care timely, the clinic must set their panel limits to "Not Accepting New Medicaid", and change their panel limits to not accepting mandatory assignments.

It is recommended that PCP/clinics check the Healthy Connections roster each month to see list of newly assigned participants and conduct outreach to encourage establishing care.

Participants not submitting a choice of provider will be assigned to an HC clinic up to 90-days after eligibility, to be effective the first of the following month, based on the following criteria:

- Assign participants to a clinic where they are currently receiving care.
- Assign family members to a clinic where other family members are enrolled, if appropriate.
- Assign participants to a prior Healthy Connections clinic, when applicable.
- Assign participants to a clinic based on geographic location.
- Assign participants based on rotation schedule agreed upon by clinic.

7.2.5. Changing Enrollment in Healthy Connections

Healthy Connections participants will be enrolled based on a fixed enrollment process. A set period of time is designated during the year when participants are allowed to change their PCP without cause. This is commonly known as the "annual enrollment period". Fixed enrollment encourages a long-term provider-patient relationship resulting in the participant receiving a consistent source of care, provides for better patient outcomes and supports the value-based model of care.

Changes in enrollment are to be submitted by the participant or an authorized representative. HC clinics may submit HC enrollment forms on behalf of a participant, as long as the enrollment form is completed and signed by the participant or an authorized representative.

Participants or their authorized representatives are allowed to initiate a change for any reason:

- During the annual enrollment period of July and August;
- Within the first ninety (90) days of enrollment with a *new* HC service location/clinic;
- Due to automatic re-enrollment and the participant misses any part of the annual open enrollment period; or
- To request a different service location/clinic within the HC Organization (same Tax ID).

Participants will remain enrolled with their primary care provider unless they qualify for a change. To see if a participant qualifies to change their provider, have them contact Healthy Connections. Some reasons for change include:

- Participant requests different PCP than one assigned by the Department;
- Participant moved outside of the PCP's service area;
- Participant requests different PCP to allow members of a household to be enrolled with the same PCP (one medical home);
- Participant requests change due to changing to/from a specialty provider (i.e., Pediatrics, etc.);
- Participant chooses to follow PCP to a different HC organization, to maintain the existing relationship with the PCP; or
- Other reasons determined to be acceptable by the Department.

Requests to change providers will be verified and approved if they meet Fixed Enrollment criteria. A request to change is not guaranteed and may not be acted on immediately. As a result, it is important for providers to obtain referrals from the provider of record in the system prior to rendering services.

Failure to adhere to these policies may result in investigation by the Medicaid Program Integrity Unit.

a) References: Changing Enrollment in Healthy Connections

(i) Idaho Medicaid Publications

Fixed Enrollment Changes for the Idaho Medicaid Healthy Connections Program, Information Release MA19-12 (8/1/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3365&dbid=0&repo=PUBLIC-DOCUMENTS.

7.2.6. Exceptions & Exemptions to HC Enrollment

Participants meeting the exception or exemption criteria in this section are not required to enroll in the Healthy Connections Program. A referral is not needed for services rendered to participants not enrolled in Healthy Connections.

Participants are not required to enroll in Healthy Connections who meet the following exception criteria:

- The participant has an eligibility period that is less than three (3) months;
- The participant has an eligibility period that is only retroactive;
- The participant only has Qualified Medicare Beneficiary eligibility;
- The participant is enrolled in one of the managed care programs for Dual Eligible participants;
- The participant resides in long-term care or ICF/IID facility; or

- The participant resides in a non-mandatory county where there are not adequate numbers of providers to deliver primary care case management services.

Participants may opt out of Healthy Connections by requesting and qualifying for one of the following exemption reasons:

- Participant is unable to access a Healthy Connections provider within a distance of thirty (30) miles or within thirty (30) minutes to obtain primary care services;
- Participant has an existing relationship with a primary care provider or clinic (currently under the care) who is not participating in Healthy Connections or is a Health Home provider. However, once the participant chooses to enroll with or receive services from an HC clinic, the participant no longer qualifies for an exemption (verified annually);
- Participant has Medicare as their primary healthcare plan;
- Participant is a member of a federally recognized tribe; or
- Participant is under 19 years of age and is:
    - Eligible for SSI under Title XVI;
    - Eligible under section 1902(e)(3) of the Act, qualified disabled children; or
    - Receiving foster care or adoption assistance.

Exempted participants not enrolled in Healthy Connections will appear as "Exempt from Healthy Connections" when checking eligibility. At any time, a participant with an exemption, but not an exception, may opt to enroll with a Healthy Connections provider.

7.2.7. Participant Disenrollment by the Provider

A PCP may choose to withdraw as the participant's primary care provider and must give written notice to both the participant and the Department at least (30) days prior to the date of disenrollment. Failure by the PCP to notify Healthy Connections will result in continued obligation to provide care and/or referrals until notice is received. *The Department may waive this notice on a case-by-case basis.* The written notice from the PCP must give the enrollee the reason for the request for disenrollment.

A PCP may request disenrollment of a participant because:

- Participant has been previously discharged from the practice – PCP to provide copy of dismissal notice sent to participant
- A documented, ongoing pattern of failure on the part of the participant to keep scheduled appointments
- A documented situation where there is an inability by the PCP, after making a reasonable effort to maintain a mutually satisfactory PCP/participant relationship
- Behavior of the participant that is disruptive or abusive (and not related to his/her special needs) to the extent that the PCP's ability to furnish services to the participant or other participants is impaired.

A PCP may not request disenrollment because of:

- An adverse change in the participant's health status
- The participant's over/under utilization of medical services
- The participant's diminished mental capacity
- The participant's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs a PCP's ability to furnish services to the participant of other participants)

Upon the reassignment of the participant to a new PCP, the former PCP must transfer a copy of the participant's medical records to the new PCP when requested by the participant.

7.3. Referrals

A referral is a documented communication from a participant's PCP of record to another Medicaid provider for a specific covered service. The participant's HC clinic is responsible for providing primary care, managing the participant's care and making referrals for **medically necessary services**. The PCP plays a key role in linking participants with community resources to facilitate referrals and respond to the participant's medical and social needs.

7.3.1. Important Referral Policy Reminders

- Referrals must always be received **prior** to delivery of care.
- Backdated or retroactive referrals are not acceptable. Any service provided with a backdated or retroactive referral is considered to be non-covered and may be subject to recoupment and civil monetary penalties.
- Referral requirements apply regardless of Medicare or other insurance coverage.
- The referral must be documented in the records of both the referring and receiving providers to be valid.
- Referrals entered online in the HealthPAS portal meet the referral documentation requirements.
- Once received a referral remains active even if the participant changes their enrollment with an HC clinic.
- Providers receiving referrals may also forward the referral to another Medicaid provider as long as the date and scope of the referral meets the condition stated in the original referral.
- The referral requirement for primary care services accessed between HC clinics affiliated either by the same NPI, Tax ID or Provider Network owned by the same organization (not VCO affiliation) is at the discretion of the HC clinic/organization of record.
- Referral authority may be externally delegated to an "outside organization" for the purposes of care coverage. However, externally delegated referral authority must be documented in the covering HC service location for the specific visit.
- In the event that a service not requiring a referral begins and must be changed to a service that requires a referral, one is not required. However, the medical documentation must support the service change.
- Referrals cannot be accepted in lieu of a prior authorization. PA's are for certain services that require review and approval prior to being provided.
- When verifying eligibility, if no HC clinic is indicated or "Exempt from Healthy Connections" is returned, no referral is required.
- If a participant has not established care, and has an urgent medical need, clinic is required to provide "timely access to care" either by seeing the participant or providing a one-time referral and working with participant to schedule an appointment.
- Healthy Connections enrolls to the clinic, not a specific provider. Any HC provider that participates and provides primary care can authorize a referral for any enrolled participant.
- Historical note: In March 2020, referral requirements were suspended due to the COVID-19 pandemic. Effective July 1, 2021, referral requirements were reinstated.

7.3.2. Referral Elements

Effective 2/1/2016, the following are the required core referral elements:

- Date issued;
- Name of HC PCP or clinic issuing referral;
- Participant information;

- Referred-to provider (suggest obtaining billing organization NPI to find accurate location in system);
- Start and end date of the referral (not to exceed one year);
- Diagnosis and/or Condition (entered in Notes section in HealthPAS); and
- Referral reason:
    - Consultation/diagnosis only;
    - Diagnose, treat, and/or forward to specialty provider;
    - One time visit until seen by PCP; and
    - Any additional referral limits or restrictions.

7.3.3. Method of Referral

A referral must be communicated by one of the following methods:

- **Electronic referral** (e.g., Gainwell Technologies HealthPAS portal or HC clinic electronic Medical Record {EMR});
- **Paper referral** (e.g., HC Referral form, prescription pad, etc.);
- **Verbal Referral** (e.g., calling an order into a specialist); or
- **Admit Order** (e.g., hospital direct admit by participant's HC clinic PCP).

7.3.4. Advantages of Electronic Referrals

There are many advantages to submitting an online electronic referral, including:

- **Improved Accessibility and Communication of Data -** The PCP, referred-to-provider and Department staff can access the referral online anytime;
- **Enhanced Capacity –** Resource for PCP to provide better coordinated care by having access to participant referrals entered online;
- **Integrity -** Authorized visits and/or date span of specified services are clear and concise;
- **Secure -** HIPAA compliant referral process; and
- **Timesaver -** No handling or storage of a paper referral.

Refer to the *Referrals* section of the Trading Partner Account (TPA) User Guide found in the **User Guides** under the *Reference Material* menu on the Gainwell Technologies Idaho Medicaid website for instructions to enter or retrieve online referrals.

7.3.5. Follow-up Communication Requirements for Referrals

Providers who receive Healthy Connections referrals must communicate their assessment, recommendations, or progress back to the HC PCP of record within a timely manner. Services provided for an extended period shall be reported to the PCP with an annual report, or more frequently if significant changes occur in the patient's overall health. Failure to communicate findings to the PCP may result in services being considered non-covered and subject to recoupment.

7.3.6. Services Not Requiring an HC PCP Referral

The following services do not require a referral by the Healthy Connections Primary Care Provider. If the service is not on this list, it may require a referral. Services are hyperlinked where applicable to direct providers to the appropriate section of the Idaho Medicaid Provider Handbook or program website. Services must meet the requirements below and the definition of the service category to qualify.

The following services do not require a referral by the PCP:

- **Adult Developmental Disability Services**, effective 03/13/2020;

- **Aged and Disabled (A&D) Waiver Services;**
- **Anesthesiology Services**;
- **Audiology Services** performed in the office of a certified audiologist;
- Behavioral Health Services through **Magellan Healthcare, Inc**;
- **Children's Developmental Disabilities Services**;
- **Children's Habilitation Intervention Services**;
- **Chiropractic Services** effective 04/01/2022:
  - 18 and over, referral required after six (6) visits
  - Less than 18, referral required for all visits
- **Colonoscopies**;
- **Dental Services**;
- **Durable Medical Equipment**;
  - This service should be coordinated with the participant's primary care provider.
- **Emergency Services**;
  - As defined in 42 CFR § 438.114, an Emergency Medical Condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
    - Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part.
- **Family Planning Services;**
  - Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling and restricted sterilization for pregnancy prevention.
- **Home Health Services**;
- **Hospice Services**;
  - This service should be coordinated with the participant's primary care provider.
- **Hospital Admissions** resulting directly from the facility's emergency room;
  - Discharge planning must be coordinated with the HC PCP.
- **Immunizations** without an office visit;
  - All providers administering immunizations are asked to either provide the participant's PCP with immunization records, or to record administered immunizations in the Idaho Immunization Registry and Information System (IRIS) to assure continuity of care and avoid duplication of services.
- **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services**;
  - This includes all services delivered to participants residing in an ICF/IID, regardless of place of service.
- **IHS, FQHC and RHC Services** provided to an American Indian/Alaskan Native;
- **Infant Toddler Program Services**;
- **Influenza Shots**;
  - Providers administering influenza shots are asked either to provide the participant's PCP with documentation of the shot, or to record the immunization in the Idaho Immunization Registry and Information system to assure continuity of care and avoid duplication of services.
- **Laboratory Services** including pathology;
- **Licensed Midwife Services**;
- **Mammography Services**;
- **Occupational Therapy Services**;
  - This service should be coordinated with the participant's primary care provider.

- **Personal Care Services (PCS)**;
- **Personal Care Services (PCS) Family Alternate Care Homes (FACH)**;
- **Pharmacy Services** or **prescription drugs**;
- **Physical Therapy**;
  - This service should be coordinated with the participant's primary care provider.
- **Podiatry Services** performed in the office;
- **Pregnancy-Related Services**;
  - This service should be coordinated with the participant's primary care provider.
- **Radiology Services**;
- **Respiratory Services**;
- **School Based Health Center (SBHC)** for acute services when coordinated with the participant's primary care provider within three business days;
- **School-Based Services**;
  - Includes all health-related services provided by a school district under an Individual Education Plan (IEP).
- **Services managed directly by the Department**, as defined in the Provider Handbook;
- **Skilled Nursing Facility Services**;
  - This includes all services delivered to participants residing in a skilled nursing facility.
- **Speech Language Pathology**;
  - This service should be coordinated with the participant's primary care provider.
- **Sexually Transmitted Disease Testing and Treatment**;
- **Substance Use Disorder (SUD) Services;**
  - Pursuant to the Code of Federal Regulations at Title 42, Chapter I, Subchapter A, Part 2, "Confidentiality of Substance Use Disorder Patient Records" a Healthy Connections referral is not required to access or receive SUD services for any participant with a SUD diagnosis regardless of diagnosis position, primary, secondary or tertiary.
- **Transportation Services**;
- **Urgent Care Services**; and
- **Vision Services** performed in the offices of ophthalmologists and optometrists and eyeglasses.

7.3.7. Reimbursement for Services Requiring a Referral

It is the responsibility of the billing provider to ensure a referral is documented and meets the requirements outlined in the Provider Handbook prior to rendering services. Claims will process regardless of referral status. The referral field in the claims processing system is a misnomer and is intended for prior authorization numbers. Entering a referral number on the claim will cause the claim to deny. Services provided and billed to Medicaid without a referral, when one is required, are subject to sanctions, recoupment or both. Billing Medicaid for services without a correct and complete referral is not allowed. Any payments received as a result of a missing or incomplete referral are subject to recoupment and/or assessment of civil monetary penalties by the Department.

See the Participant Financial Responsibility section for more information about when billing participants is permissible.

7.3.8. School Based Health Centers

A School Based Health Center (SBHC) is defined as a health center located at an elementary, middle, or high school. College health services do not qualify as an SBHC. SBHCs do not require a referral for **acute care services** provided to a student so long as all requirements of this section are met:

- The participant's PCP must be contacted within three business days with written or electronic documentation for coordination of care.
- Documentation must include:
  - A visit summary;
  - Prescriptions or orders issued; and
  - Any other information the PCP may need to be aware of.
- If secondary or specialty care is medically necessary, the SBHC provider will refer the student back to their HC PCP.
- The student's parent/guardian must be contacted with the visit outcome and any follow-up care recommendations.

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

The SBHC will be subject to periodic evaluation of policy compliance for care coordination by Department staff to include patient medical record reviews.

a) References: School Based Health Centers

(i) Idaho Medicaid Publications

"School-Based Health Centers." *MedicAide Newsletter,* May 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

7.3.9. Urgent Care Services

Effective January 1, 2020, Healthy Connections referrals will not be required for urgent care services accessed at urgent care centers, Health Districts or Healthy Connections Clinics that meet the criteria below. Urgent care services for this purpose are medical services used in the treatment of acute illness or injury which require prompt attention, but generally are not serious enough to require an emergency room visit.

Participants are encouraged to always call their Primary Care Provider first as they may offer same day or walk-in appointments. If their Primary Care Provider's office is closed or they are unable to be seen immediately for an urgent medical need, they may be seen at a qualified Urgent Care, Health District or Healthy Connections Clinic. The Department encourages providers to work together within their medical neighborhoods to effectively coordinate patient care. Urgent care service providers have the option to treat participants or contact their PCP to determine if they have availability to treat an urgent medical need.

Providers must meet all criteria listed below for urgent care services to be exempt from referral requirements:

1. Meet the requirements for an Urgent Care facility.
2. Provide and document the follow-up communication to the patient's Health Connections Clinic of record.
3. Direct the patient to their Healthy Connections Clinic for any follow-up visits.

Urgent Care facility requirements:

1. **Urgent Care Centers** – for purposes of this referral policy, defined as:

   a. Evaluates and treats a broad spectrum of illness and injury
   b. Offers walk-in appointments as the primary scheduling model
   c. Is open at least one additional hour per weekday outside the standard eight (8) hours per day, Monday through Friday, or an additional five hours on the weekend
2. **Health Districts**
   a. Offers walk-in or same day appointments
3. **Healthy Connections Clinics** that meet the following enhanced access criteria:
   a. Offers walk-in or same day appointments
   b. Is open at least one additional hour per weekday outside the standard eight (8) hours per day, Monday through Friday, or an additional five hours on the weekend

Healthy Connections Clinic follow-up requirements:

1. **Communicate** the visit summary directly to the patient's Healthy Connections Clinic of record within three (3) business days of the visit. At a minimum, this shall include:
   a. Facts and Findings
   b. Prescriptions and DME ordered
   c. Other pertinent healthcare information
2. **Direct** the patient to their Healthy Connections Clinic of record:
   a. For ongoing treatment or coordination of chronic/complex conditions
   b. When specialty or follow-up care is needed
   c. For those seeking wellness services
3. **Educate** patients when urgent care is appropriate

Compliance requires:

1. Proof of direct communication documented by the provider rendering the urgent care service and the Healthy Connections clinic of record.
   a. The communication requirement would be met when the urgent care service provider and Healthy Connections Clinic of record are under the same organization and share an Electronic Medical Record (EMR)
   b. Idaho Health Data Exchange (IHDE) record of visit without direct communication to the Healthy Connections Clinic of record does not meet the communication requirement.
2. Urgent Care Service Providers are required to, at a minimum, direct participants to their Healthy Connections Clinic of record for follow-up visits, wellness care or scheduled appointments.

Failure to meet these requirements may result in services considered non-covered and subject to recoupment and/or a civil monetary penalty.

a) References: Urgent Care Services

(i) Idaho Medicaid Publications

Healthy Connections Urgent Care Service Referral Policy effective January 1, 2020, Information Release MA19-17 (12/13/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho,

https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3353&dbid=0&repo=PUBLIC-DOCUMENTS

7.3.10. References: Referrals

a) Idaho Medicaid Publications

"Changes in Children's Developmental Disability Services and Healthy Connections Referral Requirement." *MedicAide Newsletter,* August 2013, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202013%20MedicAide.pdf

"Healthy Connections Electronic Referral Option and Other Important Policy Updates – Effective 12/1/12." *MedicAide Newsletter,* December 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202012%20MedicAide.pdf.

"Healthy Connections Primary Care Provider Webinars presented by Optum Idaho: Importance of Coordinating Behavioral Health Services with Primary Care Providers." *MedicAide Newsletter,* August 2013, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202013%20MedicAide.pdf.

Reimbursement and Referral Changes for the Idaho Medicaid Healthy Connections and Health Home Programs, Information Release MA16-02 (02/05/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho.

Removal of Requirement for Healthy Connections Referral for Outpatient Dental Services, Information Release MA07-18 (10/01/207). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=26569&dbid=0&repo=PUBLIC-DOCUMENTS.

Removal of Requirement for Healthy Connections Referral for Select Services, Information Release MA07-19 (10/01/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=26568&dbid=0&repo=PUBLIC-DOCUMENTS

7.4. Program Liaison

The HC Program provides staff to assist providers with problem resolution. Contact information for regional Healthy Connections Representatives is found in the *Directory*. Providers can also contact their local Provider Relations Consultant (PRC) with Gainwell Technologies to obtain information, training, or to answer billing questions.

8. Healthy Connections Value Care

The Healthy Connections Value Care (HCVC) program, started on January 1, 2022. Under this program, Value Care Organizations (VCOs), contracted with the Department, are held accountable for improving participant health outcomes and controlling costs. Idaho Medicaid Healthy Connections (HC) organizations may choose to form their own VCO and contract directly with the Department. Alternatively, they may choose to affiliate with hospitals, primary care organizations, and other medical service organizations to form a VCO, which then contracts with the Department. The goals of HCVC:

- Improve the health of Idahoans;
- Provide high-quality, cost effective care
- Reward organizations by sharing shared savings

New value care organization (VCO) contracts or changes in existing VCO contracts are due annually by September 1st. Each VCO must have a minimum of 2,000 attributed participants. VCO contracts must include Healthy Connections (HC) service locations and acute care hospital affiliations.

An agreement between each VCO and affiliated HC organization shall be in place prior to each performance year. This is a separate and unique agreement from the Healthy Connections Coordinated Care Agreement. It is the responsibility of the VCO to report changes in affiliated HC service locations to the Department.

- The VCO will inform the Department of their risk options.
- The Department will inform the VCO of their quality targets and the statewide standardized total cost of care per member per month (PMPM) cost.

The VCO contract with the Department will renew automatically annually. For additional information, please visit the Healthy Connections and Healthy Connections Value Care website.

8.1. References: Healthy Connections Value Care

8.1.1. Idaho Medicaid Publications

Healthy Connections Value Care, Information Release MA21-13 (04/30/2021). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=18027&dbid=0&repo=PUBLIC-DOCUMENTS.

9. Covered Services and Limitations: General

Unless otherwise noted, services must be provided directly to the participant to be eligible for reimbursement.

9.1. Medical Necessity

State Medicaid programs are mandated to only pay for medically necessary services and items covered in Idaho Medicaid's State Plan for adults twenty-one years of age and older. A service or item is considered medically necessary when it is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, cause functionally significant deformity or malfunction. Only effective treatments that are the most conservative (including setting, duration and frequency), or least costly, are considered eligible. The setting a participant receives services in, and the methods or items utilized must be safe and effective. The service or item must be of a quality that meets professionally-recognized standards of health care and substantiated by records including evidence of such medical necessity and quality. Items and services are not provided for the convenience of the patient, provider or caregiver. Diagnoses on claim submissions must support medical necessity for the services provided.

Participants under the age of 21 have an expanded definition for medical necessity to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Although services under Early Periodic Screening, Diagnosis and Treatment (EPSDT) are not required to be within the State Plan, they must fall into a category of service listed in 1905(a) of the Social Security Act, be considered safe and effective, and meet acceptable standards of medical practice. If services not covered under the State Plan are needed, an EPSDT request form must be submitted to the Department for prior authorization.

A service or item that has received FDA approval or its own CPT®/HCPCS code is not automatically considered a medically necessary service or item. It must be consistent with generally accepted professional medical standards of care and be verified through independent study published in peer-reviewed literature before being considered for medical necessity. In the absence of Idaho Medicaid direction for medical necessity criteria of covered items and services, the provider should default to Medicare standards.

Screening services are generally not medically necessary. Screening is used to detect an undiagnosed disease where early detection may prevent harm, and where the patient has no signs, symptoms, laboratory evidence, radiological evidence or personal history of the disease. Idaho Medicaid covers screening services as mandated by the Affordable Care Act (ACA) and recommended by the US Preventive Services Task Force (USPSTF) with an "A" or "B" recommendation, or when listed in the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule without co-payment. When other modes of transportation are unavailable or are not practical, Non-Emergency Transportation (NEMT) is covered for services prior authorized as EPSDT or listed on the AAP Bright Futures periodicity schedule.

See Non-Covered and Excluded Services for information about items and services that may not be reimbursable. See the Early & Periodic Screening, Diagnostic & Treatment (EPSDT) section for more information and how to request services that may exceed those under State Plan for participants under the age of 21. See www.mtm-inc.net/idaho or call 1 (877) 503-1261 for more information.

9.1.1. References: Medical Necessity

a) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(r) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

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.

State Plans for Medical Assistance, 42 U.S.C. Sec. 1396a (1984). Government Printing Office, https://www.govinfo.gov/content/pkg/USCODE-2017-title42/pdf/USCODE-2017-title42-chap7-subchapXIX-sec1396a.pdf.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(30) (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) (1981). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-230.pdf.

b) State Regulations

"EPSDT Services: Definitions." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 350. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"EPSDT Services: Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 351. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 005.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"EPSDT Services: Coverage and Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 352. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

9.2. Experimental/Investigational Services

The Department uses the terms experimental and investigational interchangeably. Services determined to be experimental are non-covered. All services and follow-ups directly associated with an experimental service are also excluded from reimbursement. The Department lists services it considers experimental throughout the handbook for provider convenience, however, on services without stated guidance from the Department providers bear a responsibility to determine if a service meets the definition of Medical Necessity and if it would be considered experimental. A service is experimental if:

- It is being provided as part of a phase 1 clinical trial;
- They are used to gain further evidence or knowledge;
- It tests the usefulness (i.e., efficacy) of a drug or treatment;
- There is inadequate data to provide the reasonable expectation that the service would be as effective as the standard treatment for a condition;
    - This includes category III CPT® codes and proprietary laboratory analyses (PLA) codes.
- Expert opinion suggests additional information is needed to assess the safety or efficacy of a treatment or procedure;
- It is determined experimental or investigational under Medicare or their local area contractor, Noridian Healthcare; or
- It is considered investigational by the Food and Drug Administration (FDA).

Services determined to be experimental are not eligible for coverage under Early & Periodic Screening, Diagnostic & Treatment (EPSDT). Procedures and treatments may be eligible for coverage with a prior authorization under a focused case review on a case-by-case basis for participants of any age with a life threatening medical illness and no other available treatment options. The Department may at its discretion seek an independent professional opinion if there is insufficient information to render a coverage decision. A focused case review involves a Department analysis of the proposed procedure or treatment and:

- The anticipated benefit and risks to the participant's health;
- Documentation of the participant's previous treatments and outcomes;
- Medicare's coverage in national coverage guidelines;
- The phase of clinical trial the procedure or treatment is in (if applicable);
- Written guidance from national organizations;
- Clinical data and peer-reviewed literature;
- Ethics Committee review, if appropriate; and
- A cost-benefit analysis consisting of:
    - Estimated long-term cost if the request is approved or denied; and
    - Potential long-term impacts to Idaho Medicaid if the request is approved.

Requests for a focused case review are submitted to the Medical Care Unit.

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009
Phone 1 (866) 205-7403
MedicalCareUnit@dhw.idaho.gov

Services approved under a focused case review that fall into Medicare's clinical trial policy, investigational device exemption policy or coverage with evidence development must use modifiers Q0 and Q1 on outpatient claims to differentiate between routine and investigational clinical services. ICD-10-CM Z00.6 must be included on the claim in the primary or secondary position.

Outpatient Experimental/Investigational Modifiers	
Modifier	**Description**
Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study. This modifier will price the claim line at zero.
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study. This modifier will not affect claim line pricing.

9.2.1. References: Experimental/Investigational Services

a) CMS Guidance

Items and Services Not Covered Under Medicare (2024). Centers for Medicare & Medicaid Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf.

"Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims." *MLN Matters MM8401, June 2014,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2014-transmittals-items/r2955cp.

"National Coverage Determination (NCD): Routine Costs in Clinical Trials (310.1) (2024)." *Medicare National Coverage Determinations (NCD) Manual.* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=1.

"Non-Covered Services." *Noridian Healthcare Solutions,* 26 October 2022, https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered_statutorily_excluded.

b) Idaho Medicaid Publications

"Billing Idaho Medicaid with CMS Modifiers Q0 and Q1." MedicAide Newsletter, December 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202016%20MedicAide.pdf.

c) State Regulations

"Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 005.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Investigational Procedures or Treatments." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 061. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Services, Treatments, and Procedures Not Covered by Medicaid." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 060. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

9.3. Qualifying Clinical Trials

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

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

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

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

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

9.3.1. References: Qualifying Clinical Trials

a) CMS Guidance

Mandatory Medicaid Coverage of Routine Patient Costs Furnished in Connection with Participation in Qualifying Clinical Trials (2022),
https://www.medicaid.gov/federal-policy-guidance/downloads/smd21005.pdf

b) Idaho Medicaid Publications

"Qualifying Clinical Trials." MedicAide Newsletter, May 2023,
https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

9.5. Service Limitations

Service limitations restrict services based on state and federal rules and regulations. Each procedure and revenue code may be reviewed for a variety of limitations. Limitations include, but are not limited to:

- Services bundled when rendered by the same provider;
- Amount of services or items in a given time frame;
- Reimbursement caps during a time period;
- Medical necessity;
- Age of the participant; and
- Lifetime procedures.

Some services that exceed limitations may be covered with a prior authorization. Refer to your specific *Provider Guidelines* carefully for additional information.

Policy limitations can be reviewed on request if the allowed amount doesn't meet the average participants' needs. Supporting documentation should be submitted to demonstrate why the current limitation would not meet the average participant's medical needs. Requests may be submitted to MCPT@dhw.idaho.gov.

9.6. Informational Codes

Services represented by informational only codes are not excluded from coverage by statute and meet all technical requirements for coverage, but have been determined non-covered for separate reimbursement because they are considered reimbursed in the coverage of another procedure code.

Informational only codes do not appear on the Idaho Medicaid Fee Schedule as they are considered non-covered services for the purposes of reimbursement. A code that is informational only is not separately reimbursable regardless of the revenue code, CPT® or HCPCS code selected for billing. Services coded as informational only cannot be billed under a CPT® or HCPCS defined as unlisted or miscellaneous or billed under a revenue code that does not require a CPT® or HCPCS. These billing practice will be subject to recoupment and penalties. See Idaho Medicaid Claim Standards in the General Billing Instructions, Idaho Medicaid Provider Handbook for more information about correct coding.

9.6.1. References: Informational Codes

a) Idaho Medicaid Publications

"Non-Covered Services." *MedicAide Newsletter,* April 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202023%20MedicAide.pdf.

9.7. Non-Covered and Excluded Services

Specific non-covered services and circumstances are detailed throughout the provider handbook. Non-covered services are not excluded from coverage by statute and meet all technical requirements for coverage, but have been determined non-covered because of one of the following:

- The service is not within the scope of the participant's eligibility for coverage;
- The service requires a Healthy Connections referral and one isn't available;
- The participant has exhausted their allowed amount;
- The service is covered in a bundle with another service, and may not be unbundled; or
- The service is not reasonable and medically necessary. See the Medical Necessity section for more information.

Services represented by codes not appearing on the Idaho Medicaid Fee Schedule are considered non-covered services. Excluded services are those services that are not allowed to be covered by state or federal statute or rule. See the List of Excluded Services section for more information.

The following fees and situations do not fall under the Department's definition of a non-covered or excluded service and can never be billed to a participant:

- No-show or missed appointment fees;
- Other insurer's co-pays;
- Failure on the part of the provider to submit a complete and correct claim to the Department or other payor;
- Failure by the provider to submit a complete and correct request for prior authorization from the Department or other payor;
- Claims voided by the provider;
- Failure of the provider to follow any payor's policy or procedure; or
- Any recoupment or penalties the provider receives as a result of their action or inaction.

A service that is non-covered or excluded is not reimbursable regardless of the revenue code, CPT® or HCPCS code selected for billing. Non-covered or excluded services billed under a CPT® or HCPCS defined as unlisted or miscellaneous will be subject to recoupment and penalties. Non-covered or excluded services billed under a revenue code that does not require a CPT® or HCPCS will also be subject to recoupment and penalties. See Idaho Medicaid Claim Standards in the General Billing Instructions, Idaho Medicaid Provider Handbook for more information about correct coding including the requirement to bill either the GA, GX, GY or GZ modifiers for non-covered services. See Participant Financial Responsibility section for information on when and how participants may be billed.

9.7.1. References: Non-Covered and Excluded Services

a) Idaho Medicaid Publications

"Non-Covered Services." *MedicAide Newsletter,* April 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202023%20MedicAide.pdf.

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

9.7.2. List of Excluded Services

Services excluded from coverage by statute or rule include:

- Acupuncture
- Biofeedback Therapy (except for urinary incontinence)
- Complications. The treatment of complications, consequences, or repair of any excluded medical procedure is not covered. Medicaid may authorize treatment with supporting documentation from a physician if the resultant condition is determined by Medicaid to be life threatening.
- Cosmetic Surgery. All surgery that is generally cosmetic in nature is excluded from payment unless it is found to be medically necessary, such as reconstructive surgery, and is prior authorized.
- Duplicative Services
- Educational Services
- Elective Treatments. Elective medical and surgical treatments are not covered without a prior authorization except for family planning services.
- Fertility-Related Services. Fertility-related services are not covered. This includes: testing; artificial insemination; consultations; counseling; donation of ovum, sperm, or surrogate womb; genetic testing and/or counseling for family planning; in vitro fertilization; office exams; penile implants; or reversal of sterilization.
- Housing except when approved for a medical institution
- Food except home-delivered meals.
- Gender Transition. Exceptions include:
    - Necessity for the health of the person (not including procedures to affirm the individual's perception of their sex when inconsistent with their biology).
    - The treatment of any infection, injury, disease or disorder caused or exacerbated by the performance of gender transition procedures.
    - The treatment of a verifiable genetic disorder of sex development such as:
        - Ambiguous and irresolvable external biological sex characteristics including 46, XX chromosomes with virilization, 46, XY chromosomes with undervirilization, or with both ovarian and testicular tissue.
        - When determined through genetic testing that there is not normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a male or female.
- Group Exercise Therapy
- Group Hydrotherapy
- **Experimental/Investigational Services**
- Laetrile Therapy
- Naturopathic Services
- Screening Services. Screening services are excluded except those with recommendations of "A" or "B" by the United States Preventive Services Task Force (USPSTF) or identified in the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule. In the event that recommendations from the USPSTF and AAP conflict, the Department follows the USPSTF.
- Recreational Services
- Surgical Procedures on the Cornea for Myopia
- Vitamin Injections. Vitamin injections are not covered if they are not needed for a specific diagnosis.
- Vocational Services not authorized under a HCBS waiver.

a) References: List of Excluded Services

(i) CMS Guidance

Items and Services Not Covered Under Medicare (2024). Centers for Medicare & Medicaid Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf.

"Non-Covered Services." *Noridian Healthcare Solutions,* 26 October 2022, https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered_statutorily_excluded.

(ii) Idaho Medicaid Publications

"Screening Services Not Mandated are Statutorily Excluded from Reimbursement." *MedicAide Newsletter,* March 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf.

(iii) State Regulations

Prohibition on Reimbursement and Coverage, Idaho Code 56-273 (2024). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-273.

"Services, Treatments, and Procedures Not Covered by Medicaid." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 060. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Use of Public Funds for Gender Transition Procedures Prohibited, Idaho Code 18-8901 (2024). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch89/sect18-8901.

Vulnerable Child Protection, Idaho Code 18-1506C (2024). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch15/sect18-1506c.

9.7.3. Exceptions to Non-Covered and Excluded Services

Procedures and treatments may be eligible for coverage with a prior authorization under a focused case review on a case-by-case basis for participants of any age with a life threatening medical illness and no other available treatment options. Additional information on focused case reviews is available under the Experimental/Investigational Services section.

Some non-covered or excluded services and procedures that require treatment, services, or supplies not included in the regular scope of Medicaid coverage may be payable when identified as medically necessary during a child wellness exam, sometimes referred to as Early & Periodic Screening, Diagnostic & Treatment (EPSDT). This benefit is available for participants up to the age of twenty-one (21). Coverage under EPSDT must be prior authorized by Medicaid and is not available for experimental or investigational services. See the Early & Periodic Screening, Diagnostic & Treatment (EPSDT) section for more information.

a) References: Exceptions to Non-Covered and Excluded Services

(i) State Regulations

"Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 005.21. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"EPSDT Services: Coverage and Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 352. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"EPSDT Services: Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 351. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

9.8. Advance Directives

Advanced directives (CPT® 99497 and 99498), or advanced care planning, is a covered benefit. Advance directives are documents appointing an agent and/or documenting the participant's decisions regarding their medical treatment should they lack the capability to communicate their wishes in the future. Planning may include Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, or Medical Orders for Life-Sustaining Treatment.

Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, hospices, and personal care service providers are required by federal law to offer advanced directives to adult participants or another person on their behalf as state law allows. It may be rendered by any physician or non-physician practitioner in any location. It may also be rendered by other staff provided they meet the minimum direct supervision requirements. Providers may contract another entity to perform the service and provide information but retain the legal responsibility of ensuring it is completed correctly. The designated providers are required to offer the following as part of advance directives:

- All material from the Department of Health and Welfare's "Your Rights As A Patient To Make Medical Treatment Decisions";
- Notification of their rights under State and Federal law to accept or refuse medical and surgical treatments; and
- Any written policies the provider has on implementing the participant' rights including any situation where the provider may have a conflict of conscience and object to the participant's wishes. The policies must:
    - Clarify institutional conscience and individual professional's objections;
    - Include the legal citation that allows an objection of conscience; and
    - Describe what services would be affected by an objection.

Advance directives are voluntary and are only reimbursable if the participant elects to receive the service. Providers cannot deny services based on the participant's decision for an advance directive. This service is billable separately from a global surgical period, an annual wellness visit, or most evaluation and management services. They are not billable on the same dates of service as a billed critical care Evaluation and Management service. Time spent on any other service or treatment is not billable under this service.

A completed Advance Directive form is not required to bill for reimbursement, but documentation of the offer for an advance directive must be maintained, the existence of any advanced directive, and if the service is accepted by the participant and additional documentation must be maintained including:

- The face-to-face encounter.
- The consent for counseling.
- The time the counseling began.
- The duration.
- The explanation of an advance directive; and
- Who was present at the counseling.

9.8.1. References: Advance Directives

a) Federal Regulations

Advance Directives, 42 C.F.R. 489 Subpart I (1992). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-part489-subpartI.pdf.

b) Idaho Medicaid Publications

"Advanced Care Planning CPTs 99497 and 99498 are Covered as of January 1, 2018." *MedicAide Newsletter,* December 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf.

c) State Regulations

The Medical Consent and Natural Death Act, Idaho Code 39-45 (2020). Idaho State Legislature, https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title39/T39CH45.pdf.

9.9. Dental

Dental services are administered through Idaho Smiles. No other claims are payable through Gainwell Technologies unless otherwise explicitly noted. All reimbursement for dental claims and services is handled through Idaho Smiles. Please call 1 (855) 235-6262 or visit the Idaho Smiles Dental website for more information on this program.

See the Ambulatory Surgical Centers, Idaho Medicaid Provider Handbook for coverage of dental procedures in an ASC.

See the Medical Services, Idaho Medicaid Provider Handbook for coverage of dental anesthesia for pediatrics provided in the office.

9.10. Early Intervention Services

Early Intervention Services are designed to work with families to meet the developmental needs of each child. Services are provided through Individuals with Disabilities Education Act (IDEA) Part C in accordance with 42 CFR 440.130(d). As the lead agency for IDEA Part C services, the Infant Toddler Program (ITP) may receive Medicaid reimbursement as detailed in the Department Intra-Agency Agreement for these medically necessary services through the following Medicaid benefits:

- Intake Screening;
- Developmental Screening;
- Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) Evaluations;
- Developmental Evaluation;
- Early Intervention Assessment;
- Early Intervention;
- Joint Visit;
- Teaming;
- Interpretive Services;
- Service Coordination;
- Transportation; and
- Assistive Technology.

When providing services, the ITP must ensure early intervention services are provided in accordance to IDEA Part C requirements and Medicaid regulations as detailed in the Department Intra-Agency Agreement. Treatment must be provided in accordance with the Individualized Family Service Plan (IFSP).

9.10.1. References: Early Intervention Services

a) State Regulations

"Early Intervention Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 196. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

9.10.2. Provider Qualifications

Early intervention services for infants and toddlers enrolled in Idaho Medicaid are provided by the Infant Toddler Program (ITP). The ITP must hold a valid Idaho Medicaid provider agreement and comply with all provider enrollment and screening requirements as specified in IDAPA 16.03.26.

All personnel providing early intervention services must be employed by or contracted with the ITP, meet established certification or licensing standards, meet IDEA, Part C requirements and meet all Medicaid regulations as specified within the Department Intra-Agency Agreement.

a) References: Provider Qualifications

(i) State Regulations

"Early Intervention Services." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 196. Department of Administration, State of Idaho,

https://adminrules.idaho.gov/rules/current/16/160326.pdf.

9.10.3. Early Intervention Services Eligibility

Eligibility for Early Intervention Services is determined by the Infant Toddler Program (ITP) in accordance with IDEA Part C requirements and Medicaid regulations as specified in the Department's Intra-Agency Agreement for Early Intervention Services. To be eligible for Medicaid reimbursement for covered services, the child must:

- Be age birth through the end of their 36th month; and
- Have a diagnosed physical or mental condition with a high probability of resulting in a developmental delay; or
- Experience delays in one or more of the following areas:
    - Cognitive development;
    - Physical development, including vision and hearing;
    - Communication development;
    - Social or emotional development; or
    - Adaptive development.

9.10.4. Evaluations

Evaluations must support services billed to Medicaid, be updated as needed to accurately reflect the child's current status and be recommended by a physician. Evaluations completed for educational services only cannot be billed to Medicaid. Evaluations must include the following information:

- Summary of Findings;
- Recommendations for treatment; and
- Dated signature of professional completing the evaluation.

9.10.5. Assessments

Assessments must support services billed to Medicaid and be used to identify strengths and needs and services appropriate to meet those needs. Assessments must include the following information:

- Indication the parent or legal guardian of the child were included in the assessment process; and
- Dated signature of professional completing the assessment.

9.10.6. Prior Authorization

Prior authorization is not required for services on the early intervention fee schedule. Prior authorization is required for transportation and certain durable medical equipment and supplies. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on prior authorized services.

9.10.7. Documentation

The Infant Toddler Program must ensure a child's record contains information in accordance to IDEA Part C requirements and all Medicaid regulations as detailed in the Department Intra-Agency Agreement. The following information must be included in the record of each child enrolled in ITP:

- Eligibility Determination;
- Physician recommendation;
- Evaluations/Assessments;
- Individualized Family Service Plan (IFSP);

- Continuing Service Report(s); and
- Other child specific documentation listed in the Department Intra-Agency Agreement for Early Intervention Services.

9.10.8. Reimbursement: IDEA Part C Services

Medicaid reimburses for early intervention services in accordance with Medicaid established rates and reimbursement methodology. The Infant Toddler Program (ITP) must follow all Idaho Medicaid requirements to be eligible for reimbursement, and ensure contracted providers do not submit a duplicate claim for services billed by ITP.

IDEA Part C services reimbursed based on the early intervention fee schedule include:

- Intake Screening;
- Developmental Screening;
- PT, OT, SLP Evaluations;
- Developmental Evaluation;
- Early Intervention Assessment;
- Early Intervention;
- Joint Visit;
- Teaming; and
- Interpretive Services.

IDEA Part C services reimbursed in ways other than the early intervention fee schedule include:

- Service Coordination;
- Transportation; and
- Assistive Technology.

All claims for services approved under early intervention services must have the TL modifier on the claim line. Services can only be provided in places of service:

- 11 Office;
- 12 Home; or
- 99 Other (Community).

a) References: Reimbursement – IDEA Part C Services

(i) State Regulations

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

9.11. Interpretive Services

Providers are required by law to provide interpretive services to assist participants who are blind, deaf or who do not speak or understand English. This requirement may be waived if an emergency situation exists with an imminent threat to the safety and welfare of the participant or public, or it may be waived if the participant specifically requests an adult family member or friend be their interpreter/translator.

9.11.1. Interpretive Services Documentation

Documentation must be maintained to support reimbursement of interpretive services. At a minimum documentation must contain:

- The name and Medicaid Identification Number of the participant;
- If services are not for the participant, the name of the person and their relationship to the participant's care;
- The name, title and signature of the Medicaid provider rendering services;
- Description of the Medicaid service being received, and the type of interpretive service provided;
- The name, title and signature of the person rendering interpretive services;
- The date, time and duration of the interpretive services; and
- The necessity for any wait time being requested.

The need for interpretive services must be in the individualized education plan (IEP) if provided for a school-based service.

9.11.2. Interpretive Services for Sterilization Procedures

The interpreter/translator is responsible for ensuring the sterilization consent form is effectively, accurately and impartially communicated to the participant or their guardian. The statement certifies the interpreter/translator's discharge of their duty, their belief that the participant understood the procedure, and that the participant was allowed to ask questions. If the interpreter/translator fails to complete the statement correctly, all claims regarding the sterilization will be denied including claims from the hospital, physician and anesthesiologist. See Sterilization Procedures in the Medical Services, Idaho Medicaid Provider Handbook for more information.

9.11.3. Interpretive Services – Reimbursement

Idaho Medicaid will reimburse for interpretation, translation, Braille and sign language services provided to participants in person or through virtual care. Reimbursement is also available when interpretive services are provided to the parent or guardian of a child under 18. The service is only eligible for reimbursement if the provider has no alternative means of oral or written communication. No additional reimbursement is available for multilingual providers that share a language with the participant. Interpreters and translators must meet state and professional licensure requirements and be at least eighteen years of age. See the Virtual Care Services section for more information about reimbursement eligibility using virtual care services.

Idaho Medicaid does not reimburse for:

- Administrative services such as:
  - Scheduling or cancelling appointments;
  - Making reminder calls;
  - The interpreter's travel time; or
  - No show appointments;
- Services in conjunction with a non-covered, non-reimbursable, or excluded service;

- Services provided by an immediate family member such as a parent, spouse, sibling or child;
- Services provided through a Medicaid managed care contractor. Contact the managed care contractor to see if they reimburse separately for interpretive services;
- Teaching sign language;
- Providers not on the fee-for-service model;
- Services through institutional providers, hospitals or facilities; or
- The interpreter or translator's waiting time, except when the participant is in surgery or receiving other covered services such as radiology.

Interpretive Services are billed under T1013 (Language Interpretive – Oral Services, per 15 minutes) and T1013-CG (Sign Language Interpretive Services, per 15 minutes).

9.11.4. References: Interpretive Services

a) Federal Guidance

Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons. Office for Civil Rights, Department of Health and Human Services, https://www.hhs.gov/sites/default/files/guidance-on-nondiscrimination-in-telehealth.pdf.

b) Federal Regulations

American with Disabilities Act of 1990. 104 STAT. 327 (1990). Government Printing Office, https://www.gpo.gov/fdsys/granule/STATUTE-104/STATUTE-104-Pg327/content-detail.html.

Civil Rights Act of 1964, Title VI. 78 STAT. 241 (1964). Government Printing Office, https://www.gpo.gov/fdsys/granule/STATUTE-78/STATUTE-78-Pg241/content-detail.html.

Equal Opportunity for Individuals with Disabilities, 42 U.S.C. CH. 126 (1990). Government Printing Office, https://www.gpo.gov/fdsys/pkg/USCODE-2009-title42/html/USCODE-2009-title42-chap126.htm.

Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance, 45 CFR 84 (2025). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2024-title45-vol1/pdf/CFR-2024-title45-vol1-part84.pdf.

Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and... Under Title I of The Patient Protection and Affordable Care Act, 45 CFR 92 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2024-title45-vol1/pdf/CFR-2024-title45-vol1-part92.pdf.

Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services Effectuation of Title VI of the Civil Rights Act of 1964, 45 CFR 80 (2024). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2024-title45-vol1/pdf/CFR-2024-title45-vol1-part80.pdf.

Other Applicable Federal Regulations, 42 CFR 430.2 (2024). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2024-title42-vol4/pdf/CFR-2024-title42-vol4-sec430-2.pdf.

Rehabilitation Act of 1973, Section 504. H.R. 8070 (1973). Government Printing Office, https://www.gpo.gov/fdsys/pkg/STATUTE-87/pdf/STATUTE-87-Pg355.pdf.

c) Idaho Medicaid Publications

"Interpretive Services." *MedicAide Newsletter,* December 2008.

"Interpretive Services." *MedicAide Newsletter,* January 2010.

"New Code for Billing Sign Language Services." *MedicAide Newsletter,* December 2006.

"Providing Sign and Oral Language Interpretive Services." *MedicAide Newsletter,* September 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202012%20MedicAide.pdf.

"Reimbursement for Interpretation, Translation, and Sign Language Services." *MedicAide Newsletter,* January 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202017%20MedicAide.pdf.

d) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

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

9.12. Non-Emergent Medical Transportation

Idaho Medicaid contracts with MTM (Medical Transportation Management Inc.) to provide all non-emergency medical transportation services. Please visit www.mtm-inc.net/idaho or call 1 (877) 503-1261 for more information.

9.13. Virtual Care Services

Virtual care or telehealth means providing medically necessary health care services without actual physical contact, using electronic means. Under Idaho Medicaid this means the participant and the provider opt to interact in real-time or "live" from two physically different locations, by video or telephone. Services delivered as virtual services are considered for reimbursement when rendered within the provider's scope of practice and billed according to all applicable administrative rules, policy, federal and state regulations, including those for protected health information and personal privacy.

Covered services may be delivered via virtual services when:

- The service can be safely and effectively delivered;
- The service fully meets the code definition;
- The service is billed with the FQ or GT modifier; and
- All other existing coverage criteria are met.

Participants (and/or legal guardians), not exempted by State of Federal law, must be informed and consent to the delivery models, and informed of any applicable cost-sharing, provider qualifications, treatment methods, and limitations. The provider must give adequate training on the technology.

If virtual services are offered, it is the rendering provider's responsibility to ensure meaningful access to virtual services for individuals with difficulty communicating due to a medical condition, who need accommodation because of a disability, advanced age, or limited English proficiency. Meaningful access includes but is not limited to ensuring high-quality audio with clear and audible transmission of voices and adequate training to users of the technology. Any electronic or written information must be provided to the participant before the virtual care appointment and provided in a form and manner which the participant can understand. The provider must make reasonable accommodations through methods such as a translator or qualified interpreter when appropriate. Remote interpreting may not be appropriate in some circumstances

The participant (and/or legal guardian) has the right to end the service or refuse the delivery of service at any time and have access to all medical information resulting from the service without affecting their right to future care or treatment. If the participant (or legal guardian) indicates that they want to stop using the technology, the service should cease immediately, and an alternative (in-person) appointment should be scheduled. Providers can deliver virtual care services from any location in the United States. Providers must meet all applicable licensure requirements required by the State of Idaho.

Services provided via asynchronous communication are not reimbursable under Idaho Medicaid. However, remote monitoring services are covered for established patients. Remote Therapeutic Monitoring (RTM) and Remote Physiological Monitoring (RTM) cannot be billed together and must be billed as a distinct and separate service. The use of virtual care services does not change Health Connections referral or prior authorization requirements established for the service. For a primary care provider to be reimbursed for virtual care services, the provider must be able to facilitate an in-person visit if necessary to treat the participant's condition. Reporting of test results only is not covered as a virtual service.

Medicaid policy is not subject to Medicare restrictions for virtual care unless the participant has Medicare primary. Otherwise, all Medicaid providers, including federally qualified health centers (FQHCs), rural health centers (RHCs), and Indian health clinics (IHCs) may bill for virtual care services according to these guidelines.

9.13.1. Virtual Care Services – Technical Requirements

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

9.13.2. Virtual Care Services – Documentation

The individual treatment record must include written documentation of evaluation process, the services provided, participant consent, participant outcomes, and those services were delivered via virtual care. The documentation must be of the same quality as is originated during an in-person visit, including but not limited to, billing the CPT® or HCPCS code with the number of minutes closest to the actual time spent providing the service, service type, amount, frequency, duration and time spent with the participant. If the code is a timed code of 15-minute increments, it must be billed with a number of units as described in the Billing 15-Minute Timed Codes section of the General Billing Instructions, Idaho Medicaid Provider Handbook. These documentation requirements are specific to delivery via virtual care and are in addition to any other documentation requirements specific to the area of service (i.e., IEP requirements for school-based services).

9.13.3. Virtual Care Services – Reimbursement

Only one eligible provider may be reimbursed per service per participant per date of service. No reimbursement is available for the use of equipment at the originating or remote sites. Reimbursement is also not available for services that are interrupted and/or terminated early due to equipment difficulties. Claims for services delivered via virtual care will be reimbursed at the same rate as face-to-face services. A service is considered audio only if 50% or more of the service is provided via audio only. Virtual service visits will be subject to retrospective review as appropriate.

Idaho Medicaid uses places of service 02 (Telehealth provided other than in patient's home) and 10 (Telehealth provided in patient's home). Providers must use these places of service on claims for virtual care. When a participant is in the office and receiving virtual care from a provider at their home, out-of-state or elsewhere, box 32 of the CMS-1500 claim form uses the location of the participant, not the provider.

Claims for virtual care must include one of the following modifiers:

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

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

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

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

9.13.4. References: Virtual Care Services

a) CMS Guidance

"Chapter 15 – Covered Medical and Other Health Services (2024)." *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.

"Chapter 12 – Physicians/Nonphysician Practitioners (2024)." *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/clm104c12.pdf.

"CY2022 Telehealth Update Medicare Physician Fee Schedule." Centers for Medicare and Medicaid Services, 14 January 2022, https://www.cms.gov/files/document/mm12549-cy2022-telehealth-update-medicare-physician-fee-schedule.pdf.

"Telehealth." Centers for Medicare and Medicaid Services, 5 February 2025, https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

b) Federal Guidance

Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons. Office for Civil Rights, Department of Health and Human Services, https://www.hhs.gov/sites/default/files/guidance-on-nondiscrimination-in-telehealth.pdf.

c) Federal Regulations

Nondiscrimination in Health Programs and Activities, Section 1557 of the Affordable Care Act, Nondiscrimination in Health Programs and Activities, 45CFR Part 92 (2024). Federal Regulations, https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities

Payment for Telehealth Services, 42 CFR 414.65 (2001). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol3/pdf/CFR-2018-title42-vol3-sec414-65.pdf.

Telehealth Services, 42 CFR 410.78 (2015). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol2/pdf/CFR-2018-title42-vol2-sec410-78.pdf.

d) Idaho Medicaid Publications

"Telehealth Place of Services (POS)." *MedicAide Newsletter,* July 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf.

Telehealth Policy, Information Release MA16-20 (12/23/2017). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Telehealth Services." MedicAide Newsletter, May 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

Telehealth Therapies, Information Release MA16-07 (5/9/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho.

Updated Telehealth Policy, Information Release MA18-07 (7/2/2018). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13004&dbid=0&repo=PUBLIC-DOCUMENTS.

Updated Telehealth Policy, Information Release MA15-11 (12/31/2015). Division of Medicaid, Department of Health and Welfare, State of Idaho.

e) State Regulations

Idaho Virtual Care Access Act, Idaho Code 54-57 (2023). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title54/t54ch57.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

The Medical Consent and Natural Death Act, Idaho Code 39-4507 (2005). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH45/SECT39-4507.

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

9.14. Weight Management Services

Weight management services are covered for Medicaid participants through the behavioral health benefit of the Preventive Health Assistance (PHA) program. Weight management services are not administered through the Idaho Behavioral Health Plan.

9.14.1. Eligible Participants: Weight Management Services

Medicaid participants are eligible for weight management services when criteria is met with a few exceptions. Medicaid participants enrolled in one of the Managed Care Programs for Dual Eligible Participants may receive applicable PHA benefits through the health plan in which they are enrolled. Participants eligible for Medicaid through Katie Beckett are not eligible for PHA benefits.

Participants interested in the Preventive Health Assistance (PHA) program begin by visiting their primary care provider (PCP). The PCP:

- Determines if the participant meets the Body Mass Index (BMI) requirements for their age group to have one of the covered diagnoses in the table below;
- Confirms the participant does not have an excluded eligibility; and
- Discusses weight management programs with patient and help to identify obtainable goals.

Covered Diagnoses for Weight Management Services	
ICD-10-CM	**Description**
E66.01	Morbid (severe) obesity due to excess calories. 100lbs overweight.
E66.09	Other obesity due to excess calories. BMI of 30 or higher.
E66.1	Drug-induced obesity. BMI of 30 or higher.
E66.3	Overweight. BMI between 25 and 29.9. Participants over the age of 21 with this diagnosis are not eligible.
E66.8	Other obesity. BMI of 30 or higher.
E66.9	Obesity, unspecified. BMI of 30 or higher.
R63.6	Underweight

If the PCP determines the participant meets the criteria for the behavioral PHA benefit, the PCP prints and completes section 1 of the Idaho Medicaid Preventive Health Assistance (PHA) Weight Management Agreement Form and provides it to the participant or their guardian. The PCP should also provide the PHA Weight Management Provider List if the participant hasn't already found an enrolled weight management services provider.

The participant must select a weight management program from an enrolled provider. The participant must then take the form to their weight management provider to receive services. The form does not need to specify the provider so long as they are enrolled in the Idaho Medicaid program. The form is only valid if the weight management provider returns it to the Medical Care Unit within two (2) months of the PCP's signature.

a) Participants Under 21

Participants between age five (5) and twenty-one (21) may qualify for weight management services if they have a body mass index (BMI) that falls into either the overweight, obese, or underweight category as determined by the Centers for Disease Control and Prevention's (CDC) BMI Percentile Calculator for Child and Teen.

b) Participants Over 21

Participants twenty-one (21) years of age and older with a body mass index (BMI) of 30 or higher, or 18½ or lower, may qualify for the weight management program.

c) References: Eligible Participants – Weight Management Services

(i) State Regulations

"Behavioral PHA." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 191.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Preventive Health Assistance, Idaho Code 56-256 (2007). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-256.

9.14.2. Provider Qualifications: Weight Management Services

Providers of weight management services include, but are not limited to, life style coaches and other suppliers in the National Diabetes Prevention program, gyms, health clubs and registered dietitians. Providers, including those that are already enrolled as another provider type, must enroll as an atypical provider with Idaho Medicaid prior to providing weight management services under the Preventive Health Program (PHA). Providers must be enrolled independently as the direct/pay-to and cannot bill as a rendering under a group NPI.

Registered dietitians, however, enrolled with Medicaid do not have to complete a separate enrollment to provide weight management services within the scope of their licensure. A registered dietitian can bill for their services as a rendering provider under a group NPI or be a direct/pay-to provider. If the dietitian offers services beyond nutrition and diet, such as operating a gym or health club, then the dietitian would need to enroll as an atypical provider type for those services.

Providers must follow the Idaho Medicaid Provider Handbook and all applicable state, and federal, rules and regulations including county and local business licensing requirements. They must also be established as a business that serves the general public.

See the Provider Enrollment section for more information on enrolling as an Idaho Medicaid provider.

9.14.3. Covered Services and Limitations: Weight Management Services

The behavioral benefit of the Preventive Health Program (PHA) awards points to enrolled Medicaid participants to redeem for weight management services. Weight management services must either address physical fitness, balanced diet or personal health education. These can include services under the National Diabetes Prevention Program, gym fees, healthy lifestyle classes or nutrition classes. Participants earn 200 points under the behavioral benefit during each benefit period.

Benefit periods last twelve months from when the participant is approved for the program. Participants may reapply after or near the end of their benefit period if they still meet criteria for the program. Benefit periods cannot overlap. Points cannot be transferred to another participant. Any points not utilized during their issued benefit period, expire. Points can be

redeemed by voucher with a Medicaid enrolled provider at a rate of one-point to one-dollar towards eligible services.

Weight management providers must verify eligibility when they receive the voucher. Providers can only verify eligibility for PHA weight management services by calling Gainwell Technologies customer service at 1 (866) 686-4272.

a) References: Covered Services and Limitations – Weight Management Services

(i) State Regulations

"Behavioral PHA." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 193.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

Preventive Health Assistance, Idaho Code 56-256 (2007). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-256.

"Preventive Health Assistance (PHA): Coverage and Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 192. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

9.14.4. Reimbursement: Weight Management Services

Services must meet all Medicaid requirements to be eligible for reimbursement. Idaho Medicaid reimburses weight management services on a fee-for-service basis. Services are reimbursed at 100% of the invoiced amount up to the maximum on the participant's voucher, so long as the participant has points remaining to redeem. Once a participant has exhausted their benefit, the participant is liable for any remaining balance due from services provided under the PHA behavioral benefit that are not otherwise covered by Idaho Medicaid. See the Participant Financial Responsibility section for requirements on billing a participant.

Claims must be submitted on a CMS-1500 form to Gainwell Technologies via mail or the provider portal for reimbursement. Covered services and the corresponding billing codes are found in the table below. Reimbursement is only available for participants with one of the diagnoses listed in the Eligible Participants: Weight Management Services section billed as the primary diagnosis on the claim. See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding policy on billing, prior authorization and requirements for billing all other third-party resources before submitting claims to Medicaid.

PHA Weight Management Covered Codes	
HCPCS	**Description**
S9449	Weight management classes, non-physician provider, per session. Weight management classes are training and education related to nutrition, physical activity, stress management, and lifestyle and how they relate to health.
S9451	Exercise classes, non-physician provider, per session. Exercise classes are formal programs of bodily activities that maintain physical fitness and overall health. They are usually performed in a group. There are generally three types of exercise: flexibility, such as stretching; aerobic, such as cycling, tennis, and swimming; and anaerobic, such as weight lifting.

PHA Weight Management Covered Codes	
HCPCS	**Description**
S9452	Nutrition classes, non-physician and non-physician practitioner provider, per session. Nutrition classes provide organized instruction in the food and foodstuffs necessary for life. Classes are usually group activities that discuss generalities.
S9970	Health club membership, annual. This code represents the annual fees for a health club, also known as a fitness club or gym. The club or gym is a location that houses exercise equipment, may offer exercise classes, and other educational opportunities.

a) References: Reimbursement – Weight Management Services

(i) State Regulations

"Preventive Health Assistance (PHA): Provider Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 195. 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.

9.15. CHIP Wellness Incentive

Children enrolled in the Children's Health Insurance Program (CHIP) are required to pay a monthly premium of $10 or $15. The Preventive Health Assistance (PHA) program as part of its wellness benefit provides ten (10) points a month to participants, who keep up-to-date on their well child exams and immunizations. Points are then converted into a $10 credit towards the participant's monthly CHIP premium. Preventive care including well child exams, vaccines and their administration (immunizations) are not subject to copayments.

Points accumulated through the PHA wellness benefit are only redeemable towards CHIP premiums. A participant can only receive 120 points in a twelve-month period. Points cannot be transferred to another participant. Any points not utilized during their issued twelve-month period, expire.

Statements are mailed to parents on a monthly basis. If a parent knows their child is up-to-date on their well checks and immunizations, they may ask their primary care provider (PCP) to fax verification of the checkup or immunizations to the Medical Care Unit at 1 (877) 845-3956. If you have questions about the PHA program, please call the Medical Care Unit toll free at 1 (877) 364-1843.

See the Wellness Examinations section of the Medical Services, Idaho Medicaid Provider Handbook for more information.

9.15.1. References: CHIP Wellness Incentive

a) Idaho Medicaid Publications

Idaho Medicaid Public Schedule of Premiums and Cost-Sharing Requirements. Idaho Department of Health and Welfare. https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2085&dbid=0&repo=PUBLIC-DOCUMENTS&cr.

b) State Regulations

"Point System." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 192.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Premiums." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 192.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Preventive Health Assistance, Idaho Code 56-256 (2007). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-256.

"Preventive Health Assistance (PHA): Definitions." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 190. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Preventive Health Assistance (PHA): Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 191.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Wellness PHA." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 193.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Appendix A. Provider Agreement Example

TERMS AND CONDITIONS

1. Compliance.

This Provider Agreement ("AGREEMENT") is entered into by and between the Department of Health and Welfare ("DEPARTMENT"), as the State of Idaho's administering agency with authority under Idaho Code, Title 56, Chapter 2, to enter into agreements with individuals or entities ("PROVIDER"). This AGREEMENT is entered into for the purpose of defining the DEPARTMENT's expectations of providers who provide healthcare services, equipment, supplies or items and hereinafter referenced as "SERVICES" through any network to persons eligible for medical assistance and who submit claims for reimbursement in accordance with all applicable provisions of Idaho Statute, administrative code and federal regulations under the Medical Assistance Program ("MEDICAID"). This AGREEMENT and the terms herein are conditions of payment as used in Section 56-§209h (5) of Idaho Code. Failure to comply with any of the Terms and Conditions, or applicable ADDENDUMS incorporated herein, may affect PROVIDER's ability to continue participation in MEDICAID or may result in recovery of payments made by the DEPARTMENT to the PROVIDER, assessment of civil monetary penalties, suspension of payments and/or exclusion from the Medicaid program.

This AGREEMENT and any applicable ADDENDUMS attached hereto and hereby incorporated by reference; are subject to modification, revisions, or termination in accordance with changes in federal or state laws, administrative code or regulations. The DEPARTMENT reserves the right to amend this AGREEMENT by providing the PROVIDER twenty-eight (28) day notice, as published within an Information Release (IR), and PROVIDER is deemed to accept, following such notice period. This AGREEMENT will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

This AGREEMENT delineates the responsibilities of the PROVIDER and any subcontractor, agent or employee of the PROVIDER, in regard to the MEDICAID Program. The PROVIDER certifies and agrees to the Terms and Conditions set forth below.

2. Regulations, Rules, Policies and Procedures.

2.1 PROVIDER certifies that SERVICES provided will be provided to participants without regard to health status or need for healthcare services and will be provided without regard to race, color, age, sex, disability, or national origin in accordance with 45 CFR Part 90, Part 91 and Part 92 and 42 CFR Part 438, as applicable and as amended.

2.2 PROVIDER shall comply with all applicable provisions of 45 CFR Part 88, consistent with applicable court orders or as amended; the Health Insurance Portability and Accountability Act (HIPAA); Sections 262 and 264 of Public Law 104 -191, 42 USC Section 1320d, and applicable

federal regulations at 45 CFR Subchapter C specific to Administrative Data Standards and 45 CFR Subchapter D - Health Information Technology and Related Requirements; 170.215. PROVIDER shall additionally be responsible for protecting the confidentiality of participant information that is collected, used, or maintained according to IDAPA 16.05.01, "Use and Disclosure of Department Records," and 42 CFR § 431. Subpart F specific to unauthorized disclosure of applicant and beneficiary information.

2.3 PROVIDER shall comply with 42 USC §1396A(a)(68) and 42 CFR §438.600(a)(6,) as amended and applicable, if PROVIDER receives or makes annual payments of MEDICAID funds of at least five million dollars ($5,000,000).

2.4 PROVIDER shall ensure any individual providing interpretive SERVICES related to the provision of a health-related service, is a minimum of eighteen (18) years of age and meets the definition of qualified interpreter consistent with 28 CFR § 35.104.

2.5 Pursuant to 42 CFR § 431.107, PROVIDER acknowledges their compliance with all requirements specific to AGREEMENTS, as applicable and amended, and Advance Directives, as applicable and specified in 42 CFR Part 489, Subpart I and 42 CFR §417.436(d), as amended.

2.6 PROVIDER acknowledges the responsibility to comply with all applicable parts of the False Claims Act (31 USC §§3729-3733) and 42 CFR §438.608(a)(6) as amended, including, but not limited to, educating employees about federal and State laws pertaining to civil or criminal penalties for false claims, false statements and whistleblower protections under such laws.

2.7 Pursuant to federal regulations at 42 CFR §455.105, PROVIDER shall if requested, furnish to the DEPARTMENT and/or the U.S. Department of Health and Human Services, within thirty-five (35) days of the date of the transaction or the date of the written request, full and complete information related to certain business transactions, specifically:

2.7.1 ownership of any subcontractor with whom the PROVIDER has had business transactions totaling more than $25,000 during the twelve (12) month period preceding the most recent business transaction or ending on the date of the request, as applicable; and

2.7.2 pursuant to 42 CFR Part 455, Subpart B, any significant business transaction, between the PROVIDER and any wholly owned supplier, or between the PROVIDER and any subcontractor, during the 5-year period preceding the most recent business transaction or ending on the date of the request.

2.8 PROVIDER certifies that SERVICES provided to participant are not in violation of Idaho Code § 18-8901.

3. Administrative Code.

PROVIDER shall comply with all applicable provisions of the Idaho Administrative Code, as amended, including but not limited to: IDAPA 16.03.01 - "Eligibility for Health Care Assistance for Families and Children", IDAPA 16.03.05 – "Eligibility for Aid to the Aged, Blind, and Disabled", IDAPA 16.03.09 – "Medicaid Basic Plan Benefits", IDAPA 16.03.10 – "Medicaid Enhanced Plan Benefits", IDAPA, 16.03.13 – "Consumer Directed Services", IDAPA 16.03.17 – "Medicare/Medicaid Coordinated Plan Benefits", and IDAPA 16.03.18 – "Medicaid Cost Sharing", IDAPA – 16.05.03 "Contested Case Proceedings and Declaratory Rulings", IDAPA 16.05.06 "Criminal History and Background Checks", and IDAPA 16.05.07 – "The Investigation and Enforcement of Fraud, Abuse and Misconduct."

4. Policy Guidance.

PROVIDER shall conduct operations in accordance with all applicable policy and guidance accessible to them via the internet at www.idmedicaid.com and healthandwelfare.idaho.gov, including, but not limited to, the MedicAide newsletter, Information Releases, the Idaho Medicaid Provider Handbook (Provider Manual), as applicable and amended. Additionally, PROVIDERS participating in a managed care program must adhere to applicable interpretations of policy specified by the managed care program.

5. Employee Training.

PROVIDER acknowledges responsibility to ensure employees, subcontractors and agents of the PROVIDER receive training specific to the usage and adherence of all applicable provisions of policy within this AGREEMENT for PROVIDERS providing services in any delivery system and by any mode including but not limited to, all applicable IDAPA rules, policy documents and guidance contained within the MedicAide newsletter, Information Releases, the Idaho Medicaid Provider Handbook (Provider Manual), and managed care program contracts as amended and applicable.

6. Provider Enrollment Process.

6.1 PROVIDER shall comply with the DEPARTMENT's enrollment processes and acknowledges the DEPARTMENT's authority to make provider enrollment decisions, which may include but is not limited to,

mandatory denial of a Provider Agreement in accordance with IDAPA 16.03.09.200.06.

PROVIDER acknowledges and agrees PROVIDER and its principals will be held responsible for violations of this AGREEMENT through any acts or omissions by the PROVIDER, its employees, its subcontractors or its agents specific to the provider enrollment process, including but not limited to, failure to disclose the revocation, termination or voluntary termination of an enrollment or if any party specified within 42 CFR § 455.106(c) has been convicted of a criminal offense.

6.1.1 PROVIDER understands this includes all applicable disclosures provided within 42 CFR §422.104 applicable to relationships between those who have an ownership interest, a control interest operational or managerial control of the PROVIDER organization as applicable.

6.1.2 Pursuant to federal regulations at 42 CFR Part 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents" and by reference 42 CFR §438.602(c) as applicable PROVIDER shall comply with the disclosure of ownership requirements; and agrees that for the purposes of this AGREEMENT, principal of the PROVIDER includes all agents, corporate officers, directors, partners of any partnership entity, including a professional corporation, association, limited liability company, those participating through a managed care program or their fiscal agent with either indirect ownership or control interest.

6.1.3 PROVIDER understands they may make agreements to provide SERVICES through a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) and acknowledge their responsibility under such agreements to comply with all applicable parts of 42 CFR Part 438, as amended in addition to all applicable provisions of this AGREEMENT.

6.1.3.1 PROVIDER further acknowledges this AGREEMENT must be approved within one hundred twenty (120) days if applicable, for enrollment or credentialing with an MCO, PIHP or PAHP, in accordance with 42 CFR §438.602.

6.1.3.2 PROVIDER understands that if rendering services only under an agreement with an MCO, PIHP or PAHP, PROVIDER is not required to render services to participants in the FFS network as provided by 42 CFR §438.608(b).

6.2 PROVIDER acknowledges this AGREEMENT is not transferable or assignable. PROVIDER also acknowledges that at any time during the course of this AGREEMENT, PROVIDER shall notify the DEPARTMENT of any change in information contained in this AGREEMENT or their Provider Enrollment application, including within thirty-five (35) days after the change. Changes PROVIDERs are required to report include, but are not limited to, changes (or impending changes) in ownership or control information described in 42 CFR 455 Subpart B; indirect ownership, service locations, changes to licensure, tax information, bankruptcy; physical, mailing or electronic addresses, phone number; or the addition or removal of Licensed Medical Service Providers. Change in ownership or control information requires full disclosure of the terms of the sale agreement, submittal of a new enrollment application and execution of a new AGREEMENT.

7. Professionalism.

7.1 PROVIDER shall provide SERVICES in accordance with all applicable requirements within, Idaho state statutes, Idaho Administrative Code And 42 CFR Part 438 Managed Care.

7.2 PROVIDER shall obtain and maintain licenses, permits, certification, registration and authority necessary to conduct business and provide service under this AGREEMENT and 42 CFR Part 438 Managed Care, as applicable. Copies of these must be submitted to Gainwell's Provider Enrollment upon request.

7.3 PROVIDER shall comply with all applicable state and federal laws.

7.4 PROVIDER attests compliance with all requirements to maintain appropriate insurance coverage as applicable within the scope of their professional license/certification and services rendered.

7.5 PROVIDER agrees to uphold professionally recognized community standards of care and if applicable, retain non-Physician practitioners or paraprofessionals who have appropriate qualifications, licensing or certification as specified by the DEPARTMENT or a contract under 42 CFR Part 438 Managed Care. PROVIDER additionally agrees to provide appropriate supervision of such individuals.

7.6 PROVIDERs shall verify and ensure all employees, subcontractors and agents meet the fingerprint-based Criminal History Background Check provisions, as required by the DEPARTMENT under IDAPA 16.05.06, "Criminal History and Background Checks" and IDAPA, 16.03.09 "Medicaid Basic Plan Benefits".

7.7 PROVIDER shall abide by all applicable laws regarding the Medicaid participant's right to privacy, dignity, and free choice of providers and agrees to comply with 42 CFR, Chapter I, Subchapter A, Part 2 specific to Confidentiality of Substance Use Disorder Patient Records and 45 CFR, §164.524, as amended to afford access to records for SERVICES.

7.8 PROVIDER shall abide by this AGREEMENT and any applicable Addendums or supplemental agreements, as amended.

8. Records Management.

8.1 PROVIDER agrees to legibly document all SERVICES in accordance with professionally recognized standards to support each claim for reimbursement by MEDICAID or its agent, at the time it is provided, in compliance with the requirements specified in the Idaho Medicaid Provider Handbook (Provider Manual), Idaho Code, §56-209h(3), applicable DEPARTMENT rules and this AGREEMENT, as amended. Such documentation shall be maintained for at least five years after the date of service, in accordance with IDAPA 16.05.07.101 or as required by other DEPARTMENT rule. Failure to comply with documentation requirements may result in the recoupment of Medicaid payments.

8.2 PROVIDER shall ensure their cooperation with the DEPARTMENT's Medicaid Program Integrity Unit (MPIU), the Attorney General's Medicaid Fraud Control Unit and the U.S. Department of Health and Human Services, or their agents by providing immediate access in accordance with Idaho Code §56-209h and IDAPA 16.05.07 "The Investigation and Enforcement of Fraud, Abuse and Misconduct" to all records, documents, material, and data in any medium which supports SERVICES billed to MEDICAID or its designee, at the time the request is made.

8.2.1 PROVIDER also agrees to comply with applicable Quality Assurance audits specific to IDAPA 16.03.10, and as provided by any ADDENDUM to this AGREEMENT or agreement in a managed care program.

9. Accurate Billing.

9.1 PROVIDER shall certify by their signature or through their designee, including electronic signatures on a claim form or transmittal document, that the SERVICES claimed were actually provided in accordance with professionally recognized standards of health care, the Idaho Medicaid Provider Handbook (Provider Manual), all applicable DEPARTMENT rules, and this AGREEMENT.

9.2 PROVIDER agrees to be responsible for the accuracy of claims submitted to the DEPARTMENT or its agent whether submitted on paper, electronically or through a billing service.

9.3 PROVIDER ensures SERVICES are claimed only under one program and one provider type regardless of the delivery system or mode of delivery and to immediately repay the DEPARTMENT or its designee for any SERVICE the DEPARTMENT or the PROVIDER determines were not properly provided, properly documented, or properly claimed.

9.4 Pursuant to 42 USC §1320a-7 and 42 USC §1320c-5, PROVIDER shall bill MEDICAID or its agent only for SERVICES delivered by individuals not excluded from MEDICAID; and additionally, assures all payments are correctly applied to participant accounts and credited timely.

10. Secondary Payor or Third-Party Liability.

10.1 PROVIDER agrees to seek payment first from all other applicable sources of payment prior to submitting a claim for SERVICES to MEDICAID or its agent specific to 42 CFR §433 - Subpart D. for third party liability. Additionally, PROVIDER acknowledges MEDICAID as the payer of last resort and agrees to comply with 42 CFR §447.20(b).

10.1.1 As an exception to 10.1, Indian Health Services (IHS), purchased or referred care healthcare (PRC) by IHS, and health insurance plans self-funded by a federally recognized tribe are secondary to MEDICAID according to 42 CFR §136.203.

10.2 PROVIDER acknowledges that if a secondary payor or third party pays the participant for the SERVICES provided, the PROVIDER may bill the participant for that amount if written notice of financial responsibility was provided in accordance with MEDICAID policy and prior to the delivery of the service; and

10.3 PROVIDER acknowledges they cannot refuse to furnish SERVICES to a participant if a third-party is potentially liable for the service.

10.4 PROVIDER agrees to not bill the DEPARTMENT or its agent if a secondary payor or third-party payment is made to the PROVIDER, unless the secondary payor or third-party payment is less than the amount paid by MEDICAID or its agent.

11. Reimbursement.

11.1 PROVIDER understands they are to complete the appropriate claim form and acknowledges responsibility for the validity and accuracy of claims whether submitted on paper, electronically or through a billing service to MEDICAID or the DEPARTMENT's agent for reimbursement.

11.2 PROVIDER agrees to submit a request for prior authorization, if one is required, and to receive an approval for that request, prior to providing the requested SERVICES to the participant except where allowed by MEDICAID or its agent.

11.3 PROVIDER understands that reimbursement for the SERVICES by MEDICAID or its agent is contingent on the PROVIDER being correctly enrolled, licensed and credentialed, if applicable; conducting a determination of medical necessity for the SERVICES that meets all DEPARTMENT requirements or its agent if applicable; eligibility of the participant for the SERVICES at the time it is rendered; coverage limitations at the time provided; timely submittal of prior authorization when applicable; and the PROVIDER billing per all applicable requirements, including but not limited to administrative code, policies and requirements specified by the National Correct Coding Initiative.

12. Payment in Full.

12.1 Pursuant to 42 CFR §447.15 PROVIDER agrees to accept MEDICAID payment or payment by its agent, as payment in full, for any SERVICES.

12.1.1 PROVIDER also agrees that prior to delivering non-covered or excluded MEDICAID SERVICES to a participant, PROVIDER will supply an itemized written notice to the participant, which informs them of their responsibility to pay for the SERVICES they are receiving, prior to rendering the SERVICES and require the participant to affix their signature as acknowledgement of their financial responsibility. If the participant qualifies for a period of retroactive eligibility for Medicaid, this subsection does not apply during the retroactive period.

12.1.2 PROVIDER agrees to comply with the billing requirements specific to participant financial responsibility as provided within the Idaho Medicaid Provider Handbook (Provider Manual), administrative code or by a managed care program, as applicable.

13. Officers and Employees of the State.

PROVIDER acknowledges that no official, employee, or agent of the DEPARTMENT shall be in any way personally liable or responsible for any term of this AGREEMENT, whether express or implied, nor for any statement, representation, or warranty made in connection with this AGREEMENT. A

guarantee of payment for SERVICES cannot be made by an official, employee or agent of the DEPARTMENT.

14. Provider Liability.

PROVIDER agrees if their organization is any type of business entity, the entity and all general or limited partnership interests and all shareholders, with a direct or indirect ownership or control interest, regardless of the percentage of ownership, are jointly and severally liable for any breach of this AGREEMENT, and that action by the DEPARTMENT against the PROVIDER may result in action against any or all such individuals in the entity.

15. Provider Revalidation.

15.1 PROVIDER acknowledges that the DEPARTMENT requires all enrolled providers to revalidate enrollment information at least every five years, in accordance with 42 CFR §455.414 and 42 CFR §438.602(b) if applicable. PROVIDER also acknowledges the DEPARTMENT may conduct off-cycle revalidations for certain program integrity purposes as allowed by 42 CFR §455.452 to ensure compliance with these requirements. Upon the DEPARTMENT's request to revalidate its enrollment, the PROVIDER has ninety (90) days from the postmark on the Revalidation Notice to submit the completed enrollment to the DEPARTMENT for approval.

15.2 PROVIDER also acknowledges all information disclosed by the PROVIDER is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in the Provider Enrollment Application, this AGREEMENT (if applicable) and Disclosure Statement or contained in any communication supplying information to the DEPARTMENT may be punishable to the full extent allowed under the law, including but not limited to, revocation of this PROVIDER AGREEMENT, recovery of payments made, and assessment of civil monetary penalties.

16. Breach.

In addition to any breaches specified in other sections of this AGREEMENT, the failure of the PROVIDER to perform any of its obligations hereunder in whole or in part or in a timely or satisfactory manner constitutes a breach. A breach in this AGREEMENT may result in termination, suspension or recoupment of any or all PROVIDER payments and/or assessment of civil monetary penalties.

17. Duration and Termination of Agreement.

17.1 PROVIDER acknowledges this AGREEMENT shall be effective from the date the applicant is enrolled as a PROVIDER or from the date the PROVIDER is approved for continued enrollment and will remain in effect until terminated in writing.

17.2 This AGREEMENT may be terminated by either party, without cause, by giving twenty-eight (28) days notice in writing to the other party except as otherwise provided in this AGREEMENT.

17.2.1 DEPARTMENT's sole obligation, in the event of termination, shall be to pay for SERVICES provided prior to the effective date of the termination that are eligible for reimbursement.

17.3 DEPARTMENT may at its discretion, terminate this AGREEMENT in writing in the event the PROVIDER has failed to submit a claim for reimbursement to Medicaid or its agent within a twenty-four (24) month period.

17.4 DEPARTMENT may terminate this AGREEMENT if judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of this AGREEMENT infeasible or impossible.

17.5 DEPARTMENT shall immediately terminate this AGREEMENT if the PROVIDER's license or certification, required by law or rule, is revoked, not renewed or is otherwise not in effect at the time SERVICE is provided.

17.6 DEPARTMENT may, at its discretion terminate this AGREEMENT if it determines the PROVIDER did not fully and accurately make any disclosure, including but not limited to board actions, or if the PROVIDER failed to notify the DEPARTMENT of any change as specified in "6. Provider Enrollment Process" of this AGREEMENT. All correspondence sent to the mailing or electronic address on file with the DEPARTMENT's fiscal agent shall be deemed to have been received by the PROVIDER.

17.7 DEPARTMENT may, at its discretion, terminate this AGREEMENT in writing when the PROVIDER fails to comply with any applicable regulations, statutes, administrative code, guidance, policy or provision of this AGREEMENT, either immediately or upon such notice as the DEPARTMENT deems appropriate in accordance with IDAPA 16.03.09.205, "Medicaid Basic Plan Benefits" or IDAPA 16.05.07.230, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct."

17.8. PROVIDER understands and agrees its conduct may be subject to additional penalties or sanctions under Idaho Code §§ 56-209h, 56-227, 56-227A, 56-227B, and 56-227E, as amended, IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse and Misconduct", and 42 CFR Part 438 Managed Care, as applicable and amended. PROVIDER also understands there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this AGREEMENT. Notice of these sanctions shall in no way imply they represent an exclusive or exhaustive list of available actions concerning fraud and abuse.

18. Additional terms.

PROVIDER agrees to abide by any applicable terms if any, as attached and/or any applicable provisions of 42 CFR Part 438 Managed Care, as amended.

19. Construction, Severability, and Venue.

This AGREEMENT shall be governed, construed, and enforced in accordance with the laws and regulations of the state of Idaho and appropriate federal statutes and regulations. The provisions of this AGREEMENT are severable and independent, and if any such provision shall be determined to be unenforceable, in whole or in part, the remaining provisions and any

partially enforceable provision shall, to the extent enforceable in any jurisdiction, nevertheless, be binding and enforceable. Any action to enforce the provisions of this AGREEMENT shall be brought in State District Court in Ada County, Boise, Idaho.

20. Interpretation.

In the event of inconsistency or ambiguity between the provisions of IDAPA and this AGREEMENT, the provisions of IDAPA shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, in which case such federal or state law shall be determinative of the obligations of the parties. In the event IDAPA is silent with respect to any ambiguity or inconsistency, the AGREEMENT (including Appendices) shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the AGREEMENT and the budgetary and statutory constraints of the DEPARTMENT.

21. Headings. The headings in this AGREEMENT have been inserted for convenient reference only and shall not be considered in any questions of interpretation or construction of this AGREEMENT.

Appendix B. General Information and Requirements for Providers, 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 Information and Requirements for Providers, Provider Handbook Modifications				
Version	**Section**	**Update**	**Publish Date**	**SME**
94.0	All	Published version	07/01/2025	TQD
93.15	5.8.1. Limited Risk Providers	Added translators to limited risk.	07/01/2025	W Deseron K Lolofie
93.14	9.14.3. Covered Services and Limitations: Weight Management Services	Updated process.	07/01/2025	W Deseron K Lolofie
93.13	9.14.1.Eligible Participants: Weight Management Services	Procedural changes.	07/01/2025	W Deseron K Lolofie
93.12	9.8. Advance Directives	New section.	07/01/2025	W Deseron K Lolofie
93.11	9.7. Non-Covered and Excluded Services	Added info about non-covered service modifiers.	07/01/2025	W Deseron K Lolofie
93.10	9. Covered Services and Limitations: General	Added that services must be provided directly to the participant unless otherwise noted.	07/01/2025	W Deseron K Lolofie
93.9	6.12.3. Billing Procedures for Managed Care Participants	Renamed Billing Procedures for Managed Care Dual Plan Participants. Clarified effected programs.	07/01/2025	W Deseron K Lolofie
93.8	6.12. Managed Care Programs for Dual Eligible Participants	Adds requirement for id card with both Medicare and Medicaid benefits.	07/01/2025	W Deseron K Lolofie
93.7	6.6.2. Developmental Disability Waiver	Clarified application to MMCP plan.	07/01/2025	W Deseron K Lolofie
93.6	6.6.1. Aged and Disabled Waiver	Clarified application to MMCP plan.	07/01/2025	W Deseron K Lolofie
93.5	6.6. Idaho Medicaid Waivers	Added overview of waivers.	07/01/2025	W Deseron K Lolofie
93.4	6.2. Medicaid Identification Card	Added United Healthcare card.	07/01/2025	W Deseron K Lolofie
93.3	5.5.1. Individual Provider Numbers	Added provider specialties.	07/01/2025	W Deseron K Lolofie
93.2	4.5. Provider Handbooks	Renamed Provider Handbooks and Guides. Added Trading Partner Account User Guide info.	07/01/2025	W Deseron K Lolofie
93.1	2. Participant Financial Responsibility	Added info about non-covered service modifiers.	07/01/2025	W Deseron K Lolofie
93.0	All	Published version	08/18/2024	TQD
92.2	5.1. Non-billing Ordering, Referring and Prescribing Providers	Removed pharmacist billing exception. Pharmacists can now bill directly.	08/16/2024	/W Deseron
92.1	1.3. Ordering, Referring and Prescribing Providers	Removed pharmacist billing exception. Pharmacists can now bill directly.	08/16/2024	W Deseron
92.0	All	Published version	07/01/2024	TQD
91.22	Appendix A. Provider Agreement Example	Updated to new edition.	06/27/2024	W Deseron M Hanifen
91.21	9.12.3. Virtual Care Services – Reimbursement	Added guidance for provider place of service.	06/27/2024	W Deseron M Hanifen
91.20	9.12. Virtual Care Services	Updated policy.	06/27/2024	W Deseron M Hanifen

General Information and Requirements for Providers, Provider Handbook Modifications				
Version	**Section**	**Update**	**Publish Date**	**SME**
91.19	8. Healthy Connections Value Care	Removed all subsections.	06/27/2024	W Deseron M Hanifen
91.18	7.2.5. Changing Enrollment in Healthy Connections	Updated website.	06/27/2024	W Deseron M Hanifen
91.17	7.2.2. Participant Enrollment Guidelines	Updated website.	06/27/2024	W Deseron M Hanifen
91.16	7.1.4. Healthy Connections Tier Requirements	Updated website.	06/27/2024	W Deseron M Hanifen
91.15	7.1. Healthy Connections Provider Enrollment	Updated website.	06/27/2024	W Deseron M Hanifen
91.14	6.14. The Pregnant Women (PW) Program	Extended coverage to 12 months after birth.	06/27/2024	W Deseron M Hanifen
91.13	6.9. Incarcerated Persons	Removed ending eligibility after discharge.	06/27/2024	W Deseron M Hanifen
91.12	6.8.5. Request Procedure: Outpatient Behavioral Health	Updated contractor to Magellan.	06/27/2024	W Deseron M Hanifen
91.11	6.8.4. Request Procedure: Services Not in State Plan	Updated required form.	06/27/2024	W Deseron M Hanifen
91.10	5.10. Change in Ownership or Tax Identification Information	Added time limit and examples. Clarified new NPIs.	06/27/2024	W Deseron M Hanifen
91.9	5.2.1. Mental Health Clinics	Updated contractor to Magellan.	06/27/2024	W Deseron M Hanifen
91.8	4.8. Secure Messaging	New section.	06/27/2024	W Deseron M Hanifen
91.7	4.4. MedicAide Newsletter	Clarified language. No substantive changes.	06/27/2024	W Deseron M Hanifen
91.6	4.2. Eligibility Checks	Renamed 4.2. Benefit Eligibility Checks. Clarified requirements.	06/27/2024	W Deseron M Hanifen
91.5	1.6. Payment Error Rate Measurement (PERM) Audits	Updated contact information.	06/27/2024	W Deseron M Hanifen
91.4	1.2.5. Retention of Records	Clarified language. No substantive changes.	06/27/2024	W Deseron M Hanifen
91.3	1.2.1. Additional Documentation	Clarified language. No substantive changes.	06/27/2024	W Deseron M Hanifen
91.2	1.2. Documentation	Clarified language. No substantive changes.	06/27/2024	W Deseron M Hanifen
91.1	General Information and Requirements for Providers	Added information on requesting records.	06/27/2024	W Deseron M Hanifen
91.0	All	Published version	02/01/2024	TQD
90.20	9.14. CHIP Wellness Incentive	Added info about co-pays for wellness visits and immunizations.	01/31/2024	W Deseron E Garibovic
90.19	9.12.3. Virtual Care Services – Reimbursement	Updated policy.	01/31/2024	W Deseron E Garibovic
90.18	9.12.2. Virtual Care Services – Documentation	Updated policy.	01/31/2024	W Deseron E Garibovic
90.17	9.12. Virtual Care Services	Updated policy.	01/31/2024	W Deseron E Garibovic
90.16	9.10.3. Interpretive Services – Reimbursement	Terminology change for virtual care services.	01/31/2024	W Deseron E Garibovic
90.15	9.9.7. Payment for Services	Updated terminology for virtual care services.	01/31/2024	W Deseron E Garibovic
90.14	7.3.6. Services Not Requiring an HC PCP Referral	Clarified immunizations referrals.	01/31/2024	W Deseron E Garibovic
90.13	7.3.1. Important Referral Policy Reminders	Updated referral requirement for non-VCO provider networks.	01/31/2024	W Deseron E Garibovic

General Information and Requirements for Providers, Provider Handbook Modifications				
Version	**Section**	**Update**	**Publish Date**	**SME**
90.12	7.2.9. Participant Disenrollment by the Provider	Removed language around participant responsibilities.	01/31/2024	W Deseron E Garibovic
90.11	7.1.5. Healthy Connections Coordinated Care Agreement and Tier Compliance by Tier	Updated terminology for virtual care services.	01/31/2024	W Deseron E Garibovic
90.10	7.1.4. Healthy Connections Tier Requirements	Updated terminology for virtual care services.	01/31/2024	W Deseron E Garibovic
90.9	7.1. Healthy Connections Provider Enrollment	Technical correction.	01/31/2024	W Deseron E Garibovic
90.8	5.6.3. High Risk Providers	Added Skilled Nursing Facility and Hospice.	01/31/2024	W Deseron E Garibovic
90.7	5.6.2. Moderate Risk Providers	Removed Hospice.	01/31/2024	W Deseron E Garibovic
90.6	5.6.1. Limited Risk Providers	Removed Skilled Nursing Facility.	01/31/2024	W Deseron E Garibovic
90.5	5.1. Non-billing Ordering, Referring and Prescribing Providers	Clarified Pharmacist billing.	01/31/2024	W Deseron E Garibovic
90.4	4.2. Eligibility Checks	New section.	01/31/2024	W Deseron E Garibovic
90.3	2.1.2.2. Co-payments	Non-substantive word changes.	01/31/2024	W Deseron E Garibovic
90.2	2. Participant Financial Responsibility	Clarified inability to refuse services for TPL.	01/31/2024	W Deseron E Garibovic
90.1	1.3. Ordering, Referring and Prescribing Providers	Clarified Pharmacist enrollment.	01/31/2024	W Deseron E Garibovic
90.0	All	Published version	08/16/2023	TQD
89.9	9.12.4.d) State Regulations	Updated references.	08/02/2023	W Deseron E Garibovic
89.8	7.3.9. Urgent Care Services	Add allowance for Health Districts.	08/02/2023	W Deseron E Garibovic
89.7	7.3.6. Services Not Requiring an HC PCP Referral	Clarify Speech language pathology requires coordination with pcp.	08/02/2023	W Deseron E Garibovic
89.6	7.1. Healthy Connections Provider Enrollment	Update provider termination and recontract requirements.	08/02/2023	W Deseron E Garibovic
89.5	6.10.1.b) Idaho State Plan	New section.	08/02/2023	W Deseron E Garibovic
89.4	6.10.1.a) Federal Regulations	New section.	08/02/2023	W Deseron E Garibovic
89.3	6.10. Katie Beckett Medicaid Eligibility	Clarified copayment and premium requirements.	08/02/2023	W Deseron E Garibovic
89.2	2.1.1.c) State Regulations	Updated references.	08/02/2023	W Deseron E Garibovic
89.1	1.3. Ordering, Referring and Prescribing Providers	Updated to reflect additional eligible physician types.	08/02/2023	W Deseron E Garibovic
89.0	All	Published version	06/02/2023	TQD
88.29	5.6 Provider Relations Consultants (PRC)	Updated contact phone numbers for PRCs – brought into existing version. Previously approved change on 11/18/2022.	06/02/2023	A Boparai M Payne J Kennedy-King
88.28	9.12.4.	References: Telehealth Services renamed section References: Virtual Care Services. Updated.	05/26/2023	W Deseron K Duke

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Version	**Section**	**Update**	**Publish Date**	**SME**
88.27	9.12.3.	Telehealth Services -- Reimbursement renamed section Virtual Care Services -- Reimbursement. Updated with new policy.	05/26/2023	W Deseron K Duke
88.26	9.12.2.	Telehealth Services -- Documentation renamed section Virtual Care Services -- Documentation.	05/26/2023	W Deseron K Duke
88.25	9.12.1.	Telehealth Services -- Technical Requirements renamed section Virtual Care Services -- Technical Requirements.	05/26/2023	W Deseron K Duke
88.24	9.12. Telehealth Services	Renamed section Virtual Care Services. Updated to incorporate new policy.	05/26/2023	W Deseron K Duke
88.23	9.8. Dental	Note about ASC coverage.	05/26/2023	W Deseron K Duke
88.22	9.7.3. References: Non-Covered and Excluded Services	Updated.	05/26/2023	W Deseron K Duke
88.21	9.7. Non-Covered and Excluded Services	Clarify codes not on fee scheduled are non-covered. Non-covered codes can't be billed under revenue codes that don't require HCPCS.	05/26/2023	W Deseron K Duke
88.20	9.6.1. References: Informational Codes	New section.	05/26/2023	W Deseron K Duke
88.19	9.6. Informational Codes	New section. Incorporating newsletter article.	05/26/2023	W Deseron K Duke
88.18	9.3.1. References: Qualifying Clinical Trials	New section.	05/26/2023	W Deseron K Duke
88.17	9.3. Qualifying Clinical Trials	New section. Incorporating newsletter article.	05/26/2023	W Deseron K Duke
88.16	9.2.1. References: Non-Covered and Excluded Services	Section renamed References: Experimental/Investigational Services.	05/26/2023	W Deseron K Duke
88.15	a) References: School Based Health Centers	New section.	05/26/2023	W Deseron K Duke
88.14	7.3.8. School Based Health Centers	Inclusion of newsletter article.	05/26/2023	W Deseron K Duke
88.13	7.3.6. Services Not Requiring an HC PCP Referral	Updated service list.	05/26/2023	W Deseron K Duke
88.12	7.3.1. Important Referral Policy Reminders	Minor technical change and adding historical note.	05/26/2023	W Deseron K Duke
88.11	6.9. Incarcerated Persons	Clarify eligibility may be for basic or enhanced plan.	05/26/2023	W Deseron K Duke
88.10	5.10.1. References: Change in Ownership or Tax Identification Information	New section.	05/26/2023	W Deseron K Duke
88.9	5.10. Change in Ownership (CHOW) or Tax Identification Information	Updated name to Change in Ownership or Tax Identification Information. Clarified when providers must enter a new provider agreement.	05/26/2023	W Deseron K Duke
88.8	1.3. Ordering, Referring and Prescribing Providers	Adds residents as ORPs.	05/26/2023	W Deseron K Duke
88.7	1.2.6. References: Documentation	Updated references.	05/26/2023	W Deseron K Duke

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88.6	1.2.5. Retention of Records	New section. Clarifies requirements.	05/26/2023	W Deseron K Duke
88.5	1.2.4. Electronic Signatures	New section. Clarifies acceptable format and requirements.	05/26/2023	W Deseron K Duke
88.4	1.2.3. Signatures	New section. Integrates previous language.	05/26/2023	W Deseron K Duke
88.3	1.2.2. Amendments or Corrections	New section. Integrates previous language.	05/26/2023	W Deseron K Duke
88.2	1.2.1. Additional Documentation	New section. Notes that additional documentation is throughout handbook.	05/26/2023	W Deseron K Duke
88.1	1.2. Documentation	Clarified requirements.	05/26/2023	W Deseron K Duke
88.0	All	Published version	11/04/2022	TQD
87.6	8.3.5. Follow-up Communication Requirements for Referrals	Clarification	11/01/2022	C Beal E Garibovic
87.5	8.3.1. Important Referral Policy Reminders	Policy Update	11/01/2022	C Beal E Garibovic
87.4	8.2.4. Mandatory Participant Enrollment in Healthy Connections	Policy Update	11/01/2022	C Beal E Garibovic
87.3	8.2. Participant Enrollment	Policy Update	11/01/2022	C Beal E Garibovic
87.2	8.1.3. Healthy Connections Clinic Panel Limit Guidelines	Policy Update	11/01/2022	C Beal E Garibovic
87.1	8.1. Healthy Connections Provider Enrollment	Clarification of definitions	11/01/2022	C Beal E Garibovic
87.0	All	Published version	07/22/2022	TQD
86.2	6.10 Change in Ownership (CHOW) or Tax Identification Information	New section	07/20/2022	Policy Team J Kennedy-King M Payne
86.1	6.9 Provider File Updates	Updated to add	07/20/2022	Policy Team J Kennedy-King M Payne