Table of Contents

Physician and Non-Physician Practitioner

This chapter of the Idaho Medicaid Provider Handbook covers Medicaid services provided by:

- All physician specialties;
- Certified nurse midwife;
- Certified registered nurse anesthetists (CRNA);
- Clinical Nurse Specialist;
- Nurse practitioners;
- Pharmacists; and
- Physician assistants.

Services must be within the scope of practice, licensure and training of the provider rendering them. This chapter of the handbook refers to certified nurse midwives, clinical nurse specialists, nurse practitioners and physician assistants collectively as non-physician practitioners. The term non-physician practitioner excludes pharmacists in this handbook. Services or situations that only apply to a specific provider type will be specified where applicable.

Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Handbook sections that always apply to these provider types include the following:

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

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

Example

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

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

- Case Law: Includes references to court cases that established interpretations of law that states and providers would be required to follow.
- CMS Guidance: These references reflect various Centers for Medicare and Medicaid Services (CMS) publications that Idaho Medicaid reviewed in the formulation of their policy. The publications 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 the Medicaid policy 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.

1. Important Contacts

The Directory, Idaho Medicaid Provider Handbook contains a comprehensive list of contacts. The following contacts are presented here for provider convenience.

1.1. Gainwell Technologies

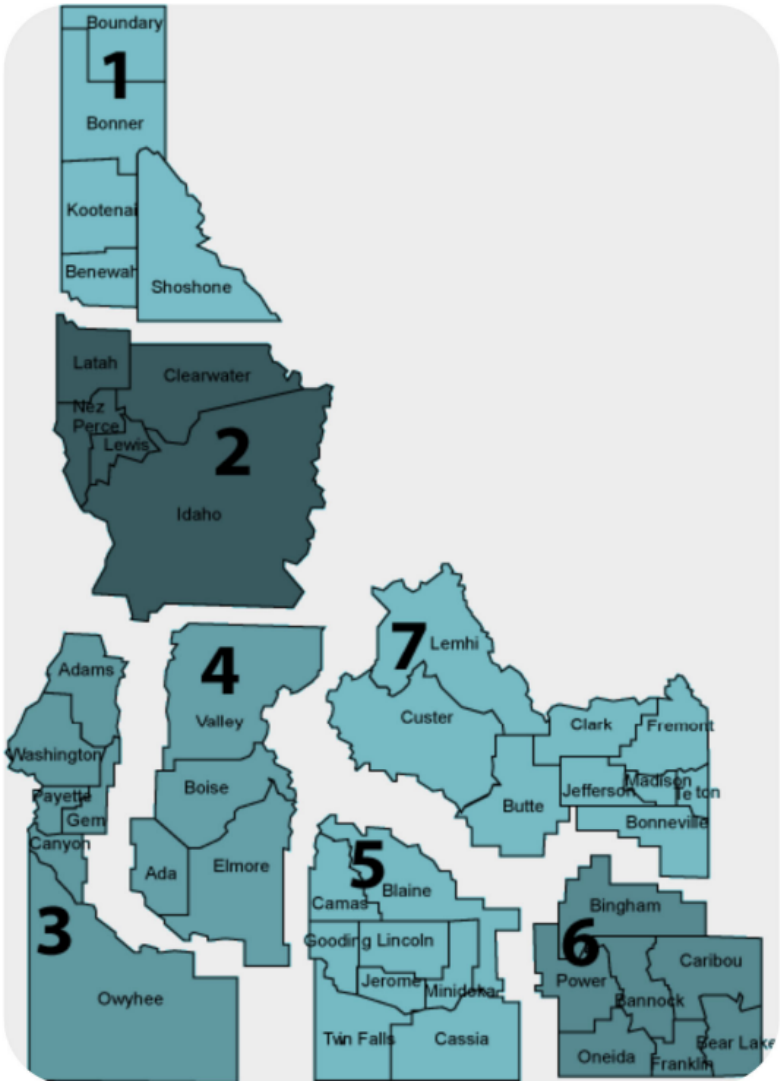
Gainwell Technologies is Idaho Medicaid's fiscal agent that handles all claims processing and customer service issues.

Gainwell Technologies Contact Information
Gainwell Technologies Provider Services P.O. Box 70082 Boise, ID 83707 Phone: 1 (888) 686-4272 Fax: 1 (877) 661-0974 IDProviderServices@gainwelltechnologies.com The Medicaid Automated Call Service (MACS) is available 24 hours a day, seven days a week. Provider service representatives are available Monday through Friday, 7:00 A.M.-7:00 P.M. MT.
Provider Enrollment P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2041 IDProviderEnrollment@gainwelltechnologies.com
Technical Services Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2040 IDEDISupport@gainwelltechnologies.com

1.2. Provider Relations Consultants

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

1.3. Medicaid

The Medical Care Unit is Idaho Medicaid's team that reviews prior authorizations for some services.

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

The status of a prior authorization request submitted to the Medical Care Unit may be checked online at the Gainwell Technologies portal under "Authorization Status", using your NPI. If you have questions on a Denial, click on the Notes, which will explain the reason for the Denial.

1.4. Telligen, Inc.

Telligen, Inc. is Idaho Medicaid's quality improvement organization (QIO) that reviews prior authorization (PA) requests for some services and surgical procedures as listed on the Numerical Fee Schedule. They also conducted reviews of inpatient stays and laboratory services.

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

See the QIO Provider Manual for a listing of diagnoses and procedures that require PA and details regarding review processes.

2. Provider Qualifications

2.1. Physicians

Physicians in any state are eligible to participate in the Idaho Medicaid Program. Physicians must have a National Provider Identification (NPI). They must have a Doctorate of Medicine or Osteopathy, and be licensed to practice medicine in the state where the services are performed. Physicians must also enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. Physicians acting as contractors for other providers must still enroll and bill directly for their services. Physicians are eligible to be ordering, prescribing, referring and rendering providers.

Physicians must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.1.1. References: Physicians

(a) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

(b) Federal Regulations

"**Definitions**: Physician Services." Social Security Act, Sec. 1905(a)(5) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

(c) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(i) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Physician." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 012.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.1.2. Bridge Year Physician

Bridge year physicians in any state are eligible to participate in the Idaho Medicaid Program. Bridge year physicians must have a National Provider Identification (NPI). They must have a Doctorate of Medicine or Osteopathy, and be licensed to practice medicine in the state where the services are performed. Bridge year physicians must also enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. Bridge year physicians acting as contractors for other providers must still enroll and bill directly for their services. Bridge year physicians are eligible to be ordering, prescribing, referring, and rendering providers.

Bridge year physicians must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: Bridge Year Physician

(i) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

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

(ii) Federal Regulations

"**Definitions**: Physician Services." Social Security Act, Sec. 1905(a)(5) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

(iii) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(i) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Physician." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 012.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.1.1. International Medical Graduate

International medical graduates located within the United States are eligible to participate in the Idaho Medicaid Program. International medical graduates must have a National Provider Identification (NPI) and a Doctorate of Medicine or Osteopathy. The international medical graduate must be licensed to practice medicine in the state where the services are performed. They must also enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. International medical graduates acting as contractors for other providers must still enroll and bill directly for their services. They are eligible to be ordering, prescribing, referring, and rendering providers.

International medical graduates must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: International Medical Graduate

(i) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

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

(ii) Federal Regulations

"**Definitions**: Physician Services." Social Security Act, Sec. 1905(a)(5) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

(iii) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(i) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Physician." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 012.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.1.2. Residents

Residents in any state are eligible to participate in the Idaho Medicaid Program. Residents must have a National Provider Identification (NPI). They must have a Doctorate of Medicine or Osteopathy, and be licensed to practice medicine in the state where the services are performed. Residents must enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. Residents acting as contractors for other providers must still enroll and bill directly for their services.

First year residents are eligible to be ordering, prescribing, referring, and rendering providers. Claims for their services are submitted under the supervising physician's NPI.

Second year residents and beyond are enrolled as full providers and may submit claims under their NPI.

Residents must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

(a) References: Residents

(i) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

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

(ii) Federal Regulations

"**Definitions**: Physician Services." Social Security Act, Sec. 1905(a)(5) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

(iii) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(i) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Physician." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 012.04. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.2. Certified Nurse Midwives

Certified nurse midwives in any state are eligible to participate in the Idaho Medicaid Program. Certified nurse midwives must have a National Provider Identification (NPI). They must be licensed in the state where the services are performed. Certified nurse midwives must enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. Non-physician practitioners acting as contractors for other providers must still enroll and bill directly for their services. Certified nurse midwives are eligible to be ordering, prescribing, referring and rendering providers.

Certified nurse midwives must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.2.1. References: Certified Nurse Midwives

(a) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

(b) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(ii) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Nurse Midwife (NM)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 011.20. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Non-Physician Practitioner (NPP)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 011.23. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.3.Certified Registered Nurse Anesthetists

A Certified registered nurse anesthetist (CRNA) is a licensed registered nurse qualified by advanced training in an accredited program in the specialty of nurse anesthesia to manage the care of the patient during the administration of anesthesia in selected surgical situations. A CRNA in any state is eligible to participate in the Idaho Medicaid Program. CRNAs must have a National Provider Identification (NPI). They must be licensed and certified in the state where the services are performed. CRNAs must enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. CRNAs acting as contractors for other providers must still enroll and bill directly for their services. CRNAs are eligible to be ordering, prescribing, referring and rendering providers.

CRNAs must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.3.1. References: Certified Registered Nurse Anesthetist

(a) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

(b) State Regulations

"Certified Registered Nurse Anesthetist (CRNA)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 010.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(ii) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Non-Physician Practitioner (NPP)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 011.23. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.4. Clinical Nurse Specialists

Clinical nurse specialists in any state are eligible to participate in the Idaho Medicaid Program. Clinical nurse specialists must have a National Provider Identification (NPI). They must be licensed in the state where the services are performed. Clinical nurse specialists must enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. Clinical Nurse Specialists acting as contractors for other providers must still enroll and bill directly for their services. Clinical nurse specialists are eligible to be ordering, prescribing, referring and rendering providers.

Clinical nurse specialists with a certification in psychology/mental health must provide a copy of their certificate with their enrollment.

Clinical nurse specialists must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.4.1. References: Clinical Nurse Specialists

(a) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

(b) State Regulations

"Clinical Nurse Specialist (CNS)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 010.13. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(ii) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Non-Physician Practitioner (NPP)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 011.23. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.5.Nurse Practitioners

Nurse practitioners in any state are eligible to participate in the Idaho Medicaid Program. Nurse practitioners must have a National Provider Identification (NPI). They must be licensed in the state where the services are performed. Nurse practitioners must enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. Nurse practitioners acting as contractors for other providers must still enroll and bill directly for their services. Nurse practitioners are eligible to be ordering, prescribing, referring and rendering providers.

Nurse practitioners with a certification in psychology/mental health must provide a copy of their certificate with their enrollment.

Nurse practitioners must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.5.1. References: Nurse Practitioners

(a) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

(b) State Regulations

"Non-Physician Practitioner (NPP)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 011.23. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(ii) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Nurse Practitioner (NP)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 011.24. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.6. Pharmacists

Pharmacists in any state are eligible to participate in the Idaho Medicaid Program. Pharmacists must have a National Provider Identification (NPI). They must be licensed in the state where the services are performed. Pharmacists must enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. Pharmacists are only eligible to be ordering, prescribing, referring providers and cannot be enrolled as rendering providers. Pharmacists can only enroll via a paper application. Pharmacist services are billed under the pharmacy or clinic's NPI and the pharmacist is listed as the referring provider on the claim. Usual and customary fees are paid up to the 85% of the Medicaid maximum allowance listed in the Numerical Fee Schedule, as is the case for all non-physician practitioners enrolled with Idaho Medicaid.

Pharmacists are eligible to provide and bill evaluation and management services. Pharmacists can bill for services provided in most outpatient settings including those provided at an Indian Health Services (IHS) clinic, Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). Pharmacists are not eligible for the encounter rate but are eligible for fee-for-service reimbursement for services provided, as long as an encounter with an eligible healthcare professional does not occur and is not billed on the same day of service.

Pharmacists are restricted to the following evaluation and management codes:

- 99605-99607;
- 99202-99205;
- 99211-99215;
- 99341, 99342, 99344, 99345, 99347-99350;
- 99401-99404;
- 99406-99409;
- 99441-99443;
- 99453, 99454;
- 99457, 99458;
- G2211, G2212 and G2214.

Pharmacists must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an ordering, referring and prescribing Idaho Medicaid provider.

2.6.1. References: Pharmacists

(a) Idaho Medicaid Publications

"Attention Pharmacists: Enrollment with Idaho Medicaid." *MedicAide Newsletter,* July 2020, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202020%20MedicAide.pdf.

"Attention Pharmacy Providers." *MedicAide Newsletter,* September 2020, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202020%20MedicAide.pdf.

"New Codes Available for Pharmacy Services." *MedicAide Newsletter,* September 2020, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202020%20MedicAide.pdf.

"Pharmacist Addition to Evaluation and Management." *MedicAide Newsletter,* April 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202024%20MedicAide.pdf.

"Pharmacist Billing Clarification." *MedicAide Newsletter,* January 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf.

"Pharmacist Evaluation and Management." *MedicAide Newsletter,* October 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202023%20MedicAide.pdf.

(b) State Regulations

"Non-Physician Practitioner (NPP)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 011.23. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(ii) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Pharmacist." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 012.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

2.7. Physician Assistants

Physician assistants in any state are eligible to participate in the Idaho Medicaid Program. Physician assistants must have a National Provider Identification (NPI). They must be licensed in the state where the services are performed. Physician assistants must enroll as an Idaho Medicaid provider prior to providing services for Idaho Medicaid participants, however, exceptions may apply for emergency circumstances. Non-physician practitioners acting as contractors for other providers must still enroll and bill directly for their services. Physician assistants are eligible to be ordering, prescribing, referring and rendering providers.

Physician assistants must follow the provider handbook and all applicable state, and federal, rules and regulations. See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.7.1. References: Physician Assistants

(a) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter,* September 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

(b) State Regulations

"Non-Physician Practitioner (NPP)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 011.23. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(ii) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

"Physician Assistant (PA)." IDAPA 16.03.09, *"Medicaid Basic Plan Benefits,"* Sec. 012.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

3. Eligible Participants

Providers must check participant eligibility prior to delivery of the service by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website. When billing for participants enrolled in other eligibility segments, refer to General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for coverage.

3.1. Referrals

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's primary care case management (PCCM) model of managed care. If a participant is enrolled, a referral may be required from the participant's primary care physician (PCP) prior to rendering services. Prior Authorization may be required for the service in addition to obtaining a referral. Information on the Healthy Connections program can be found in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

4. Covered Services and Limitations: General

4.1. Abortions

An abortion is the interruption or termination of pregnancy before the fetus is viable. Abortion is not considered a family planning service by CMS. The FP modifier should not be used for abortions.

Professional and facility services related to non-covered abortions such as pre and post-operative care, visits, facility fees, supplies, drugs including preventive antibiotics and Rho-GAM, anesthesia and laboratory tests are not reimbursable. Services that are reimbursable related to a non-covered abortion are pregnancy tests, pap smears, urinalysis, testing for sexually transmitted diseases and charges related to complications.

4.1.1. Induced Abortion

An induced abortion is a voluntary, or elective, surgical or medical termination to pregnancy. Idaho Medicaid only covers induced abortions in the case of rape or incest. Documentation must be attached to the claim as a requirement for payment. The only acceptable documentation is:

- A copy of the court determination of rape or incest must be provided; or
- Where no court determination has been made, a copy of the report filed with a law enforcement agency or child protective services showing rape or incest; or
- Where no court determination has been made and no report has been filed, a licensed physician must certify in writing that, in the physician's professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest. The certification must contain the name and address of the woman. Medical records are not a substitution for a physician’s certification.

4.1.2. Medical Abortion

Medical abortions are an alternative to surgical procedures using prescription drugs to terminate a pregnancy. Only Mifeprex is covered for medical abortions. Mifeprex is an FDA approved drug for medical abortion through 10 weeks gestation. Mifeprex is billed with S0190 (Mifepristone oral 200mg) and S0191 (Misoprostol oral 200mcg). A prior authorization is required for all medical abortions.

The participant must receive a copy of the mifepristone medication guide and give informed consent before the drug is administered. Administration of the drug must be in a physician’s office, a clinic or hospital under the supervision of a physician with a manufacturer’s prescriber agreement. The physician must be able to determine and document the duration of the gestation and discern if the pregnancy is ectopic or not. The physician must be able to provide or arrange immediate necessary intervention including surgery and blood transfusion in the case of complications, incomplete abortion, infection or severe bleeding. Follow-up must include an ultrasound to ensure complete evacuation and a pregnancy test with a negative result. Mifepristone is not covered for any other indication.

Services rendered to a recipient for a medical abortion should be billed under a global period with code S0199. The global period is performed over an eighteen (18) day period and includes all office visits, pelvic ultrasounds, laboratory studies, urine pregnancy tests and recipient education.

Medical abortions are only covered in the case of rape, incest or to save the life of the mother. See Induced Abortion and Therapeutic Abortion for coverage requirements.

4.1.3. Spontaneous Abortion

A spontaneous abortion, otherwise known as a miscarriage, occurs when the fetus is lost before the 20th week of pregnancy without apparent cause. Services for a spontaneous abortion are covered including dilation and curettage.

4.1.4. Therapeutic Abortion

A therapeutic abortion is a surgical or medical abortion performed when the termination of a pregnancy is necessary to save the life of the mother. Documentation must be attached to claims when abortion was performed to save the life of the mother. A licensed physician must certify in writing that the woman may die if the fetus is carried to term. Under no circumstance are medical records a substitution for the physician's certification. The certification must also contain the name and address of the woman. A copy of the documentation should be provided to the hospital for their billing purposes. Therapeutic abortions are also covered for the following:

(a) Blighted Ovum

A blighted ovum occurs when the embryo degenerates or is absent from the ova. Services are covered to remove a blighted ovum.

(b) Ectopic Pregnancy

An ectopic pregnancy is caused by implantation of the ovum outside the cavity of the uterus in the abdominal viscera, cervix, fallopian tubes, ovaries or peritoneum. Services for aborting an ectopic pregnancy are covered.

(c) Incomplete Abortion

Incomplete abortion is a pregnancy that is associated with vaginal bleeding, dilatation of the cervical canal, and passage of some but not all the products of conception. If the retained products become infected it is considered a septic abortion. Services for incomplete abortions are covered.

(d) Missed Abortion

Missed abortion is the prolonged retention of an embryo or fetus that died in the first twenty weeks of the pregnancy. It would include an empty gestational sac, blighted ovum, but not a spontaneous or induced abortion, or delivery. Services for a missed abortion are covered.

(e) Molar Pregnancy

Hydatidiform mole is a rare condition that occurs when the placenta undergoes degenerative cystic, edematous changes that resembles a cluster of grapes. Services are covered to treat a molar pregnancy.

(f) Septic Abortion

A septic abortion occurs when the lining of the uterus and products of conception become infected. Services for septic abortions are covered.

(g) Sample Documentation for Abortions to Save the Life of the Mother

I, _____(Name of physician), attending physician to

_____(Name of participant), certify that in my professional judgment, allowing this participant's present pregnancy to be carried to term will endanger her life.

Date: _____

Signature of physician: _____

Name of participant: _____

Address of participant: _____

4.1.5. References: Abortions

(a) Case Law

Supreme Court of The United States (2022). *Dobbs, State Health Officer of Mississippi Department of Health, Et AL. v. Jackson Women's Health Organization Et AL*. https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf.

(b) CMS Guidance

"Chapter 3 – Eligibility." *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.

"Chapter 4 – Services." *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.

State Medicaid Director Letter December 28, 1993. Center for Medicaid and State Operations, Department of Health and Human Services.

State Medicaid Director Letter February 12, 1998. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd021298.pdf.

State Medicaid Director Letter# 01-018. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd033001.pdf.

(c) Federal Regulations

Abortions, 42 C.F.R. 441 Subpart E (1987). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part441-subpartE.pdf.

"Definitions." Social Security Act, Sec. 1905(a)(4)(c) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions." Social Security Act, Sec. 2110(a)(16) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title21/2110.htm.

Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019. H.R. 6157 (2018). Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-115hr6157enr/pdf/BILLS-115hr6157enr.pdf.

Executive Order No. 13535: Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act, 3 C.F.R. 15599 (2010). Government Printing Office, https://www.govinfo.gov/content/pkg/FR-2010-03-29/pdf/2010-7154.pdf.

Further Consolidated Appropriations Act, 2020. H.R. 1865 (2019). Government Printing Office, https://www.congress.gov/bill/116th-congress/house-bill/1865/text.

Limitations on coverage: Abortions, 42 C.F.R. 457.475 (2001). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec457-475.pdf.

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.

Payment for Covered Outpatient Drugs, 42 U.S.C. §1396r–8 (1993). Government Printing Office, https://www.govinfo.gov/content/pkg/USCODE-2008-title42/pdf/USCODE-2008-title42-chap7-subchapXIX-sec1396r-8.pdf.

"Payments to States." Social Security Act, Sec. 2105(c) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title21/2105.htm.

(d) Idaho Medicaid Publications

Information Release MA02-29 (2/1/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho.

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

(e) State Regulations

"Abortion and Contraceptives." *Idaho Code Title 18, Chapter 6, "Crimes and Punishments."* Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch6/.

"Abortion Procedures: Participant Eligibility." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 511. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Abortion Procedures: Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 514. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Denial of Payment for Abortions Under Certain Conditions, Idaho Code 56-209c (1977). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209c/.

Interpretation of State Statutes and the State Constitution, Idaho Code 18-601 (2001). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch6/sect18-601/.

4.2. Acupuncture

Acupuncture services are not a covered benefit under Idaho Medicaid. These services are considered experimental and investigational. They are not eligible for coverage under EPSDT. The treatment of complications, consequences or repair of acupuncture services received by the participant are not covered by the Department unless they are deemed life threatening.

4.2.1. References: Acupuncture

(a) State Regulations

"Service Categories Not Covered." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390.01.a. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Types of Treatments and Procedures Not Covered." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390.02.c. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Types of Treatments and Procedures Not Covered." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390.02.j. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.3. Advance Directives

Advanced directives (CPT® 99497 and 99498), or advanced care planning, is a covered benefit under Idaho Medicaid as of January 1, 2018. 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.

Advanced directives are required to be offered by hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, hospices, and personal care service providers to adult participants or another person on their behalf as allowed by state law. 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. Time spent on any other service or treatment is not billable under this service.

The Advance Directive form does not have to be completed to be eligible for reimbursement, but there must be documentation. Documentation must be maintained of the offer for an advanced directive, the existence of any advanced directive, and if the service is accepted by the participant 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.

4.3.1. 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.

"Patient "Advance Directives"." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 235. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.4. Albumin Replacement in the Office

Effective January 1, 2020, Idaho Medicaid will cover albumin replacement (P9045- P9047) in the office setting when provided by a physician or non-physician practitioner. Participants must meet the criteria for coverage in order for claims to be reimbursable.

Coverage is available with any of these diagnoses:

Preapproved Diagnoses	
ICD-10-CM	Description
K70.11	Alcoholic hepatitis with ascites
K70.31	Alcoholic cirrhosis of liver with ascites
K71.51	Toxic liver disease with chronic active hepatitis with Ascites

Participants with diagnosis R18.8 (Other Ascites) are eligible when they have one of the following:

Preapproved Diagnoses When Combined with R18.8	
ICD-10-CM	Description
B16.0	Acute hepatitis B with delta-agent with hepatic coma
B16.1	Acute hepatitis B with delta-agent without hepatic coma
B16.2	Acute hepatitis B without delta-agent with hepatic coma
B16.9	Acute hepatitis B without delta-agent and without hepatic coma
B17.0	Acute delta-(super) infection of hepatitis B carrier
B17.10	Acute hepatitis C without hepatic coma
B17.9	Acute viral hepatitis, unspecified
I82.0	Budd-Chiari syndrome
K70.2	Alcoholic fibrosis and sclerosis of liver
K74.1	Hepatic sclerosis
K74.3	Primary biliary cirrhosis
K74.60	Unspecified cirrhosis of liver
K74.69	Other cirrhosis of liver (includes cryptogenic)
K75.81	Nonalcoholic steatohepatitis (NASH)
P78.81	Congenital cirrhosis (of liver)

Participants with a diagnosis not preapproved can be covered for albumin replacement in the office based on the physician or non-physician practitioner's clinical judgement. Claims must be billed with a KX modifier for other diagnoses. However, albumin replacement following large volume paracentesis for malignancy-related ascites is not covered and should not be billed with a KX modifier. Research suggests that albumin replacement is not usually necessary in patients with malignancy-related paracentesis as they are not at risk of hemodynamic sequelae or circulatory failure.

4.4.1. References: Albumin Replacement in the Office

(a) Idaho Medicaid Publications

"Albumin Replacement in the Office." *MedicAide Newsletter,* January 2021, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202021%20MedicAide.pdf.

4.5. Allergy Injections

Reimbursement for office visits is included in the reimbursement for allergy injections. Office visits may only be billed if there is a separately identifiable service, such as treatment for an ear infection.

4.6. Cardiac Rehabilitation, Outpatient

Cardiac Rehabilitation (CR) in the outpatient setting is a medically supervised program with the goal of preventing future cardiac events. Effective April 1, 2015, CR is aligned with Medicare's policy.

4.6.1. Cardiac Rehabilitation: Eligible Participants

Outpatient cardiac rehabilitation is available for participants with a diagnosis of:

Covered Diagnoses for Cardiac Rehabilitation	
ICD-10-CM	Description
I20.1 – I20.9	Angina pectoris
I21.01 – I21.4	Acute myocardial infarction
I22.0 – I22.9	Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
I25.111 – I25.119	Atherosclerotic heart disease of native coronary artery with angina pectoris
I25.2	Old myocardial infarction
I25.5	Ischemic cardiomyopathy
I25.6	Silent myocardial ischemia
I25.700 – I25.812	Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris
I25.89	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unspecified
I50.22	Chronic systolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.812	Chronic right heart failure
I50.814	Right heart failure due to left heart failure
I50.82 – I50.89	Heart Failure
Z48.21	Encounter for aftercare following heart transplant
Z48.280	Encounter for aftercare following heart-lung transplant
Z48.812	Encounter for surgical aftercare following surgery on the circulatory system
Z94.1	Heart transplant status
Z94.3	Heart and lungs transplant status
Z95.1 – Z95.5	Presence of cardiac and vascular implants and grafts
Z96.89	Presence of other specified functional implants
Z98.61	Coronary angioplasty status
Z98.890	Other specified postprocedural states

4.6.2. Coverage and Limitations: Cardiac Rehabilitation

Cardiac Rehabilitation is only reimbursable for an eligible participant when provided by an eligible provider, and with adherence to all Medicaid requirements. A physician must be immediately available and accessible for medical consultations and emergencies at all times.

Covered Cardiac Rehabilitation CPT® Codes	
Code	Description
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

Cardiac rehabilitation program sessions are limited to a maximum of two, one-hour sessions per day for up to 36 sessions, over a period of 36 weeks with the option for an additional 36 sessions over an extended period with prior authorization. Participation in another outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational. Intense Cardiac Rehabilitation is not covered.

CR can be provided in places of service:

- 11 – Office;
- 19 – Off Campus – Outpatient Hospital; and
- 22 – On Campus – Outpatient Hospital.

Programs that only offer supervised exercise training are not considered to be cardiac rehabilitation. Physical and/or occupational therapy are not medically necessary in conjunction with cardiac rehabilitation unless performed for an unrelated diagnosis.

4.6.3. References: Outpatient Cardiac Rehabilitation

(a) CMS Guidance

"Cardiac and Pulmonary Rehabilitation Programs." *Noridian Healthcare Solutions,* 09 December 2023, https://med.noridianmedicare.com/web/jeb/specialties/cardiology/cardiac-and-pulmonary-rehabilitation-programs.

"Chapter 32 – Billing Requirements for Special Services." *Medicare Claims Processing Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf.

Decision Memo for Cardiac Rehabilitation (CR) Programs - Chronic Heart Failure (CAG-00437N) (2/18/2014). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=270.

(b) Federal Regulations

Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage, 42 C.F.R. Sec. 410.49 (2009). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol2/pdf/CFR-2019-title42-vol2-sec410-49.pdf.

(c) Idaho Medicaid Publications

"Outpatient Cardiac Rehabilitation." *MedicAide Newsletter,* April 2015, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202015%20MedicAide.pdf.

4.7. Cervical Cancer Screening

Cervical cancer screenings should be billed with Preventive Medicine CPT® Codes and the appropriate ICD-10-CM diagnosis code. Screening with cervical cytology (i.e. pap smear) is a covered benefit for female Idaho Medicaid participants between the ages of 21 and 65 every three years. Female participants between 30 and 65 may instead receive high-risk human papillomavirus (hrHPV) testing every five years with or without cervical cytology at the same visit (i.e. co-testing). Participants over the age of 65 are covered for continued screenings if they have experienced spontaneous regression or management for a precancerous lesion within the past 20 years.

The sample collection for the pap smear is part of the pelvic examination and is not separately reimbursable. The Pap smear is reimbursable only to the provider who performs and reads the Pap smear and issues the written report. Requirements for billing a global laboratory code, and the use of modifiers 26 and TC in the Laboratory, Idaho Medicaid Provider Handbook apply.

Female participants diagnosed with a compromised immune systems, high-grade precancerous cervical lesion or cervical cancer, or exposure to diethylstilbestrol in utero may receive screenings outside of age and frequency limitations. Participants with a hysterectomy including removal of the cervix are not eligible for screening unless there are indications of a high-grade precancerous lesion or cervical cancer.

4.7.1. References: Cervical Cancer Screening

(a) Idaho Medicaid Publications

"Coverage for Cervical Cancer Screening." *MedicAide Newsletter,* July 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf.

(b) Professional Organizations

"Cervical Cancer: Screening." *U.S. Preventive Services Task Force,* 21 August 2018, https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening2.

4.8. Clinic Services

Effective January 1, 2013, physicians and non-physician practitioners providing services in hospital owned outpatient clinics must bill their services on the CMS-1500 form with place of service 22, outpatient hospital. The reimbursement for these claims will be subject to the site of service differential.

4.8.1. References: Clinic Services

(a) Idaho Medicaid Publications

"Attention: Institutional and Professional Providers." *MedicAide Newsletter,* March 2009.

"Revenue Codes 0510, 0456, 0760, and 0761", *Information Release MA12-21* (12/21/2012). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13291&dbid=0&repo=PUBLIC-DOCUMENTS.

4.9. Consultations

Idaho Medicaid does not recognize or reimburse codes for consultation services (CPT® codes 99241– 99245 and 99251–99255), instead the appropriate evaluation and management code for office, other outpatient services, hospital or nursing facility should be billed for the services rendered. As Idaho Medicaid does not use consultation codes, more than one physician will be permitted to bill an initial visit.

4.9.1. References: Consultations

(a) CMS Guidance

Revisions to Consultation Services Payment Policy, MLN Matters Number: MM6740 (11/08/2011). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/MM6740.pdf.

(b) Idaho Medicaid Publications

Changes to Medicaid's Reimbursement of CPT Codes, Information Release MA10-07 (6/10/2010). Division of Medicaid, Department of Health and Welfare, State of Idaho.

4.10. Critical Care Services

Critical care includes the care of critically ill participants, in a variety of medical emergencies that requires the constant attention of the physician. Critical care is usually, but not always, given in a critical care area, such as the Coronary Care Unit, Intensive Care Unit, Respiratory Care Unit, or the Emergency Department.

The following services are included in the global reporting and billing of critical care when performed during the critical period by the physician providing critical care:

- Interpretation of cardiac output measurements.
- Interpretation of chest x-rays.
- Pulse oximetry.
- Blood gases and information data stored in computers (e.g., electrocardiogram [ECG]), blood pressure, hematologic data.
- Gastric intubation.
- Temporary transcutaneous pacing.
- Ventilator management.
- Vascular access procedures.

Other procedures that are not directly connected to critical care management (the suturing of laceration, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap, etc.) are not included in the critical care and should be reported separately.

4.11. Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training as a supplement to physician services when all requirements of this section are met. Diabetes education and training includes diet, nutrition, medications, home glucose monitoring, insulin administration, foot care and other complications of the disease. The physician is responsible to furnish basic diabetic care and instruction to the participant and may not use a formally structured program, or a Certified Diabetes Educator (CDE), as a substitute. Physician responsibility includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of agents for glycemic management.

An order and referral from the participant's primary care provider are required before beginning services. Services must be conducted face-to-face between a CDE and the participant in a physician's office or outpatient hospital department. Reimbursement is limited to 12 hours per participant every five years for individual counseling, and 24 hours per participant every five years for group counseling.

4.11.1. References: Diabetes Education and Training

(a) Idaho Medicaid Publications

"Idaho Medicaid and Diabetes." *MedicAide Newsletter,* June 2003.

(b) State Regulations

"Diabetes Education and Training Services: Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 642. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Diabetes Education and Training Services: Procedural Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 643. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.11.2. Provider Qualifications: Diabetes Education and Training

Providers must have a diabetes management program recognized by the American Diabetes Association (ADA) or the Association of Diabetes Care and Education Specialists (ADCES). The program must be administered by a state-licensed health professional that is also a Certified Diabetes Educator (CDE) through the Certification Board for Diabetes Care and Education (CBDCE), formerly the National Certification Board for Diabetes Educators (NCBDE). The billing provider must submit and maintain proof to Gainwell Technology's provider enrollment of the CDE's current certification with the CBDCE/NCBDE and that their program is recognized by the ADA or ADCES.

(a) References: Provider Qualifications – Diabetes Education and Training

(i) Idaho Medicaid Publications

"Idaho Medicaid and Diabetes." *MedicAide Newsletter,* June 2003.

(ii) State Regulations

"Diabetes Education and Training Services: Definitions." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 640. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Diabetes Management Program." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 644.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.11.3. Participant Eligibility: Diabetes Education and Training

Participants are eligible that have:

- A recent diagnosis of diabetes within the past 90 days, and have not received prior diabetes education;
- Uncontrolled diabetes manifested by two (2) or more fasting blood sugar levels of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar levels greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or
- Recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds.

(a) References: Eligible Participants - Diabetes Education and Training

(i) State Regulations

"Participants with Diabetes." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 641.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.11.4. Reimbursement: Diabetes Education and Training

Services must be billed under the dietitian, hospital or physician's clinic provider number.

Covered Codes for Diabetes Education and Training	
HCPCS	Description
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (two or more), per 30 minutes

(a) References: Reimbursement – Diabetes Education and Training

(i) State Regulations

"Diabetes Education and Training Services: Provider Reimbursement." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 645. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.12. Durable Medical Equipment

Idaho Medicaid will allow ordering physicians that are also the supplier to meet documentation requirements in the medical record instead of writing a separate order. Physicians are still expected to be compliant with the Physician Self-Referral Law. Physicians acting as suppliers are required to follow the Suppliers, Idaho Medicaid Provider Handbook, for these services.

4.12.1. References: Durable Medical Equipment

(a) CMS Guidance

"Order Requirements When Prescribing Practitioner is also the Supplier and is Permitted to Furnish Specific Items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)." *MLN Matters MM10984, October 2018,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10984.pdf.

(b) Idaho Medicaid Publications

"Ordering DMEPOS When You're Also the Supplier." *MedicAide Newsletter,* July 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf.

4.13. Excluded and Non-Covered Services

For information regarding excluded and non-covered procedures, please see the *Excluded Services* section and the Non-Covered section in the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook portion of the handbook.

4.14. Evaluation and Management

Physicians, pharmacists and non-physician practitioners are required to use either the 1995 or 1997 evaluation and management (E&M) documentation guidelines to document E&M office and outpatient visits with some modifications. Modifications to these guidelines include:

- Elimination of the requirement to document the medical necessity of a home visit instead of an office visit;
- Elimination of history and physical exam in code determination;
- Prioritizing code selection by medical decision-making or total time;
- Focusing documentation on changes and persisting problems since the last visit for established patients, provided the physician or non-physician practitioner indicate in the record the patient's medical record was reviewed and updated if necessary; and
- Clarification that practitioners do not need to re-enter the participant's chief complaint and history into the medical record if ancillary staff or the participant have already updated it. The practitioner only needs to indicate in the medical record that the information has been reviewed and verified.

4.14.1. References: Evaluation and Management

(a) CMS Guidance

1995 Documentation Guidelines for Evaluation and Management Services. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf.

1997 Documentation Guidelines for Evaluation and Management Services. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf.

Evaluation and Management Services Guide. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf.

"Summary of Policies in the Calendar Year (CY) 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List." *MLN Matters MM11063, November 2018,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11063.pdf.

(b) Idaho Medicaid Publications

"2019 Evaluation and Management (E&M) Documentation Updates." *MedicAide Newsletter,* January 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202019%20MedicAide.pdf.

"Evaluation and Management Codes." *MedicAide Newsletter,* December 2020, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202020%20MedicAide.pdf.

4.15. Family Planning

Idaho Medicaid covers contraceptive supplies, including prescription diaphragms, intrauterine devices (IUDs), implants, injections, contraceptive patches, oral emergency contraceptives and oral contraceptives. Emergency contraceptives are not considered abortion services. Oral contraceptives are limited to a three-month supply and must be provided by a pharmacy. Medicaid does not pay a physician's office for take-home contraceptives. Family planning services and supplies are excluded from co-pay requirements. See the Sterilization Procedures section for information about the surgical procedure.

Family planning services, devices and prescriptions **must** be billed with the **FP modifier**, and an NDC if applicable. The FP modifier allows the State of Idaho to receive 90% federal reimbursement on family planning services. If the modifier is not utilized by providers, it may lead to a civil monetary penalty from the Medicaid Program Integrity Unit. Claims with multiple services should have the FP modifier only on lines for the family planning service. Evaluation and management services for family planning services should include the FP modifier as well. A Healthy Connections referral is not required for family planning if the service is billed with the FP modifier.

Reimbursement for an IUD insertion includes any fees for the office visit. A separate office exam may only be billed for treatment of an unrelated diagnosis. Attach modifier 25 to the evaluation and management code. Insertion is covered following a delivery including in an inpatient setting when billed by the physician or non-physician practitioner with the ICD-10-CM diagnosis Z30.430 and FP modifier. Insertion is not reimbursable inpatient for any other indication.

If Depo-Provera and Lunelle are used for any purpose other than contraception, or for dosages up to 100 mg, use J3490 (Unclassified Drug) and indicate the NDC, quantity dispensed, and units of measure.

4.15.1. References: Family Planning

(a) CMS Guidance

Medicaid Family Planning Services and Supplies, SHO#16-008 (6/14/2016). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.

(b) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(a)(4)(C) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Family Planning Services, 42 C.F.R. Sec. 441.20 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec441-20.pdf.

Limitations on Premiums and Cost Sharing, 42 C.F.R. Sec. 447.56 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec447-56.pdf.

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." Social Security Act, Sec. 1902(a)(23)(B) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

(c) Idaho Medicaid Publications

"Intrauterine Device (IUD)." *MedicAide Newsletter,* August 2015. https://www.idmedicaid.com/MedicAide%20Newsletters/August%202015%20MedicAide.pdf.

"Reminder: Family Planning Services Require the FP Modifier." *MedicAide Newsletter,* September 2018. https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf.

Reporting Family Planning Services, Information Release MA03-63 (10/20/2003). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Use FP Modifier When Billing Family Planning Services." *MedicAide Newsletter,* September 2005.

(d) Professional Organizations

"Emergency Contraception." *The American College of Obstetricians and Gynecologists,* August 2019, https://www.acog.org/womens-health/faqs/emergency-contraception.

(e) State Regulations

"Family Planning." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 680 – 699. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Medicaid Outpatient Services Subject to Copayments." *IDAPA 16.03.18, "Medicaid Cost-Sharing,"* Sec. 320. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160318.pdf.

4.16. Fertility Services

Fertility services are not a covered benefit of Idaho Medicaid. This includes:

- 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;
- Reversal of sterilization; and
- Testing.

The treatment of complications, consequences or repair of fertility services received by the participant are not covered by the Department unless they are deemed life threatening.

4.16.1. References: Fertility Services

"Service Categories Not Covered." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390.01.e. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Types of Treatments and Procedures Not Covered." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390.02.f. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Types of Treatments and Procedures Not Covered." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390.02.j. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.17. Fluoride Treatments

For participants up to the age of 21, physicians may provide in their office the application of topical fluoride varnish using CPT® 99188. Dentists should continue to bill services through the Idaho Smiles program.

4.17.1. References: Fluoride Treatments

(a) Idaho Medicaid Publications

"Attention Physicians: new Code for Application of Fluoride Varnish." *MedicAide Newsletter,* January 2015.
https://www.idmedicaid.com/MedicAide%20Newsletters/January%202015%20MedicAide.pdf.

4.18. Focus Case Review

Services may also be covered 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. See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook section on Exceptions to Non-Covered and Excluded Services for information.

4.19. Forensic Examinations and Interviews

A forensic medical examination is a head-to-toe examination looking for injuries and taking samples that may be used as evidence in a police investigation and any subsequent prosecution. A forensic interview is a structured conversation with a participant that is intended to elicit detailed information about a possible event(s) that the participant may have experienced or witnessed. Forensic examinations and interviews conducted for the sole purpose of gathering evidence of an alleged crime are not covered and may not be billed to the participant. However, services, such as evaluation and management or comprehensive diagnostic assessments, may be billed to Medicaid if they are medically necessary to establish a plan of care and meet the criteria of the billed code.

A medically necessary service that is performed by a physician or non-physician practitioner (except pharmacists) must be billed with the appropriate level evaluation and management CPT® code (99202—99215) or psychiatric diagnostic evaluation (90791—90792). Psychiatric diagnostic evaluations may also be provided by a mental health practitioner using their individual provider number. Any photographs taken during the examination are included in the reimbursement for the covered codes.

4.20. Hyperbaric Oxygen Therapy

Hyperbaric Oxygen (HBO) therapy is a technique of delivering higher pressures of oxygen to the tissues. Two methods of administration are available including topical and systemic HBO therapy.

Topical HBO therapy is a technique of delivering 100% oxygen directly to an open, moist wound at a pressure slightly higher than atmospheric pressure. Topical HBO therapy is considered investigational and is not covered by Idaho Medicaid.

In systemic HBO, the patient is entirely enclosed in a pressurized chamber and breathes oxygen at a pressure greater than one atmosphere (the pressure of oxygen at sea level). Idaho Medicaid follows Medicare criteria found in National Coverage Determination (NCD) 20.29. Conditions not listed as covered in National Coverage Determination 20.29 are considered investigational and are not covered under the Medicaid Program.

4.20.1. References: Hyperbaric Oxygen Therapy

(a) Idaho Medicaid Publications

"Attention: Providers of Hyperbaric Oxygen Treatment." *MedicAide Newsletter,* December 2009.

"Medicaid Coverage of Hyperbaric Oxygen Treatment." *MedicAide Newsletter,* November 2017. https://www.idmedicaid.com/MedicAide%20Newsletters/November%202017%20MedicAide.pdf.

4.21. Immunization and Vaccines

Universal immunization is a crucial piece of an equitable and quality health care system. Removing or reducing barriers through education and providing access to immunizations for infants, children, and adults is critical for improving health related outcomes. A comprehensive policy for universal immunization will ensure all Idaho Medicaid participants receive quality healthcare and are protected from vaccine-preventable disease, illness, or injury. This policy allows for vaccine administration in a variety of healthcare settings such as, but not limited to, healthcare facilities, provider offices, public health clinics, and school-based settings. Vaccination has reduced many vaccine-preventable diseases and incidence of childhood disease over time and continues to be a valuable investment for improving population health and our health care system.

Idaho Medicaid covers medically necessary immunization and vaccines for all ages. Vaccines must be FDA approved and conform to the Advisory Committee on Immunization Practices (ACIP) guidelines. The claim should include the following information:

- The CPT® or HCPCS code for the vaccine.
- The CPT® code that accurately reflects the administration of the vaccine(s).

If there is a significant, separately identifiable service performed at the time of the vaccine administration, an E/M visit may also be billed with modifier 25. Documentation in the participant's record must reflect the additional services rendered.

Some vaccines may be provided by a state or federal government agency, such as the Vaccine for Children (VFC) program, which offers a free-vaccine program for children under 19 years old. When a vaccine supplied by the government at no cost to the provider is administered, the CPT® code for the vaccine should be billed with modifier SL at a zero-dollar amount ($0.00). Provider purchased vaccines should only be administered when a free vaccine is not available. When a provider purchased vaccine(s) is administered, the CPT® code for the vaccine should be billed at the usual and customary rate. No modifier is required.

Co-payments do not apply to immunizations. Participants under the age of 19 or eligible for Medicare are exempt from Third Party Liability requirements for medically necessary vaccines and their administration. All other participants are subject to the requirements of the Third Party Liability section in General Billing Instructions, Idaho Medicaid Provider Handbook. If the primary payer combines payment for the administration with the cost of the vaccine, a separate administration fee may not be billed.

COVID-19 vaccinations are available to all participants six (6) months of age and older.

FluMist™ billed with CPT® 90660 is only covered for healthy participants 2-49 years of age, who are not pregnant.

The tetanus, diphtheria, and pertussis vaccine (Tdap) is available for all participants age seven (7) years and older.

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

See the Stand-Alone Vaccine Counseling section for more information. See the Wellness Examinations section for the complete schedule of age-appropriate health history and health screening services.

4.21.1. References: Immunization and Vaccines

(a) CMS Guidance

Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/sites/default/files/2022-05/covid-19-vaccine-toolkit-05062022.pdf.

(b) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(a)(13) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions." Social Security Act, Sec. 1905(r)(1) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Mandatory coverage of COVID-19 vaccines and administration and treatment under Medicaid." *H.R. 1319, "American Rescue Plan Act of 2021,"* Sec. 9811. Department of Administration, State of Idaho, https://www.govinfo.gov/content/pkg/BILLS-117hr1319eas/pdf/BILLS-117hr1319eas.pdf.

Vaccines for Children Program, 42 C.F.R. Sec. 441.600 – 441.615 (2012). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartL.pdf.

(c) Idaho Medicaid Publications

"Attention: Providers of Flu Vaccine." *MedicAide Newsletter,* January 2008.

"Attention: Providers of Immunization Services." *MedicAide Newsletter,* October 2011. https://www.idmedicaid.com/MedicAide%20Newsletters/October%202011%20MedicAide.pdf.

"Billing for Immunization Services." *MedicAide Newsletter,* June 2008.

Change in Policy on Billing for Immunizations, *Information Release MA06-39* (11/22/2006). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"COVID-19 Vaccinations." *MedicAide Newsletter,* May 2023. https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

"Reminder: Immunizations." *MedicAide Newsletter,* October 2023. https://www.idmedicaid.com/MedicAide%20Newsletters/October%202023%20MedicAide.pdf.

"State-Supplied Vaccine Claims." *MedicAide Newsletter,* June 2012. https://www.idmedicaid.com/MedicAide%20Newsletters/June%202012%20MedicAide.pdf.

"Well Child Visits." *MedicAide Newsletter,* October 2002.

(d) Professional Organizations

ACIP Vaccine Recommendations and Guidelines. Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention, Department of Health and Human Services, https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Immunization Schedules. Centers for Disease Control and Prevention, Department of Health and Human Services, https://www.cdc.gov/vaccines/schedules/hcp/index.html.

(e) State Regulations

Health and Safety – Immunization, Idaho Code 39-4801 (2021). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title39/t39ch48/sect39-4801/.

4.21.2. Stand-Alone Vaccine Counseling

Stand-alone vaccine counseling can be helpful with addressing parental concerns about vaccine hesitancy and can provide education and vaccine confidence to participants and their families. Stand-alone counseling refers to when a participant, or caregiver, receives counseling for a vaccine from a health care professional and possibly other services, but during the same visit the participant doesn't receive an immunization. Counseling can also serve as an important educational tool to participants for all vaccine types in addition to the COVID-19 vaccine.

All Medicaid participants are eligible for stand-alone vaccine counseling. Medicaid eligible participants, under the age of 21 are covered under the Early and Periodic Screening and Diagnostic Treatment (EPSDT) benefit. Coverage applies to all covered immunization types in addition to COVID-19.

Vaccine Stand-Alone Counseling Codes	
HCPCS	Description
G0310	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5 to 15 mins time.
G0311	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 16-30 mins time.
G0312	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5 to 15 mins time.
G0313	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time.
G0314	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16-30 mins time.
G0315	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 5-15 mins time.

Qualified health care professionals must adhere to the proper billing practices for these benefits. There are no cost-sharing, copayments, or deductibles to receive this service. Stand-alone vaccine counseling is also reimbursable when delivered as virtual care services. See the Virtual Care Services section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more details.

(a) References: Stand-Alone Vaccine Counseling

(i) CMS Guidance

COVID-19 Stand-alone Vaccine Counseling-Specific HCPCS Codes. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/sites/default/files/2022-06/stnd-vacc-cou-spec-hcpcs-codes.pdf.

State Health Official Letter# 22-002. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/sites/default/files/2022-05/sho22002.pdf.

4.22. Injections Administered as Part of a Procedure

Medicaid will not pay the administration fee(s) when an injection is part of a procedure (i.e., allergy injections, therapeutic, and diagnostic radiology, etc.).

4.23. Instrument-Based Ocular Screening

Medicaid covers instrument-based ocular screening (99174) (e.g. photo screening, automated-refraction) for children three years to five years of age, who are unable to cooperate with routine acuity screening (e.g. intellectual disability, developmental delay and severe behavioral disorders). Ocular screening is only covered when completed by a physician or a non-physician practitioner. Standard vision screening methods are included in the reimbursement for the age appropriate wellness examination.

Screening services generally are not covered by Idaho Medicaid due to statutory requirements for medical necessity. The Affordable Care Act requires certain screening services be required including services with an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF).

The USPSTF gives a "B" recommendation for vision screening of all children at least once at the age of three and once again at the age of four or five to detect the presence of amblyopia or its risk factors. The USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of vision screening for children less than three years of age. These services are non-covered.

Additional information on screening services is available under the Medical Necessity section in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

4.23.1. References: Instrument-Based Ocular Screening

(a) Federal Regulations

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

(b) Idaho Medicaid Publications

"Idaho Medicaid Helps to Prevent Early Childhood Vision Loss." *MedicAide Newsletter,* June 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202014%20MedicAide.pdf.

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

(c) Professional Organizations

Vision in Children Ages 6 Months to 5 Years: Screening. United States Preventive Services Task Force. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/vision-in-children-ages-6-months-to-5-years-screening.

4.24. Laboratory Coverage

See the Laboratory Services, Idaho Medicaid Provider Handbook for coverage and criteria of laboratory services including specimen collection.

4.25. Lung Cancer Screening

Idaho Medicaid covers lung cancer screening (71271 and G0296) that meets the criteria of this section. Screening services generally are not covered by Idaho Medicaid due to statutory requirements for medical necessity. The Affordable Care Act requires certain screening services be required including services with an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF).

The USPSTF gives a "B" recommendation for the annual screening of lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years, who smoke 20 packs a year currently or have quit within the past 15 years. Participants are not eligible for screening if:

- They are under 50 or over 80;
- They have not smoked in the past 15 years;
- They have a health condition that substantially limits life expectancy; or
- They lack the ability or will not participate in curative lung surgery.

Claims must have one of the preapproved diagnoses to be eligible for reimbursement.

Preapproved Diagnoses for Lung Cancer Screening	
ICD-10-CM	Description
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
Z87.891	Personal history of nicotine dependence

4.25.1. References: Lung Cancer Screening

(a) Federal Regulations

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

(b) Idaho Medicaid Publications

"Lung Cancer Screening Coverage Update." *MedicAide Newsletter,* April 2021. https://www.idmedicaid.com/MedicAide%20Newsletters/April%202021%20MedicAide.pdf.

"New Codes: G0296 and G0297." *MedicAide Newsletter,* January 2017. https://www.idmedicaid.com/MedicAide%20Newsletters/January%202017%20MedicAide.pdf.

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

(c) Professional Organizations

Lung Cancer: Screening. United States Preventive Services Task Force. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening.

4.26. Mammography Services

Medicaid covers biennial screening mammograms for participants forty (40) to seventy-four (74) years of age. Participants forty (40) to forty-nine (49) require shared decision-making and education about the risks of screening. Diagnostic mammograms are available to all participants when medically necessary and ordered by a qualified provider. Services must be performed with mammography equipment and by staff that are considered certifiable or certified by the Bureau of Laboratories, or equivalent for other states.

Digital breast tomosynthesis (CPT® 77061-77063) is considered covered when provided with a diagnostic or screening mammogram except where otherwise noted. Codes for these services should be billed in addition to the standard mammography codes. Reimbursement for digital breast tomosynthesis is considered bundled into the screening or diagnostic mammogram provided. Additional reimbursement for digital tomosynthesis beyond the standard mammography fee is not provided.

Screening services generally are not covered by Idaho Medicaid due to statutory requirements for medical necessity. The Affordable Care Act requires certain screening services be required including services with an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF). The USPSTF gives a "B" recommendation for women aged forty (40) to seventy-four (74) years of age. The USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of screenings for the following non-covered services:

- People over the age of seventy-four (74);
- Digital breast tomosynthesis (DBT) as a primary screening method;
- Adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, DBT, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram.

Additional information on screening services is available under the Medical Necessity section in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

4.26.1. References: Mammography Services

(a) Federal Regulations

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

(b) Idaho Medicaid Publications

"CORRECTION to Idaho Medicaid Mammography Benefit: Provider Handbook Update." *MedicAide Newsletter,* February 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202023%20MedicAide.pdf .

(c) Professional Organizations

Breast Cancer: Screening. United States Preventive Services Task Force. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening.

(d) State Regulations

"Screening Mammographies: Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 602. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Screening Mammographies: Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 604. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.27. National Diabetes Prevention Program

Effective July 1, 2023, Idaho Medicaid covers the National Diabetes Prevention Program (NDPP) for eligible participants, once per 5 years. Idaho Medicaid covers preventive 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 Bright Futures periodicity schedule. The USPSTF has made a "B" recommendation for referring patients with prediabetes to preventive interventions.

Services can also be accessed through the Preventive Health Assistance program with a prior authorization if the participant has exhausted their regular benefit or doesn't meet the usual criteria for the program, but is considered at-risk for pre-diabetes. A prior authorization is necessary for a participant who started the program but did not finish and wishes to try again. Services are eligible for virtual care.

4.27.1. References: National Diabetes Prevention Program

(a) Idaho Medicaid Publications

"National Diabetes Prevention Program." *MedicAide Newsletter,* July 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202023%20MedicAide.pdf.

4.27.2. Provider Qualifications: NDPP

Providers must meet the requirements of the National Diabetes Prevention Program (NDPP) to be eligible to provide services under Idaho Medicaid.

(a) References: Provider Qualifications – NDPP

(i) State Regulations

"The National Diabetes Prevention Program." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 644.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.27.3. Participant Eligibility: NDPP

Participants over the age of 18 and a BMI>25 (or 23 for Asian Americans) with a diagnosis of pre-diabetes are eligible for the service. Participants at-risk of pre-diabetes are only eligible for coverage through Idaho Medicaid through the use of the Preventive Health Assistance Program.

(a) References: Eligible Participants - NDPP

(i) Idaho Medicaid Publications

"National Diabetes Prevention Program." *MedicAide Newsletter,* July 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202023%20MedicAide.pdf.

(ii) State Regulations

"Concurrent Diagnosis." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 642.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Participants with Pre-Diabetes." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 641.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.27.4. Reimbursement: NDPP

Idaho Medicaid follows Medicare guidelines for billing NDDP services with the following exceptions. NDDP services are provided under employment or contract of a physician, clinic, hospital, public health district and should be billed by those providers. ICD-10-CM R73.03 (Prediabetes) must be listed on the claim for reimbursement. Idaho Medicaid does not allow for the billing of G9882-G9885, G9890 or G9891.

Covered Codes for National Diabetes Prevention Program	
HCPCS	**Description**
G9873	First Medicare Diabetes Prevention Program (MDPP) core session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions
G9874	Four total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.
G9875	Nine total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions
G9876	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.
G9877	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12.

Covered Codes for National Diabetes Prevention Program	
HCPCS	**Description**
G9878	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.
G9879	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12
G9880	The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session.
G9881	The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session.

(a) References: Reimbursement - NDPP

(i) Idaho Medicaid Publications

"National Diabetes Prevention Program." *MedicAide Newsletter,* July 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202023%20MedicAide.pdf.

(ii) State Regulations

"Diabetes Education and Training Services: Provider Reimbursement." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 645. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.28. Naturopathic Services

Naturopathic services are not a covered benefit of Idaho Medicaid. These services are considered experimental and investigational. They are not eligible for coverage under EPSDT. The treatment of complications, consequences or repair of naturopathic services received by the participant are not covered by the Department unless they are deemed life threatening.

4.28.1. References: Naturopathic Services

(a) State Regulations

"Service Categories Not Covered." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Service Categories Not Covered." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390.01.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.29. Nutritional Services

Nutritional services are available for children, and pregnant participants until the end of the month in which 60 days have passed from delivery. See the Dietary and Nutritional Service Providers, Idaho Medicaid Provider Handbook for more information.

4.30. Obstetric Care

Obstetric (OB) care must be billed as a global charge unless the attending physician, or non-physician practitioner did not render all components of the care. Antepartum and postpartum care may only be billed separately from the delivery when the delivery is performed by a person outside the rendering provider's practice. Providers eligible for a global charge may not separately bill per-visit antepartum or postpartum visits.

The global charge includes antepartum, intrapartum and postpartum care, a cesarean section or vaginal delivery, with or without episiotomy, with or without forceps, or breech delivery. Prenatal diagnostic laboratory charges, such as a complete urinalysis, are not included in the global charge, and may be billed according to the Laboratory Services, Idaho Medicaid Provider Handbook. Any surgical procedures must also abide by the Covered Services and Limitations – Surgery section.

Charges for total OB care must be billed after the delivery using the date of delivery as the to and from date. When the Medicaid participant has active eligibility that begins on the date of delivery or any point prior, the global CPT® must be billed to Idaho Medicaid. Any previously collected payment from the participant for antepartum care must be reimbursed. The place-of-service on the claim should reflect where the delivery occurred. The initial office examination for diagnosis of a pregnancy may be billed separate from the total OB charges if that is the provider's standard practice for all OB participants. The initial examination must be identified as such and billed with the appropriate Evaluation and Management (E/M) CPT® code.

Claims for deliveries with a participant under the age of 13 will be denied. Providers may submit a claim review request and a request for Medicaid review of claim determination with medical documentation to demonstrate a pregnancy at a younger age. The process for requesting a review is detailed in the General Billing Instructions, Idaho Medicaid Provider Handbook.

See the Surrogates section for information about participants providing surrogacy services. See the Family Planning, Hysterectomy and Sterilization Procedures sections for information about providing these services at the conclusion of delivery and during the postpartum periods. Please, see the Abortions section under Covered Services and Limitations – General.

4.30.1. References: Obstetric Care

(a) Idaho Medicaid Publications

"Global Charge for Total Obstetric (OB) Care." *MedicAide Newsletter,* August 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202017%20MedicAide.pdf.

"New Limitation on Claims for Deliveries." *MedicAide Newsletter,* March 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202019%20MedicAide.pdf.

"Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT." *MedicAide Newsletter,* November 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf.

4.30.2. Antepartum Care

Antepartum care includes recording weight, blood pressure and fetal heart tones, routine dipstick urinalyses and maternity counseling. Providers that also provide intrapartum and postpartum services to the participant must bill a global charge per the main Obstetric Care section. They are not eligible to bill antepartum care.

Antepartum care may only be billed separately if the delivery and/or postpartum is provided by person outside of the physician or non-physician practitioner's practice. When billing for the first three visits, use the appropriate evaluation and management CPT® codes. When billing for four or more visits use CPT® codes 59425 (Antepartum care only;4-6 visits) and 59426 (Antepartum care only;7 or more visits), as appropriate, with one unit and the total charge for all visits on one line. Do not split out each visit after the third visit as they are bundled into these two codes. Claims should use the first date the participant was seen in both the **from** and **to** date fields. If billing a paper CMS-1500 claim form, note the date for each additional visit in field 19.

(a) References: Antepartum Care

(i) Idaho Medicaid Publications

"Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT." *MedicAide Newsletter,* November 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf.

4.30.3. Cesarean Section

Cesarean sections must be billed under the mother's Medicaid Identification Number (MID), with the appropriate diagnosis code indicating the reason for the cesarean section and the appropriate procedure code.

See the ICD-10 Diagnosis Codes Accepted by Idaho Medicaid Supporting Medical Necessity for Cesarean Section Appendix for a list of preapproved diagnoses for a cesarean section. Procedures conducted for reasons not on the preapproved list require a prior authorization from the Quality Improvement Organization (QIO), Telligen. Approved prior authorizations can use the same authorization number on claims for facility and professional services.

In the event of an emergency situation that prevents a prior authorization from being requested, providers may follow the Medicaid Review (DHW review) process as detailed in the General Billing Instructions, Idaho Medicaid Provider Handbook. The provider must attach supporting documentation showing the reason for the emergency and that the procedure was medically necessary. Documentation from the evaluation determining the surgery is recommended over the operative report.

Approved procedures have a four-day length of stay (LOS) without additional QIO review for the mother when a claim is billed under the newborn MID with a diagnosis in the table below. If a participant with a preapproved diagnosis is not discharged after the third day and a C-section delivery surgical procedure is not indicated on the mother's claim, or a C-Section diagnosis is not indicated on the newborn's claim, a review with the QIO is required.

Contact Telligen at 1 (866) 538-9510 for a review or fax your requests to 1 (866) 539-0365.

Cesarean Diagnoses for Newborn	
ICD-10-CM Diagnosis Code	Description
P03.4	Newborn affected by Cesarean delivery
Z38.01	Single liveborn infant, delivered by cesarean
Z38.31	Twin liveborn infant, delivered by cesarean
Z38.62	Triplet liveborn infant, delivered by cesarean
Z38.64	Quadruplet liveborn infant, delivered by cesarean
Z38.66	Quintuplet liveborn infant, delivered by cesarean
Z38.69	Other multiple liveborn infant, delivered by cesarean

(a) References: Cesarean Section

(i) Idaho Medicaid Publications

"Attention Hospitals: Cesarean Diagnoses for Inpatient Stays." MedicAide Newsletter, November 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf.

"Cesarean Section: 4-day Length of Stay." MedicAide Newsletter, January 2006.

"Cesarean Section Procedure and Anesthesia Diagnoses Restriction." *MedicAide Newsletter,* February 2020,

https://www.idmedicaid.com/MedicAide%20Newsletters/February%202020%20MedicAide.pdf
.

Hospital Providers, *Information Release MA03-72* (2003). Division of Medicaid, Department of Health and Welfare, State of Idaho.

4.30.4. Delivery of the Placenta

When delivery has occurred without the direct physical assistance of the provider, and the provider is present to deliver the placenta (as documented in the medical record) CPT code 59414 delivery of placenta (separate procedure) should be submitted with the appropriate CPT codes for antepartum and/or postpartum care, rather than a global CPT which includes labor and delivery.

(a) References: Delivery of the Placenta

(i) Idaho Medicaid Publications

"Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT." *MedicAide Newsletter,* November 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf.

4.30.5. Dilation and Curettage (D&C)

All D&C procedures require documentation in the form of an operative report, emergency department report, or office notes. Please attach required documentation to claim for submission.

4.30.6. High Risk Pregnancy Case Management Services

High risk pregnancy case management services are available for coordination of in-home and community support services to pregnant people who are at risk of premature labor or congenital issues of the fetus. To make a referral, contact Telligen at 1 (866) 538-9510 and request Case Management Services.

4.30.7. Lactation Counseling

Medicaid reimburses for individual or group lactation counseling when provided by the physician, non-physician practitioner or certified lactation consultant. Providers may bill for these preventive services by utilizing the following Individual Counseling CPT® codes (99401–99404) or Lactation Classes HCPCS (S9443). Services are covered for one initial antepartum session within two weeks of the expected date of delivery and two postpartum visits within the first month of delivery. Lactation counseling is reimbursable in addition to services covered under the global billing. Services provided by a certified lactation consultant are provided under employment or contract of a physician, clinic, hospital and should be billed by those providers.

(a) References: Lactation Counseling

(i) Idaho Medicaid Publications

"Medicaid Covers Services to Promote Breastfeeding." *MedicAide Newsletter,* November 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202014%20MedicAide.pdf.

4.30.8. Multiple Deliveries

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

Example 1

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

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

Example 2

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

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

Example 3

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

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

(a) References: Multiple Deliveries

(i) Idaho Medicaid Publications

"Multiple Deliveries." *MedicAide Newsletter,* May 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

4.30.9. Postpartum Care

Postpartum care includes home, hospital and office visits, and contraceptive counseling until the end of the month in which 60 days have passed from delivery. Postpartum care (CPT® 59430) may only be billed separately if the delivery is provided by a physician from a different practice. All visits for postpartum care are bundled into one unit of 59430. Enter the first date the participant was seen for postpartum care in both the **from** and **to** date fields. Postpartum care includes, but is not limited to:

- Exploration of the uterus;
- Episiotomy and repair;
- Repair of cervical, vaginal, or perineal lacerations; and
- Placement of a hemostatic pack or agent.

The use of evaluation and management codes for postpartum visits is prohibited. See Family Planning for more information on contraceptive counseling.

(a) References: Postpartum Care

(i) Federal Regulations

Pregnant Women Eligible for Extended or Continuous Eligibility, 42 C.F.R. Sec. 435.170 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec435-170.pdf.

(ii) Idaho Medicaid Publications

"Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT." *MedicAide Newsletter,* November 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf.

"Postpartum Care." *MedicAide Newsletter,* January 2009.

4.30.10. Presumptive Eligibility (PE) Services

Services are limited for participants covered by Medicaid under Presumptive Eligibility programs. T1023 may be billed for the PE determination. Please see the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information about billing requirements for these participants.

4.30.11. Resuscitation – Newborn

Resuscitation of the newborn infant is covered separately if billed under the child's name and Medicaid identification (MID) number.

4.30.12. Surrogates

Participants that have a gestational agreement and are pregnant with a child who is not inheriting one of their, or their spouse's, gamete is a surrogate. Idaho requires all gestational agreements to include reasonable healthcare expenses. Providers are required to collect payment from all responsible third parties per the Third Party Liability section of the General Billing Instructions, Idaho Medicaid Handbook, prior to billing Medicaid. Services for surrogates must be billed with the ICD-10 diagnosis code Z33.3 for all pregnancy and delivery-related claims. Claims for these services will be denied and the provider can follow the process for billing the participant for non-covered services per the Participant Financial Responsibility section of the General Information and Requirements for Providers, Idaho Medicaid Handbook. Claims not for pregnancy or delivery-related services with diagnosis Z33.3 should be submitted with documentation supporting that the service was not related to the gestational agreement. These claims will be pended and reviewed by the Department to determine eligibility for reimbursement. If a gestational agreement is terminated for a pregnant participant, providers may submit a claim review request and a request for Medicaid review of claim determination with documentation of the terminated agreement. The process for requesting a review is detailed in the General Billing Instructions, Idaho Medicaid Provider Handbook.

(a) References: Surrogates

(i) Idaho Medicaid Publications

"Gestational Agreements Act." *MedicAide Newsletter,* June 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/June%202023%20MedicAide.pdf.

(ii) Federal Regulations

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

"Strengthening Medicaid Third-Party Liability." H.J.R. 59, "Continuing Appropriates Resolution, 2014," Sec. 202. Government Printing Office, https://www.congress.gov/bill/113th-congress/house-joint-resolution/59.

Third Party Liability, 42 CFR 433 Subpart D (2013). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-part433-subpartD.pdf.

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

(iii) State Regulations

"Gestational Agreements Act." *Idaho Code Title 7, Chapter 16, "Special Proceedings."* Idaho Legislature, https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title7/T7CH16.pdf.

4.31. Ophthalmology

Please see the Eye and Vision Services, Idaho Medicaid Provider Handbook for ophthalmology services.

4.32. Physician-Administered Drugs

Certain PAD require prior authorization by the Idaho Medicaid Pharmacy Unit. Please refer to the Numerical Fee Schedule on the DHW website. The pharmacy request forms can be found at https://healthandwelfare.idaho.gov/providers/pharmacy-providers/idaho-medicaid-pharmacy-program. If there is no PA form listed for the specific drug given, use the Universal PA form. At the top of the form please write "Physician Administered Drug" so that your PA is directed to the correct authorizing entity.

4.32.1. Reporting National Drug Code (NDC) for Drugs Billed with HCPCS Codes

Federal mandates require that professional claims for drugs reported with HCPCS must include the appropriate NDC of the drug supplied, units dispensed, and basis of measurement for each HCPCS drug. This requirement applies to drugs with HCPCS codes, whether submitted electronically, on a paper CMS-1500 claim form, or as a Medicare cross-over claim.

The HCPCS drugs that require NDC information are listed in the current HCPCS Manual, *Appendix 1,* and are listed alphabetically by generic, brand, or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will not be accepted.

4.32.2. Compound Drugs

Paper Claims: Attach the NDC Detail Attachment.
Electronic Claims: To designate the claim as a compound drug claim combining two or more ingredients (one of which is a covered Medicaid product), a compound indicator value of two (2) is required.

If one or more of the ingredients being billed is a non-covered item and the pharmacy has chosen to be paid for the covered ingredients only, use a submission clarification code equal to eight (8). This will post a zero payment to the non-covered ingredient(s) and process the rest of the covered ingredients to pay at the applicable allowed amount.

Required for All Compound Claims:

- National Drug Code for each individual ingredient
- Drug name and strength
- Quantity of each ingredient
- A unit of measure for each individual ingredient of the compound:
    - Each (EA)
    - Grams (GM)
    - Milliliters (ML, CC)
- Ingredient cost for each ingredient (if no value is entered, no payment will be made)

4.33. Prolonged Services

Prolonged services (CPT® 99354, 99355, 99356, 99357, 99415, 99416 and 99417) are a covered service. Services before or after direct patient care (CPT® 99358 or 99359) on a given date are not separately reportable, because the work involved is included in the evaluation and management codes.

4.33.1. References: Prolonged Services

(a) Idaho Medicaid Publications

"Prolonged Services Before or After Direct Patient Care – CPT® 99358 and 99359." *MedicAide Newsletter,* October 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202018%20MedicAide.pdf.

4.34. Psychiatric Care

Medicaid covers preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided by a psychiatrist in an inpatient or outpatient setting. A psychiatrist billing for these services will use their own physician provider number.

4.34.1. Inpatient Psychiatric Care

The QIO conducts concurrent review of all admissions to inpatient psychiatric facilities for Idaho Medicaid participants if care exceeds three days.

The Department of Health and Welfare (DHW) will only pay for medically necessary inpatient psychiatric hospital services in an Institute for Mental Disease (IMD) for participants under the age of 21 who have a current DSM diagnosis with substantial impairment in thought, mood, perception, or behavior. If a participant reaches age 21 while receiving services, treatment may continue until services are no longer required, or the participant reaches age 22.

See the QIO Idaho Medicaid Provider Manual for more information.

4.34.2. Outpatient Psychiatric Care

Effective September 1, 2013, Medicaid participants who are eligible for the basic plan are automatically enrolled in the Idaho Behavioral Health Plan to obtain outpatient behavioral health services administered by Optum Idaho. Physicians are not required to enroll as network providers with Optum Idaho to provide and bill for Medicaid-reimbursable outpatient behavioral health services. Physicians and non-physician practitioners that provide more than behavioral health services can still bill the Department by submitting claims to Gainwell Technologies.

4.34.3. Psychiatric Crisis via Virtual Care

Physicians and psychiatric nurse practitioners may provide psychotherapy (CPT® 90839 and 90840) to participants in crisis via virtual care. The medical record of the participant must support a crisis service was provided for the full duration billed and demonstrate that an urgent assessment of the participant's mental state was necessary, and/or their health or safety was at risk. The participant must be in the room for the duration of the visit or a majority of the service, which is focused on the individual. 90839 is a stand-alone code not to be reported with psychotherapy or psychiatric diagnostic evaluation codes, the interactive complexity code, or any other psychiatry section code.

4.35. Radiology

The complete radiology procedure may be billed without a modifier if the physician, or non-physician practitioner, owns the equipment, and supervises and interprets the procedure. If these requirements aren't met, the procedure must be broken down into professional and technical components.

4.35.1. Technical Component

The technical component is billed with a TC modifier, and includes charges for:

- Personnel
- Material, including usual contrast media* and drugs
- Film or xerograph
- Space, equipment, and other facility charges

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes with the appropriate HCPCS. Attach an invoice to your claim identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered. Because of the wide variations in costs to providers and the radioisotopes billed, this information is necessary to price each claim.

4.35.2. Professional Component

The professional component represents services of the physician (radiologist) to interpret and report on the procedure. Unless there is a procedure code for *Supervision and Interpretation Only,* identify a charge for the professional component using the modifier 26. This component is applicable in any situation in which the physician does not provide the technical component as described above.

4.36. Skin Substitute Products

Skin substitute products are a covered benefit through Idaho Medicaid.

4.36.1. EpiCord® and EpiFix®

EpiCord® and EpiFix® are two of the many options for skin substitute products. These two products require a prior authorization by Telligen. EpiCord® and EpiFix® are only considered medically necessary for the treatment of:

- A non-healing diabetic lower-extremity ulcer as demonstrated by standard wound care for two weeks or more with less than a 20% reduction in wound area; or the following ophthalmic indications:
- Corneal ulcers and melts;
- A persistent epithelial defect that with conservative treatment has failed to close completely within 5 days or decrease in size after 2 days;
- Neurotrophic keratitis;
- Pterygium repair; or
- Stevens-Johnson syndrome.

EpiCord® and EpiFix® Codes	
Codes	Description
Q4186	EpiFix®, per sq. cm
Q4187	EpiCord®, per sq. cm

Any other use is considered investigational and non-covered per IDAPA 16.03.09, "Medicaid Basic Plan Benefits."

4.36.2. References: Skin Substitute Products

(a) Idaho Medicaid Publications

"Criteria for Prior Authorization of EpiFix® and EpiCord®." *MedicAide Newsletter,* April 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf.

4.37. Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If the prescription cannot be faxed, phoned, or electronically sent to the pharmacy, then providers must ensure that the prescription form meets all three of the following requirements:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

The intent of this requirement is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

4.37.1. References: Tamper Resistant Prescription Requirements

(a) CMS Guidance

State Medicaid Director Letter# 07-012. Center for Medicaid and State Operations, Department of Health and Human Services, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081707.pdf.

(b) Federal Regulations

"Payment for Covered Outpatient Drugs." Social Security Act, Sec. 1927(k)(2) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1927.htm.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007. P.L. 110-28 (2007). Government Printing Office, https://www.govinfo.gov/content/pkg/PLAW-110publ28/pdf/PLAW-110publ28.pdf.

(c) Idaho Medicaid Publications

"Attention: All Prescribers and Outpatient Pharmacy Providers." *MedicAide Newsletter,* September 2008.

"Attention Pharmacy, Physicians, and Midlevel Practitioner Providers: New Federal Regulations for Tamper-Resistant Prescription Pads." *MedicAide Newsletter,* March 2008.

Tamper-Resistant Prescription Forms, Information Release MA07-21 (10/1/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho.

4.38. Therapy Services

See the Therapy Services, Idaho Medicaid Provider Handbook for covered therapy services and criteria.

4.39. Tobacco Cessation

Effective January 1, 2014, tobacco cessation benefits are available to all eligible Medicaid participants. Benefits include nicotine replacement, such as gum, lozenges and patches, bupropion SR, and services such as cessation counseling. Items listed on the Preferred Drug List on the Idaho Medicaid Pharmacy Program webpage do not require a prior authorization. Non-preferred drugs do require a prior authorization from the Pharmacy Unit.

4.39.1. References: Tobacco Cessation

(a) Idaho Medicaid Publications

"How Medicaid Beneficiaries Can Obtain Tobacco Cessation Products." *MedicAide Newsletter,* March 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202014%20MedicAide.pdf.

4.40. Transcranial Magnetic Stimulation

Transcranial Magnetic Stimulation (TMS) is a non-invasive method of delivering electrical stimulation to the brain. A magnetic field is delivered through the skull, where it induces electric currents that affect neuronal function. TMS is a not a covered service. Idaho Medicaid considers TMS of the brain to be investigational as a treatment of depression and other psychiatric/neurologic disorders such as schizophrenia or migraine headaches.

4.40.1. References: Transcranial Magnetic Stimulation

(a) Idaho Medicaid Publications

"Transcranial Magnetic Stimulation." *MedicAide Newsletter,* September 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202012%20MedicAide.pdf.

4.41. Virtual Care Services

Physicians and non-physician practitioners are eligible to receive reimbursement for virtual care services. See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for covered services and requirements.

4.42. Vitamin Injections

Vitamin injections are only covered if medically necessary for a specific diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination.

4.42.1. References: Vitamin Injections

(a) State Regulations

"Injectable Vitamins." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 502.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4.43. Wellness Examinations

Routine well checks are an important part of preventive health services and are covered by Idaho Medicaid at age-appropriate intervals. Wellness examinations should include age-appropriate developmental screenings, anticipatory guidance, review of immunization status, depression, tobacco, alcohol, and possible opioid use. Reimbursement for these activities is bundled into the wellness examination. Providers are encouraged to bill G8431 for a positive depression screen or G8510 for a negative depression screen. Value care organizations should consider appropriate use of these codes in support of their quality measures. The exception to bundled reimbursement is Maternal Postpartum Depression Screening, which is a service performed on someone other than the participant for the participant's benefit.

Wellness exams must be billed with the Preventive Medicine CPT® Codes. The CPT® codes **96110** should be billed when using a standardized tool (such as the Ages & Stages Questionnaire) to screen development and behavior. Routine well checks and all medically necessary immunizations are excluded from co-payments. See the Adult Wellness Exams and Child Wellness Exams sections for specific information regarding those age groups.

Physical exams for sports participation, camp attendance, employment, driving licensure, admission to an educational institution, military recruitment, insurance coverage, paternity determination, adoption, immigration, or marriage are not considered medically necessary and are not covered by Idaho Medicaid. A non-covered physical may be rendered as incidental to a Medicaid-covered service, but only the Medicaid-covered service will be reimbursed, and no additional payment will be made for the physical exam.

Administrative exams that are required by Idaho Medicaid are a covered service. Examples of covered administrative exams are health risk assessments and preventive physical examinations for refugees entering the country and participants in the Developmental Disability program. Examinations and laboratories for refugee immigration should be billed with Z02.89 (Encounter for other administrative examinations) as the primary diagnosis and modifier U7. When an exam and/or report is required by Department of Health and Welfare (DHW) for an adult participant, including annual history and physical exams for adults living in an Intermediate Care Facility (for Developmentally Disabled)/Intellectually Disabled (ICF/ID), use ICD-10-CM code Z02.89 as the primary diagnosis.

4.43.1. References: Wellness Examinations

(a) CMS Guidance

Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV), MLN Matters Number: SE18004 (08/28/2018). Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18004.pdf.

(b) Federal Regulations

Refugee Medical Assistance – Medical Screening, 45 C.F.R. Sec. 400.107 (1989). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=0a34f4d3cf26941ec1bdafbbe551e398&mc=true&node=se45.2.400_1107&rgn=div8.

(c) Idaho Medicaid Publications

"Depression Screening." *MedicAide Newsletter,* April 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202024%20MedicAide.pdf.

"Physicals for Non-Medical Reasons are Not Covered." *MedicAide Newsletter,* December 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf.

"Wellness Examinations for Refugee Screening." *MedicAide Newsletter,* July 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf.

(d) Professional Organizations

Refugee Health Guidance. Centers for Disease Control and Prevention, Department of Health and Human Services. https://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html.

(e) State Regulations

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

4.43.2. Adult Wellness Exams

Adult wellness exams are annual preventive exams to assess the health status of adult participants. Participants are eligible for one exam every calendar year. Wellness exams, immunizations, and family planning services are excluded from co-payment. The content of the exam is expected to be similar to an Annual Wellness Visit (AWV) through Medicare. Screenings are covered if they have received an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF). Elements of an adult wellness exam include:

- A health risk assessment;
- Review of medical and family history (including opioid use);
- A list of providers the participant receives services from;
- Measurement of weight, BMI and blood pressure;
- Survey of potential risk factors for depression and other mood disorders;
- Detection of cognitive impairment;
- A screening schedule aligned with USPSTF "A" and "B" recommendations;
- Review of risk factors;
- Personalized health advice;
- Laboratory and diagnostic orders; and
- Any necessary referrals to other medical professionals.

(a) References: Adult Wellness Exams

(i) CMS Guidance

Medical Wellness Visits. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html.

(ii) Federal Regulations

Coverage of Preventive Health Services, 45 C.F.R. Sec. 147.130 (2017). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec147-130.pdf.

Provision of EHB, 45 C.F.R. Sec. 156.115(a)(4) (2018). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec156-115.pdf.

(iii) Idaho Medicaid Publications

"Adult Wellness Examinations." *MedicAide Newsletter,* July 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf.

"Adult Wellness Visits." *MedicAide Newsletter,* January 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf.

(iv) Professional Organizations

USPSTF A and B Recommendations. U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P&grades%5B%5D=A&grades%5B%5D=B&searchterm=.

(v) State Regulations

"Physician Office Visit", IDAPA 16.03.18, "Medicaid Cost-Sharing," Sec. 320.08.a. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160318.pdf.

4.43.3. Child Wellness Exams

All children ages birth through 21 should receive regular wellness exams from their Primary Care Provider (PCP). Services for children such as wellness examinations, are considered EPSDT under federal law. Baby and child wellness exams, immunizations, and family planning services are excluded from co-payment. Federal law requires that the wellness exams include:

- Appropriate immunizations;
- Appropriate vision and hearing testing;
- Appropriate developmental and behavioral health screenings;
- Comprehensive physical and mental health and developmental history;
- Comprehensive unclothed physical exam;
- Health education including anticipatory guidance; and
- Laboratory tests as indicated in periodicity schedule.

Federal regulations require that all Medicaid eligible children are tested for lead poisoning at the ages of 12 months and 24 months, as part of their wellness exam. Children over the age of 24 months up to 21 years of age should receive a screening blood lead test if there is no record of a previous test. See the Lead Screening section of the Laboratory Services, Idaho Medicaid Provider Handbook, for more information.

Coverage is also available for maternal postpartum depression screening.

Idaho Medicaid has adopted the American Academy of Pediatrics (AAP) periodicity schedule as the recommended frequency for child wellness exams and the American Academy of Pediatric Dentistry periodicity schedule for dental care. If a child has not received the recommended care previously, the schedule should be brought up to date at the earliest possible time. Additionally:

- If the PCP has never seen the participant before and the participant is establishing care, a child wellness exam can be provided at any time during the year;
- If the PCP has no record of the child wellness exam or the age-appropriate screenings (as indicated on the AAP periodicity schedule), the child wellness exam/age-appropriate screenings can be conducted at any time;
- If the child is an established patient, the scheduling of the child wellness exam or the interim exam is at the discretion of the provider; and
- If a concern with an existing condition worsens or a new one presents, then an interperiodic exam would be covered.

Interperiodic screens can be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screens may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary.

If a PCP determines during a wellness exam or an interperiodic screen that a child needs a medically necessary service or product that is not covered under the child's Medicaid benefits, the PCP should consult the Early Periodic Screening and Diagnostic and Treatment (EPSDT) benefit section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for coverage and prior authorization information.

Children younger than 37 months of age with a physical or mental condition that has a high probability of developmental delay are eligible for Early Intervention Services through the Infant Toddler Program. See the Early Intervention Services section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information.

Weight management is a covered benefit for children aged five (5) years and older, with a Body Mass Index (BMI) that falls in either the overweight, obese, or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. If a PCP determines a child may benefit from a weight management program and the child, they should review the *Preventive Health Assistance (PHA)* section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information.

(a) References: Child Wellness Exams

(i) Federal Regulations

Coverage of Preventive Health Services, 45 C.F.R. Sec. 147.130 (2017). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec147-130.pdf.

Provision of EHB, 45 C.F.R. Sec. 156.115(a)(4) (2018). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec156-115.pdf.

(ii) Professional Organizations

USPSTF A and B Recommendations. U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P&grades%5B%5D=A&grades%5B%5D=B&searchterm=.

(iii) State Regulations

Child Wellness Services: Coverage and Limitations, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 582. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Child Wellness Services: Definitions, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 580. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Child Wellness Services: Participant Eligibility, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 581. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Child Wellness Services: Provider Qualifications and Duties, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 584. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Physician Office Visit, IDAPA 16.03.18, "Medicaid Cost-Sharing," Sec. 320.09.a. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160318.pdf.

4.43.4. Child Wellness Exam: Maternal Postpartum Depression Screening

Effective January 1, 2018, maternal postpartum depression screening may be billed for the mother of an infant under 12 months of age if a standardized screening instrument is used. Acceptable screening instruments are:

- Edinburgh Postnatal Depression Scale (EPDS);
- Patient Health Questionnaire – 9 (PHQ-9) Screener; and
- Beck Depression Inventory (BDI).

Claims should be billed under the infant's Medicaid ID number with G8431 for a positive depression screen or G8510 for a negative depression screen. No additional diagnosis codes should be added for this service. If a screening is positive for depression, mothers with:

- Active Medicaid coverage should be directed to contact OPTUM Idaho Member Line at (855) 202-0973 for assistance finding a provider;
- Other insurance should be directed to contact their carrier for a list of available providers; or
- No insurance should be directed to contact community resources in their area.

Reimbursement for the screening is limited to three (3) per infant.

(a) References: Child Wellness Exam – Maternal Postpartum Depression Screening

(i) Idaho Medicaid Publications

"**Attention Pediatric Care Providers:** Postpartum Depressions Screening During an EPSDT Well-Child Visit as of January 1, 2018." MedicAide Newsletter, December 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf.

(ii) Professional Organizations

Perinatal Depression: Preventive Interventions. United States Preventive Services Task Force. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/perinatal-depression-preventive-interventions?ds=1&s=depression.

5. Covered Services and Limitations – Surgery

Medicaid pays all surgical fees based on the global fee concept as defined by CMS and the Current Procedural Terminology (CPT®) Manual. The global surgical package includes all preoperative, intra-operative and postoperative services that are normally a usual and necessary part of the procedure. It also includes all medical and surgical services during the postoperative period to treat complications that do not require a return to the operating room. The following services are always included in the global fee payment for the procedure:

- Access to the site;
- Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia;
- Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of the procedure (including history and physical);
- Supplies, except those identified as exclusions by Medicare;
- Miscellaneous services such as:
    - Dressing changes;
    - Local incisional care;
    - Removal of cutaneous sutures, lines, wires, tubes, drains, casts and splints;
    - Insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and
    - Changes to and removal of tracheostomy tubes.
- Administration of fluids and drugs during the procedure;
- Immediate postoperative care, including dictating operative notes and talking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the post anesthesia recovery area;
- Postoperative visits and miscellaneous services related to the surgery including, but not limited to, the application of casts, splints and straps; and
- Postoperative pain management provided by the surgeon.

If a provider, outside of the performing surgeon's practice, delivers part of the global components listed above, he/she must bill the appropriate CPT® code for the actual services delivered with the appropriate modifier.

Some surgeries may require a prior authorization. Surgeries requiring a prior authorization require an authorization for both the professional component and the facility, but only a single request needs to be submitted for both.

Reconstructive and plastic surgery always require a prior authorization. See the Prior Authorization (PA) section for more information on determining if a procedure requires a prior authorization.

5.1. References: Covered Services and Limitations – Surgery

5.1.1. CMS Guidance

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

Global Surgery Booklet. Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf.

5.1.2. Idaho Medicaid Publications

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

"**Medicaid Program Integrity:** Casting, Splinting, or Strapping During Post-Operative Period." *MedicAide Newsletter,* January 2020, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202020%20MedicAide.pdf.

"**Medicaid Program Integrity:** Services Included in Global Surgical Packages." *MedicAide Newsletter,* March 2014, https://www.idmedicaid.com/MedicAide%20Newsletters/March%202014%20MedicAide.pdf.

5.2. Provider-Preventable Conditions

Provider-preventable conditions (PPC) are required to be submitted on a claim when applicable with one of the modifiers below. Effective September 1, 2012, all claim lines for PPC will be denied. Any provider present at the time of a surgical or invasive procedure error will not be paid for the procedure. Services necessary to treat the PPC are also not covered, unless the PPC existed prior to the initiation of treatment for that participant by a provider and their group.

Provider-Preventable Condition Modifiers	
Modifier	Description
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

5.2.1. References: Provider-Preventable Conditions

(a) Idaho Medicaid Publications

Payment Reduction for Hospital Acquired Conditions (HACs), Information Release MA12-08 (06/29/2012). Division of Medicaid, Department of Health and Welfare, State of Idaho, https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13282&dbid=0&repo=PUBLIC-DOCUMENTS.

"Payment Reduction for Provider-Preventable Conditions." *MedicAide Newsletter,* December 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202012%20MedicAide.pdf.

5.3. Surgical Modifiers

Modifiers are mandatory in certain circumstances. Refer to the most recent Current Procedural Terminology (CPT®) Manual for specific guidance using modifiers. Anatomical modifiers are required when the procedure is unilateral (left arm/right arm). If the procedure is a unilateral code, and there is no more specific code available as with 28126 (Resection, single toe, each) or 28153 (Resection, head of phalanx, toe), it may be billed as many times as anatomically appropriate—for this example, ten times, with use of the appropriate modifier to identify each toe. In order to recognize assistant-at-surgery services provided by a physician assistant or nurse practitioner (mid-level practitioners), surgical codes should be billed under the mid-level practitioner number with an AS modifier.

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

5.3.1. References: Surgical Modifiers

(a) Idaho Medicaid Publications

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

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

5.3.2. Coronary Artery Modifiers

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using coronary artery modifiers.

5.3.3. Eyelid Modifiers

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using eyelid modifiers.

5.3.4. Finger Modifiers

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using finger modifiers.

5.3.5. Modifier 22: Increased Procedural Services

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier 22.

5.3.6. Modifier 24: Unrelated Evaluation and Management

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

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

(a) References: Modifier 24

(i) Idaho Medicaid Publications

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

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

5.3.7. Modifier 25: Separately Identifiable Service

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

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

(a) References: Modifier 25

(i) CMS Guidance

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

(ii) Idaho Medicaid Publications

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

5.3.8. Modifier 50: Bilateral Procedure

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier 50.

5.3.9. Modifier 51: Multiple Surgical Procedures

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier 51.

5.3.10. Modifier 53: Discontinued Procedure

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier 53.

5.3.11. Modifier 54: Surgical Care Only

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

(a) References: Modifier 54

(i) Idaho Medicaid Publications

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

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

5.3.12. Modifier 55: Postoperative Care Only

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

(a) References: Modifier 55

(i) Idaho Medicaid Publications

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

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

5.3.13. Modifier 56: Preoperative Management Only

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

(a) References: Modifier 56

(i) Idaho Medicaid Publications

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

5.3.14. Modifier 57: Decision for Surgery

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

(a) References: Modifier 57

(i) CMS Guidance

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

5.3.15. Modifier 58: Staged or Related Procedure

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier 58.

5.3.16. Modifier 59: Separate Encounters and Distinct Procedures

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier 59.

5.3.17. Modifier XE: Separate Encounter

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier XE.

5.3.18. Modifier XP: Separate Practitioner

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier XP.

5.3.19. Modifier XS: Separate Structure

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier XS.

5.3.20. Modifier XU: Unusual Non-Overlapping Service

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using modifier XU.

5.3.21. Right and Left Side Modifiers

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using right and left side modifiers.

5.3.22. Toe Modifiers

See the General Billing Instructions, Idaho Medicaid Provider Handbook for requirements on using toe modifiers.

5.4. Hospital Admissions

If the surgery is elective or non-trauma, the hospital admission is included in the fee for surgery. If the surgery is the result of an emergency or trauma situation, the hospital admission can be paid in addition to the surgery. Indicate in field **24C** of the CMS-1500 claim form or in the electronic claim form emergency indicator when the admission is trauma or emergency related.

See Inpatient Stay Reviews for information on QIO requirements and penalties.

5.5. Anesthesiology

Anesthesia claims must include the CPT® anesthesia code for the surgical procedure that was performed on the participant. Base units will be added by the system automatically and should not be billed separately. Units are equal to Medicare base units multiplied by fifteen (15). A list of Idaho Medicaid base units may be found in Appendix B. Anesthesia Base Units. Base units include preoperative evaluation, reviewing the participant's medical record, and post-operative visits.

Anesthesia time begins when the anesthesiologist physically starts to prepare the participant for the induction of anesthesia in the operating room, or equivalent area, and ends when the anesthesiologist is no longer in personal attendance. Units are equal to the total amount of time in one (1) minute increments, and any necessary modifiers. Only time spent in personal attendance in the room with the participant should be counted. The anesthesiologist may account for discontinuous time by adding time before and after interruptions of personal attendance. Documentation of personal attendance should be maintained as part of the participant's record.

Idaho Medicaid limits reimbursement for anesthesia procedures to once per day. The anesthesia start date is the only date that should be used. Do not date span. A repeat anesthesia procedure on the same day that is billed with the CPT® modifier **76** or **77** will be considered included in the original payment. Medicaid considers that a second separate session of anesthesia has occurred when a patient is returned to surgery after spending time in another unit of the hospital. In these cases, Medicaid will reimburse both CPT® anesthesia codes plus the total time for both sessions, with adequate documentation.

Medicaid does not pay for supervision of anesthesia services. The provider who administers the anesthesia, either a physician or Certified Registered Nurse Anesthetist (CRNA), is paid 100 percent of the allowed amount for the procedure.

Postoperative pain management is included in the surgeon's global payment when related to the procedure. An anesthesiologist may only render services if they are separate, medically necessary and the surgeon does not have the skill or experience for treatment. The surgeon is responsible to document in the medical record the referral to the anesthesia practitioner, and why.

Anesthesia Modifiers	
A repeat anesthesia procedure on the same day which is billed with the CPT® modifier **76** or **77** will be paid at $0.00.	
AA	Anesthesia services personally performed by an anesthesiologist. The AA modifier is used for all basic procedures
AD	Medical supervision by a physician, more than four concurrent anesthesia procedures.
P1	Normal healthy patient.
P2	Patient with mild systemic disease
P3	Patient with severe systemic disease
P4	Patient with severe systemic disease that is a constant threat to life
P5	Moribund patient who is not expected to survive without the operation.
QS	Monitored anesthesia care service (can be billed by CRNA or a physician). Modifier QS (Monitored Anesthesia Care) is for informational purposes. Please report actual

Anesthesia Modifiers	
	monitoring time on the claim form. This modifier must be billed with another modifier to show that the service was personally performed or medically directed.
QX	CRNA service, with medical direction by a physician.
QZ	CRNA service, without medical direction by a physician.

5.5.1. References: Anesthesiology

(a) CMS Guidance

Anesthesia and Pain Management. Jurisdiction F – Medicare Part B. Noridian Healthcare Solutions. https://med.noridianmedicare.com/web/jfb/specialties/anesthesia-pain-management.

Anesthesia Services Webinar. Noridian Healthcare Solutions, February 2016. Webinar.

"Chapter 2 – Anesthesia Services." *Medicaid NCCI Policy Manual,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.html.

"Chapter 12 – Physicians/Nonphysician Practitioners." *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.

(b) Idaho Medicaid Publications

All Anesthesia Providers, Information Release MA02-24 (8/01/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho.

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

Anesthesia Providers, Information Release MA02-19 (1/01/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho.

Anesthesia Providers, Information Release MA04-01 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"**Medicaid Program Integrity Unit:** Billing Anesthesia Services." *MedicAide Newsletter,* July 2016, https://www.idmedicaid.com/MedicAide%20Newsletters/July%202016%20MedicAide.pdf.

5.5.2. Certified Registered Nurse Anesthetist

Payments may be made directly to the certified registered nurse anesthetist (CRNA) under their individual provider number, or through an anesthesiologist group. The services of a CRNA may be billed on a UB-04 if the hospital has received an exemption from Medicare. The hospital must send Idaho Medicaid an application with a copy of the valid CRNA license and exemption attached. Exemptions must be updated annually.

(a) References: Certified Registered Nurse Anesthetist

(i) CMS Guidance

Anesthesia and Pain Management. Jurisdiction F – Medicare Part B. Noridian Healthcare Solutions.
https://med.noridianmedicare.com/web/jfb/specialties/anesthesia-pain-management.

Anesthesia Services Webinar. Noridian Healthcare Solutions, February 2016. Webinar.

"Chapter 2 – Anesthesia Services." *Medicaid NCCI Policy Manual,* Centers for Medicare and Medicaid Services, Department of Health and Human Services,
https://www.cms.gov/medicare/coding-billing/ncci-medicaid/medicaid-ncci-policy-manual.

"Chapter 12 – Physicians/Nonphysician Practitioners." *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.

(ii) Idaho Medicaid Publications

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

5.5.3. Obstetrical Anesthesia

Time for epidural anesthesia services rendered during labor is counted differently from other anesthesia services. Obstetrical neuraxial anesthesia/epidural, CPT 01967 for vaginal delivery time is not counted like general anesthesia time. Obstetrical epidural time is counted in minutes from beginning to end even if the anesthesiologist is not physically in the room. This is allowed because the anesthesiologist may attend more than one patient concurrently under continuous epidural analgesia for obstetrical deliveries.

Medications for pain relief given during the time of the epidural anesthesia are included and must not be billed as a separate procedure. Only one provider will be paid for epidural services. Medicaid does not pay for supervision of anesthesia services. The provider who administers the anesthesia, either a physician or Certified Registered Nurse Anesthetist (CRNA), is paid 100 percent of the allowed amount for the epidural procedure.

Anesthesia for Cesarean Delivery Following a Planned Vaginal Birth
Coding for scheduled cesarean deliveries can be done on a single claim line. When a delivery is planned as a vaginal delivery, but concludes as a cesarean delivery, two claim lines are required to fully describe the services. CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. When an appropriately licensed and enrolled rendering/performing provider starts a planned vaginal delivery (CPT code 01967) which results in a cesarean delivery (CPT code 01968), both procedures may be billed. Do not report CPT 01968 for "standing-by" if the patient elects natural childbirth and the physician/provider doesn't perform an epidural.

Anesthesia for Sterilization at the Time of Delivery
Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately. All sterilization consent and documentation requirements must be met.

5.5.4. References: Obstetrical Anesthesia

(a) Idaho Medicaid Publications

"Anesthesia for Obstetrical/Maternity Services." *MedicAide Newsletter,* November 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf.

5.6. Circumcisions

Idaho Medicaid covers circumcisions only when medically necessary. Coverage is not available for religious or cultural reasons. Common medical reasons to have a circumcision is to protect against infections of the urinary tract and the foreskin, prevent cancer, lower the risk of getting sexually transmitted diseases and prevent phimosis. Prior authorization is not required. Claims billed with circumcision CPT® codes 54150, 54160, or 54161, and related charges are paid for one of the diagnosis codes listed below, or with documentation of medical necessity attached to the claim.

Preapproved Diagnoses for Circumcision	
ICD-10 Diagnoses	Description
C60.0	Malignant neoplasm of prepuce
C60.8	Malignant neoplasm of overlapping sites of penis
C63.7	Malignant neoplasm of other specified male genital organs
C63.8	Malignant neoplasm of overlapping sites of male genital organs
C79.82	Secondary malignant neoplasm of genital organs
D07.61	Carcinoma in situ of scrotum
D07.69	Carcinoma in situ of other male genital organs
D29.0	Benign neoplasm of penis
N47.0 – N47.8	Disorders of prepuce
N48.0 – N48.29	Other disorders of penis
S31.21XA – S31.25XS	Open wound of penis
S38.221A – S38.222S	Amputation of the Penis
S39.848A – S39.848S	Other specified injuries of external genitals

5.6.1. References: Circumcisions

(a) Idaho Medicaid Publications

Change in Medicaid Coverage for Male Circumcision, Information Release MA05-22 (6/22/2005). Division of Medicaid, Department of Health and Welfare, State of Idaho.

5.7. Hysterectomy

A hysterectomy is a medical procedure for removing the uterus. Hysterectomies are not covered for the sole purpose of rendering the participant unable to reproduce. Therefore, they are not considered for coverage under the sterilization policy. A prior authorization (PA) is required by the QIO for coverage. In addition, one of the following circumstances and supporting documentation must be met for reimbursement:

- The participant was advised both verbally and in writing that the hysterectomy would result in permanent sterility and the inability to bear children. Providers may either create their own form or use the Sterilization Consent Form available on the Gainwell Technologies' website. If a provider elects to create their own form, they must treat it as any other standalone informed consent form. In addition to the language the provider drafts for the form, it must also contain the language verbatim in the handbook example below, the participant's signature, Medicaid ID number or date of birth and the date it is signed. The Medicaid ID number and date of birth does not have to be filled in by the participant and can be printed on the form. The date of signature can be electronically populated if the participant signs electronically. Either form used must be signed by the participant, regardless of the participant's age or reproductive capabilities, and submitted with claims for the procedure. The provider may not use a copy of the handbook page in place of a consent form.
- The participant was sterile before the hysterectomy. The physician must certify this in writing and include the prior cause of sterility. The certification must be attached to claims for the procedure. Medical records are not a substitution for certification.
- The hysterectomy was necessary for a life-threatening emergency in which prior acknowledgement was not possible. The physician must certify this in writing and include a description of the emergency. The certification must be attached to claims for the procedure. Medical records are not a substitution for certification.

Medicaid may cover a hysterectomy for a participant found to be retroactively eligible for Medicaid benefits. Prior authorization requests must be submitted to the QIO retroactively. Instructions for retroactive eligibility in the *General Billing Instructions*, Idaho Medicaid Provider Handbook must be also be followed. In the event of retroactive eligibility, one of the three scenarios above must be met for reimbursement, or additionally, if applicable, the physician may submit a written statement certifying that the participant was informed before the hysterectomy that the procedure would make them permanently incapable of reproducing. The certification must be attached to claims for the procedure. Medical records are not a substitution for certification.

If using the Sterilization Consent Form, the field for "*operation known as"* should be completed with "hysterectomy" and the form should be signed and dated by the participant.

If using a form that meets the required elements below for hysterectomy consent, but not the Sterilization Consent Form, the form may be signed either before or after the surgery has been performed. If the form is signed after the surgery has been performed, the participant must sign a statement clearly stating that they were informed, both verbally and in writing, before the surgery was performed, that the hysterectomy would render them sterile.

Example of Hysterectomy Consent Form Requirements

I have been informed orally and in writing that the hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed.

Patient's Name: _____

Patient's Medicaid ID number or birth date: _____

Date of Surgery: _____

Signature: _____

Date of Signature: _____

5.7.1. References: Hysterectomy

(a) Federal Regulations

Additional Condition for Federal Financial Participation (FPP), 42 C.F.R. Sec. 441.256 (1982). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Applicability, 42 C.F.R. Sec. 441.250 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Definitions, 42 C.F.R. Sec. 441.251 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

State Plan Requirements, 42 C.F.R. Sec. 441.252 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Sterilization by Hysterectomy, 42 C.F.R. Sec. 441.255 (1982). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

(b) Idaho Medicaid Publications

"Hysterectomies and Sterilizations." *MedicAide Newsletter,* May 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

"Hysterectomy Form Requirements." *MedicAide Newsletter,* May 2021, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202021%20MedicAide.pdf.

"Hysterectomy Form Update." *MedicAide Newsletter,* January 2024, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf.

(c) State Regulations

"Circumstances Under Which Payment Can be Made for a Hysterectomy." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 681.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Family Planning Services: Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 682. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 681.02.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

5.8. Oral and Maxillofacial Surgery

An oral surgeon who is also enrolled as a dental provider, when performing medical surgical procedures is required to bill the appropriate CPT® code on the CMS-1500 claim form with their physician provider number and submit to Gainwell Technologies.

Extractions must be billed under the provider's dental provider number to Idaho Smiles. Idaho Smiles may require authorization for some extractions. Please call Idaho Smiles provider services at 1 (855) 233-6262 for more information.

Claims for certain dental implants require the prior authorization documentation from Idaho Smiles be attached to the claim submitted to Gainwell Technologies. These codes are:

Codes Requiring Claim Attachments from Idaho Smiles	
CPT®	Description
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete

5.9.Subcutaneous Cardiac Rhythm Monitor

Use of a subcutaneous cardiac rhythm monitor is only covered when a participant meets all the following criteria:

- Evidence of recurrent transient loss of consciousness (TLOC);
- A comprehensive evaluation with 30 days of noninvasive ambulatory cardiac monitoring that was unable to find a cause for TLOC, but cardiac arrhythmia is suspected; and
- There is likely to be a recurrence of TLOC within the battery life of the device.

Covered Codes for Subcutaneous Cardiac Rhythm Monitor	
Code	Description
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming

5.9.1. References: Subcutaneous Cardiac Rhythm Monitor

(a) Idaho Medicaid Publications

"Criteria for Subcutaneous Cardiac Rhythm Monitor." *MedicAide Newsletter,* April 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf.

5.10. Sterilization Procedures

A sterilization is any procedure performed for the purpose of rendering a participant permanently incapable of reproducing. Sterilization coverage includes tubal ligation (by cautery, occlusion, or ligation), salpingectomy and vasectomy as a benefit under Idaho Medicaid for participants 21 years of age and older, who are mentally competent and not institutionalized. Opportunistic salpingectomies, which are effective for sterilization and can prevent future ovarian cancer, are also covered if provided during a cesarean section or hysterectomy. Institutionalized participants are those that are involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, such as a mental hospital or other facility for the care and treatment of mental illness. Participants voluntarily committed to an inpatient program for mental health services are also considered institutionalized. Hysterectomies are not considered sterilizations under this policy.

Sterilizations do not require prior authorization from the Department or QIO; however, informed participant consent and an interpreter's statement, if applicable, must be obtained with strict adherence to federal regulations including mandatory waiting times. All supporting documentation must use the same name for the participant in all three (3) name fields. Claims will be denied if consent is not documented correctly. Providers may not bill the participant for errors related to completing the form.

Sterilization claims must include the consent form, court order, if applicable, and an interpreter's statement, if applicable, and the ICD-10-CM code Z30.2. Procedures, other than hysterectomies, performed for a purpose other than sterilization, but that result in sterilization, instead require attached chart notes and an operative report to the claim. Should the claim deny for lack of sterilization diagnosis code Z30.2, a claim review request as detailed in the *Claim Review Request* section of General Billing Instructions, Idaho Medicaid Provider Handbook, will be required for successful processing.

5.10.1. References: Sterilization Procedures

(a) Federal Regulations

Additional Condition for Federal Financial Participation (FFP), 42 C.F.R. Sec. 441.256 (1982). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Applicability, 42 C.F.R. Sec. 441.250 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Definitions, 42 C.F.R. Sec. 441.251 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Mentally Incompetent or Institutionalized Individuals, 42 C.F.R. Sec. 441.254 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

State Plan Requirements, 42 C.F.R. Sec. 441.252 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Sterilization of a Mentally Competent Individual Aged 21 or Older, 42 C.F.R. Sec. 441.253 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

(b) Idaho Medicaid Publications

"Hysterectomies and Sterilizations." *MedicAide Newsletter,* May 2023, https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf.

Sterilization Consent Form Requirements, *Information Release MA06-30* (07/14/2006). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Sterilizations Incidental to Medical Procedure." *MedicAide Newsletter,* December 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf.

(c) State Regulations

"Family Planning Services: Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 682. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 682.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization Procedures – General Restrictions." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 681.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

5.10.2. Informed Participant Consent

A sterilization consent form must be signed by the participant, the person obtaining consent and the physician performing the procedure. An interactive Sterilization Consent Form can be downloaded from the Gainwell Technologies Medicaid website. The form, HHS-687, is available in English and Spanish. Three copies are needed – one for the patient, one for the physician, and one is required to be attached to the claim. Providers are required to use these forms or other forms that have been approved by the Secretary of Health and Human Services. Providers are encouraged to use these forms to prevent any possible discrepancies that may affect reimbursement.

Prior to the procedure, the participant must voluntarily sign and date the consent form in the presence of the person obtaining the consent. The participant must be at least 21 years of age, and mentally competent before signing. Mentally competent means the participant has not been declared mentally incompetent by a Federal, State or local court, unless the court has ruled the participant is competent to give consent for sterilization. All communications must be provided in a manner the participant can understand including accommodations for participants, who are blind, deaf, handicapped or speak a language other than English as their primary language. Consent does not qualify as informed if the participant is:

- In active labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other mind-altering substances.

Before the participant signs and dates the consent form, they must be advised that other medical care and federal benefits will not be withheld based on their decision to be or not be sterilized. The person obtaining consent must offer to answer any of the participant's questions about the procedure and provide a copy of the consent form. The person obtaining consent must also communicate and then certify the following occurred:

- The requirements on the consent form were verbally explained to the participant;
- The participant was advised of alternative options for birth control;
- The participant was informed that sterilization procedures are considered to be irreversible;
- A thorough explanation to the participant of the procedure being performed including a full description of the discomforts, risks, benefits and advantages of the procedure;
- Explain that the procedure cannot be performed except after the mandatory waiting time; and
- To the best of the person obtaining consent's knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization.

The person obtaining consent may sign the form any time on or after the date the person giving consent signed the form. If the physician obtains the participant's signature, then the physician must sign both statements on the form, once as the person obtaining the consent and again as the physician performing the surgery.

The physician who performs the surgery does not need to be the physician who obtains the consent from the participant. However, the physician who performs the surgery must also sign the consent form. The performing surgeon's signature must be obtained either within three days prior to surgery or any time after the surgery. The performing physician must perform and certify that shortly before the procedure, the physician:

- Reviewed the consent form with the participant;
- Reiterated the required components performed by the person obtaining consent;
- Received a copy of a court order requiring the sterilization, if applicable, and

- To the best of the physician's knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization.

There must be a lapse of 30 days between the time the participant signs the consent form and the time the sterilization is performed. This allows the participant time to consider the decision to be sterilized. The form expires 180 days after the participant's signature if the procedure is not performed.

Date signed	Participant signs form. This does not count as the first day.
Day 1	Count begins, and 30 days must lapse. This counts as the first day.
Day 31	First day surgery can be performed.
Day 180	Last day surgery can be performed.

The sterilization may be performed 72 hours after the signature if premature delivery occurs or emergency abdominal surgery is required. In the event of a premature delivery, the informed consent must be signed 30 days or more before the expected due date to qualify as a premature delivery. The surgeon must certify the reason for the exception in paragraph two of the physician's statement of the consent form with either:

- The expected delivery date; or
- The emergency nature of the abdominal surgery.

If the participant, person obtaining consent or physician fails to complete the statement correctly, all claims regarding the sterilization, including physician, hospital, and anesthesiologist charges, may be denied. Corrections to the participant signature and signature date are not allowed. Corrections are allowed for other fields of the form.

(a) References: Informed Participant Consent

(i) Federal Regulations

Additional Condition for Federal Financial Participation (FFP), 42 C.F.R. Sec. 441.256 (1982). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Applicability, 42 C.F.R. Sec. 441.250 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Consent Form Requirements, 42 C.F.R. Sec. 441.258 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Definitions, 42 C.F.R. Sec. 441.251 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Informed Consent, 42 C.F.R. Sec. 441.257 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Sterilization of a Mentally Competent Individual Aged 21 or Older, 42 C.F.R. Sec. 441.253 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

(ii) Idaho Medicaid Publications

"Federal Sterilization Consent Form, HHS-687." *MedicAide Newsletter,* January 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/January%202019%20MedicAide.pdf.

"Sterilization Consent Form." *MedicAide Newsletter,* September 2012, https://www.idmedicaid.com/MedicAide%20Newsletters/September%202012%20MedicAide.pdf.

Sterilization Consent Form Requirements, *Information Release MA06-30* (07/14/2006). Division of Medicaid, Department of Health and Welfare, State of Idaho.

(iii) State Regulations

"Exceptions to Sterilization Time Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 682.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 682.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization Consent Form Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 683.01 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization Procedures – General Restrictions." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 681.01 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

5.10.3. Interpreter's Statement

An interpreter must be provided to ensure that information is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped. An interpreter must also be provided if the participant does not understand either the language used on the consent form or spoken by the person obtaining the consent. Providers may bill Medicaid for reimbursement for oral or sign language interpreter services that they provide for participants. Interpreters may not bill Medicaid directly for their services.

The interpreter must certify, sign and date the consent form signed by the participant that they:

- Translated the information and advice presented orally;
- Read the consent form to the participant, and explained its contents to the participant being sterilized; and
- To the best of the interpreter's knowledge and belief, the participant understood the interpreter.

See the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for additional information about billing interpretive services.

(a) References: Interpreter's Statement

(i) Federal Regulations

Consent Form Requirements, 42 C.F.R. Sec. 441.258 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

Informed Consent, 42 C.F.R. Sec. 441.257 (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf.

(ii) State Regulations

"Sterilization." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 682.02.d. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization Consent Form Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 683.01.a.ii. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization Consent Form Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 683.01.c. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Sterilization Consent Form Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 683.01.g. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

*5.11.*Surgical Procedures for Weight Loss

Medicaid will cover bariatric surgeries, abdominoplasty, or panniculectomy when all conditions listed below are met.

- The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than 40, or greater than 35 with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented either by the primary physician who refers the patient for the procedure, or by a physician specializing in the participant's comorbid condition. The physician who refers the participant must not be associated by a clinic or other affiliation with the surgeons who will perform the surgery.
- The obesity is caused by a serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory, or other systemic disease.
- The participant must have a psychiatric evaluation to determine the stability of personality at least 90 days prior to the date a request for PA is submitted to Medicaid.
- The procedure is prior authorized by the QIO. If approval is granted, the QIO will issue the authorization number and conduct any necessary length-of-stay reviews.
- The procedure(s) must be performed in an Idaho Medicaid-enrolled hospital that is also Medicare certified.
- Physicians and Hospitals practices must meet national medical standards for weight loss surgery.

5.11.1. Abdominoplasty or Panniculectomy

Abdominoplasty or panniculectomy is covered only with medical necessity, and a PA from the QIO. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for PA includes, but is not limited to:

- Photographs of the front, side, and underside of the participant's abdomen.
- Documented treatment of the ulceration and skin infections involving the panniculus.
- Documented failure of conservative treatment, including weight loss.
- Documentation that the panniculus severely inhibits the participant's walking.
- Documentation that the participant is unable to wear a garment to hold the panniculus up.
- Documentation of other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body.

5.11.2. References: Surgical Procedures for Weight Loss

(a) State Regulations

"Surgical Procedures for Weight Loss." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 431 – 434. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

5.12. Transplants

See the *Hospital*, Idaho Medicaid Provider Handbook for information and coverage of organ transplants.

6. Inpatient Stay Reviews

Idaho Medicaid contracts with a Quality Improvement Organization (QIO) to conduct review on a preadmission basis for selected diagnoses and procedures and a concurrent length of stay review on all hospital stays that exceed a specified number of days.

All inpatient admissions must be reviewed by the QIO if the stay exceeds three days, except for a qualifying cesarean delivery (admitting or principal diagnosis) which needs review if the stay exceeds four days. If the patient is not discharged by the end of the third day (count the day of the admission as day one), a review must be obtained on day four, and thereafter at intervals determined by the QIO. If the review due date falls on a weekend or a holiday, the review is due by the next business day.

The QIO performs retrospective reviews for services that were not reviewed in a timely manner (penalties may apply). Retrospective reviews may also be requested from the QIO for services requiring prior authorization (PA) and for admissions longer than three days when the patient receives retroactive eligibility.

The participant's physician or the treating facility may initiate the request for PA. Both providers are equally responsible for obtaining authorization. See procedures and instructions detailed in the QIO Provider Manual or contact the QIO.

6.1. Penalties

Medicaid assesses a penalty to physicians and hospitals for failure to obtain a timely QIO review instead of withholding total payment. Information on the penalty amounts are detailed in the *Medicaid Basic Plan Benefits, IDAPA 16.03.09.505 Physician Services - Provider Reimbursement and IDAPA 16.03.09.705.03 Inpatient Psychiatric Hospital Services - Provider Reimbursement; Physician Penalty Schedule*, available online or by calling the Division of Financial Management, Office of Administrative Rules Coordinator at 1 (208) 334-3900.

7. Prior Authorizations

See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on billing prior authorized services.

8. Documentation

All providers are required to maintain documentation. General requirements for documentation can be found in General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, including standard retention requirements. Records limited to checklists with attendance/appointments, procedure codes, and units of time are insufficient to meet this requirement. Documentation must be signed and dated by the person delivering the service with their name clearly printed.

Documentation must be made available to Department personnel acting in their official capacity immediately upon request. Services without documentation are not eligible for reimbursement. Providers should only submit records requested by the Department. Documentation sent unsolicited, or not for a service requiring prior authorization, will not be reviewed by the Department. Unreviewed documentation does not constitute approval or authorization of a service.

8.1. References: Documentation

8.1.1. State Regulations

"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.

"Review of Records." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 230.05. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

9. Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Idaho Medicaid reimburses physician and non-physician practitioner services on a fee-for-service basis except for services provided in Rural Health Clinics (RHC), Federally Qualified Health Clinic (FQHC), or Indian Health Services (IHS). Usual and customary fees are paid up to the Medicaid maximum allowance listed in the Numerical Fee Schedule. The Medicaid maximum allowance is set at 100% of the Medicare fee schedule for primary care procedures, and 90% of the Medicare fee schedule for all others, when the code becomes covered by Idaho Medicaid, if available. Most non-physician practitioner services are reimbursed up to 85 percent of the allowed maximum.

See the IHS, FQHC and RHC Services, Idaho Medicaid Provider Handbook for information on encounter fees for services provided in an RHC, FQHC or IHS.

See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

Some services may be subject to a co-pay. See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-pays.

9.1. References: Reimbursement

9.1.1. Idaho Medicaid Publications

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

House Bill 260 Budget Reductions – Provider Payments, Information Release MA11-19 (05/26/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho.

9.2. Site of Service Differential

Idaho Medicaid reduces physician and non-physician practitioner reimbursement when certain procedures are provided in a facility setting. For these procedure codes there is a 30 percent reduction for physicians, and a 40 percent reduction for non-physician practitioners, of the Idaho Medicaid Numerical Fee Schedule in the following places of service (POS):

- 02 Telehealth (Not recognized by Idaho Medicaid);
- 19 Outpatient Hospital-Off Campus;
- 21 Inpatient Hospital;
- 22 Outpatient Hospital;
- 23 Emergency Room – Hospital;
- 24 Ambulatory Surgical Center;
- 26 Military Treatment Facility;
- 31 Skilled Nursing Facility;
- 34 Hospice – Inpatient Care;
- 41 Ambulance – Land;
- 42 Ambulance – Air or Water;
- 51 Inpatient Psychiatric Facility;
- 52 Psychiatric Facility - Partial Hospitalization;
- 53 Community Mental Health Center;
- 56 Psychiatric Residential Treatment Center;
- 61 Comprehensive Inpatient Rehabilitation Facility; and
- 62 Comprehensive Outpatient Rehabilitation Facility.

If the space and supplies are provided by the hospital, and are included in the hospital's cost settlement, the physician or non-physician practitioner can bill under his own provider number on the 1500 form, and there is a site of service deduction. The facility fees are billed by the hospital on their UB-04 form under the hospital provider number.

There is no site of service reduction if office space is rented from the hospital and the physician or non-physician practitioner provides his own supplies. The hospital cannot use the same space, etc. to bill for services under their hospital provider number.

Refer to CMS and their Idaho regional Medicare contractor, Noridian, for a list of codes the differential affects.

9.2.1. References: Site of Service Differential

(a) Idaho Medicaid Publications

"Places of Service with Site of Service Reductions." *MedicAide Newsletter,* August 2019, https://www.idmedicaid.com/MedicAide%20Newsletters/August%202019%20MedicAide.pdf.

"Site of Service Differential." *MedicAide Newsletter,* September 2003.

"Site of Service Differential Applied to Mid-Level Providers' Claims." *MedicAide Newsletter,* February 2015, https://www.idmedicaid.com/MedicAide%20Newsletters/February%202015%20MedicAide.pdf .

"Site of Service Differential Will be Applied to Mid-Level Providers' Claims." *MedicAide Newsletter,* September 2014,

https://www.idmedicaid.com/MedicAide%20Newsletters/September%202014%20MedicAide.pdf.

"Site of Service Reduction List." *MedicAide Newsletter,* April 2018, https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf.

9.3. Physician Employees

Services provided by employees of a physician may not be billed directly to Idaho Medicaid. However, psychological testing services provided by a licensed psychologist or social worker who are employees of the physician, may be billed under the physician's provider number. This exception applies to testing only.

Occupational, Physical or Speech therapy services that are provided by a physician may be billed with that physician's provider number. If services are provided by a licensed therapist employed by the physician, the therapist must apply for a separate Medicaid provider number and the services billed with that number.

9.4. Misrepresentation of Services

Any representation that a service provided by a nurse practitioner, nurse midwife, licensed midwife, physical therapist, physician assistant, psychologist, social worker, or other non-physician professional was rendered as a physician service is prohibited. For the purposes of misrepresentation of services, the Department considers a non-physician professional to be any professional with a provider type or specialty enrolled by Idaho Medicaid. All providers, of a provider type and specialty eligible for enrollment, must submit claims using their own National Provider Identification (NPI) number. Idaho rule and policy requires payment be made only for claims submitted by the enrolled provider who is physically present (not simply on-site) and performing the service.

Examples of misrepresentation of services prohibited by Idaho Medicaid includes, but is not limited to:

- 'Incident to' billing of services performed by a non-physician provider of a type or specialty enrolled by Idaho Medicaid under a physician's NPI;
- Global billing when services are rendered by two different provider types in the same group practice;
- By any provider who is not an enrolled with Idaho Medicaid, under the NPI of any enrolled provider;
- Students or unlicensed aides of an Idaho Medicaid provider;
- Unenrolled subcontractors to an Idaho Medicaid provider; and
- For supervision of services rendered by any other provider of medical services or supplies, whether or not enrolled with Idaho Medicaid.

9.4.1. References: Misrepresentation of Services

(a) State Regulations

"Physician Services: Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 504. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

9.5. Out-of-Idaho Care

Out-of-state providers in the United States of America, who are enrolled in the Idaho Medicaid Program and have an active Idaho Medicaid provider number may render services to Idaho Medicaid participants without receiving out-of-state prior approval. All medical care provided outside the state of Idaho is subject to the same utilization review, coverage requirements, and restrictions as medical care provided within Idaho.

Idaho Medicaid does not cover services outside of the United States of America.

9.6. Locum Tenens and Reciprocal Billing Arrangements

Idaho Medicaid allows for physicians to bill for locum tenens and reciprocal billing arrangements. Arrangements may be made with one or more substitute physicians, and do not have to be in writing. The absent physician continues to bill and receive payment for the substitute physician's services as though they were performed by the absent physician.

Locum tenens and reciprocal billing arrangements are allowed when:

- The regular physician is unavailable to provide the services.
- The Medicaid participant has arranged or seeks to receive services from their regular physician.
- The regular physician identifies the services provided by a substitute physician by appending the appropriate modifier to the procedure code on claims.
- The regular physician maintains a record of each service provided by the substitute physician and their National Provider Identifier (NPI). Records must be available to DHW upon request.
- Services are not reported separately as substitute services for an operation and/or post-operative care covered by a global fee.

Locum tenens arrangements occur when the substitute physician covers the regular physician during absences for illness, pregnancy, vacation, or continuing education. The regular physician pays the substitute physician for their services on a per diem, or similar fee-for-time basis. Locum tenens arrangements cannot exceed a period of 90 continuous days. The regular physician must use the Q6 modifier on claims for services provided by the substitute physician in a locum tenens arrangement.

Reciprocal billing arrangements occur when the substitute physician covers the regular physician during occasional absences such as on-call coverage. The absent physician agrees to cover the substitute physician at a later time in exchange for their services. Arrangements are not to exceed a period of 14 continuous days. The regular physician must use the Q5 modifier on claims for services provided by the substitute physician in a reciprocal billing arrangement.

9.6.1. References: Locum Tenens and Reciprocal Billing Arrangements

(a) Idaho Medicaid Publications

All Hospitals and Physicians, *Information Release MA01-19* (2001). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Locum Tenens and Reciprocal Billing Arrangements." *MedicAide Newsletter,* December 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf.

Appendix A. ICD-10 Diagnosis Codes Accepted by Idaho Medicaid Supporting Medical Necessity for Cesarean Section

The following ICD-10-CM diagnosis codes have been identified as preapproved covered conditions for cesarean sections. Codes not listed require a prior authorization from Telligen.

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
A60.03	Herpesviral cervicitis
A60.04	Herpesviral vulvovaginitis
A60.9	Anogenital herpesviral infection, unspecified
O10.02	Pre-existing essential hypertension complicating childbirth
O10.12	Pre-existing hypertensive heart disease complicating childbirth
O10.22	Pre-existing hypertensive chronic kidney disease complicating childbirth
O10.32	Pre-existing hypertensive heart and chronic kidney disease complicating childbirth
O10.42	Pre-existing secondary hypertension complicating childbirth
O11.4	Pre-existing hypertension with pre-eclampsia, complicating childbirth
O12.04	Gestational edema, complicating childbirth
O12.24	Gestational edema with proteinuria, complicating childbirth
O13.4	Gestational (pregnancy-induced) hypertension without significant proteinuria, complicating childbirth
O14.04	Mild to moderate pre-eclampsia, complicating childbirth
O14.13	Severe pre-eclampsia, third trimester
O14.14	Severe pre-eclampsia complicating childbirth
O14.24	HELLP syndrome, complicating childbirth
O15.03	Eclampsia in pregnancy, third trimester
O15.1	Eclampsia in labor
O26.72	Subluxation of symphysis (pubis) in childbirth
O28.0	Abnormal hematological finding on antenatal screening of mother
O30.002 – O30.003	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester
O30.012 – O30.013	Twin pregnancy, monochorionic/monoamniotic, second or third trimester
O30.022 – O30.023	Conjoined twin pregnancy, second or third trimester
O30.032 – O30.033	Twin pregnancy, monochorionic/diamniotic, second or third trimester
O30.042 – O30.043	Twin pregnancy, dichorionic/diamniotic, second or third trimester

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O30.092 – O30.093	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester
O30.102 – O30.103	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester
O30.112 – O30.113	Triplet pregnancy with two or more monochorionic fetuses, second or third trimester
O30.122 – O30.123	Triplet pregnancy with two or more monoamniotic fetuses, second or third trimester
O30.132 – O30.133	Triplet pregnancy, trichorionic/triamniotic, second or third trimester
O30.192 – O30.193	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester
O30.202 – O30.203	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester
O30.212 – O30.213	Quadruplet pregnancy with two or more monochorionic fetuses, second or third trimester
O30.222 – O30.223	Quadruplet pregnancy with two or more monoamniotic fetuses, second or third trimester
O30.232 – O30.233	Quadruplet pregnancy, quadrachorionic/quadra-amniotic, second or third trimester
O30.292 – O30.293	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester
O30.802 – O30.803	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester
O30.812 – O30.813	Other specified multiple gestation with two or more monochorionic fetuses, second or third trimester
O30.822 – O30.823	Other specified multiple gestation with two or more monoamniotic fetuses, second or third trimester
O30.832 – O30.833	Other specified multiple gestation, number of chorions and amnions are both equal to the number of fetuses, second or third trimester
O30.892 – O30.893	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, second or third trimester
O32.0XX0 – O32.0XX9	Maternal care for unstable lie
O32.1XX0 – O32.1XX9	Maternal care for breech presentation
O32.2XX0 – O32.2XX9	Maternal care for transverse and oblique lie
O32.3XX0 – O32.3XX9	Maternal care for face, brow and chin presentation
O32.4XX0 – O32.4XX9	Maternal care for high head at term

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O32.6XX0 – O32.6XX9	Maternal care for compound presentation
O32.8XX0 – O32.8XX9	Maternal care for other malpresentation of fetus
O33.0	Maternal care for disproportion due to deformity of maternal pelvic bones
O33.1	Maternal care for disproportion due to generally contracted pelvis
O33.2	Maternal care for disproportion due to inlet contraction of pelvis
O33.3XX0 – O33.3XX9	Maternal care for disproportion due to outlet contraction of pelvis
O33.4XX0 – O33.4XX9	Maternal care for disproportion of mixed maternal and fetal origin
O33.5XX0 – O33.5XX9	Maternal care for disproportion due to unusually large fetus
O33.6XX0 – O33.6XX9	Maternal care for disproportion due to hydrocephalic fetus
O33.7XX0 – O33.7XX9	Maternal care for disproportion due to other fetal deformities
O33.8	Maternal care for disproportion of other origin
O34.12 – O34.13	Maternal care for benign tumor of corpus uteri, second or third trimester
O34.211	Maternal care for low transverse scar from previous cesarean delivery
O34.212	Maternal care for vertical scar from previous cesarean delivery
O34.29	Maternal care due to uterine scar from other previous surgery
O34.32 – O34.33	Maternal care for cervical incompetence, second or third trimester
O34.42 – O34.43	Maternal care for other abnormalities of cervix, second or third trimester
O34.512 – O34.513	Maternal care for incarceration of gravid uterus, second or third trimester
O34.522 – O34.523	Maternal care for prolapse of gravid uterus, second or third trimester
O34.532 – O34.533	Maternal care for retroversion of gravid uterus, second or third trimester
O34.592 – O34.593	Maternal care for other abnormalities of gravid uterus, second or third trimester
O34.62 – O34.63	Maternal care for abnormality of vagina, second or third trimester
O34.72 – O34.73	Maternal care for abnormality of vulva and perineum, second or third trimester
O34.82 – O34.83	Maternal care for other abnormalities of pelvic organs, second or third trimester
O40.2XX0 – O40.3XX9	Polyhydramnios

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O41.02X0 – O41.03X9	Oligohydramnios
O41.1220 – O41.1239	Chorioamnionitis
O41.1420 – O41.1439	Placentitis
O41.8X20 – O41.8X39	Other specified disorders of amniotic fluid and membranes
O42.012 – O42.013	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, second or third trimester
O42.112 – O42.113	Premature rupture of membranes, onset of labor more than 24 hours following rupture, second or third trimester
O43.012 – O43.013	Fetomaternal placental transfusion syndrome, second or third trimester
O43.022 – O43.023	Fetus-to-fetus placental transfusion syndrome, second or third trimester
O43.112 – O43.113	Circumvallate placenta, second or third trimester
O43.122 – O43.123	Velamentous insertion of umbilical cord, second or third trimester
O43.192 – O43.193	Other malformation of placenta, second or third trimester
O43.212 – O43.213	Placenta accreta, second or third trimester
O43.222 – O43.223	Placenta increta, second or third trimester
O43.232 – O43.233	Placenta percreta, second or third trimester
O43.812 – O43.813	Placental infarction, second or third trimester
O43.892 – O43.893	Other placental disorders, second or third trimester
O44.02 – O44.03	Placenta previa specified as without hemorrhage, second or third trimester
O44.12 – O44.13	Placenta previa with hemorrhage, second or third trimester
O44.22 – O44.23	Partial placenta previa NOS or without hemorrhage, second or third trimester
O44.32 – O44.33	Partial placenta previa with hemorrhage, second or third trimester
O44.42 – O44.43	Low lying placenta NOS or without hemorrhage, second or third trimester
O44.52 – O44.53	Low lying placenta with hemorrhage, second or third trimester
O45.012 – O45.013	Premature separation of placenta with afibrinogenemia, second or third trimester

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O45.022 – O45.023	Premature separation of placenta with disseminated intravascular coagulation, second or third trimester
O45.092 – O45.093	Premature separation of placenta with other coagulation defect, second or third trimester
O45.8X2 – O45.8X3	Other premature separation of placenta, second or third trimester
O46.012 – O46.013	Antepartum hemorrhage with afibrinogenemia, second or third trimester
O46.022 – O46.023	Antepartum hemorrhage with disseminated intravascular coagulation, second or third trimester
O46.092 – O46.093	Antepartum hemorrhage with other coagulation defect, second or third trimester
O46.8X2 – O46.8X3	Other antepartum hemorrhage, second or third trimester
O61.0 – O61.8	Failed induction of labor
O62.0 – O62.2	Abnormalities of forces of labor
O62.4 – O62.8	Abnormalities of forces of labor
O64.0XX0 – O64.0XX9	Obstructed labor due to incomplete rotation of fetal head
O64.1XX0 – O64.1XX9	Obstructed labor due to breech presentation
O64.2XX0 – O64.2XX9	Obstructed labor due to face presentation
O64.3XX0 – O64.3XX9	Obstructed labor due to brow presentation
O64.4XX0 – O64.4XX9	Obstructed labor due to shoulder presentation
O64.5XX0 – O64.5XX9	Obstructed labor due to compound presentation
O64.8XX0 – O64.8XX9	Obstructed labor due to other malposition and malpresentation
O65.0 – O65.8	Obstructed labor due to maternal pelvic abnormality
O66.0 – O66.3	Other obstructed labor
O66.41 – O66.8	Other obstructed labor
O67.0 – O67.8	Labor and delivery complicated by intrapartum hemorrhage
O68	Labor and delivery complicated by abnormality of fetal acid-base balance
O69.0XX0 -- O69.89X9	Labor and delivery complicated by umbilical cord complications

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O71.02 – O71.1	Rupture of uterus before or during labor
O75.1	Shock during or following labor and delivery
O75.3	Other infection during labor including sepsis
O75.81	Maternal exhaustion complicating labor and delivery
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O77.0 – O77.8	Other fetal stress complicating labor and delivery
O88.02	Air embolism in childbirth
O88.12	Amniotic fluid embolism in childbirth
O88.22	Thromboembolism in childbirth
O88.32	Pyemic and septic embolism in childbirth
O88.82	Other embolism in childbirth
O98.72	Human immunodeficiency virus [HIV] disease complicating childbirth
O99.354	Diseases of the nervous system complicating childbirth
O99.42	Diseases of the circulatory system complicating childbirth
O99.52	Diseases of the respiratory system complicating childbirth
O99.824	Streptococcus B carrier state complicating childbirth
O9A.12	Malignant neoplasm complicating childbirth
Q42.3	Congenital absence, atresia and stenosis of anus without fistula

Appendix B. Anesthesia Base Units

Code	Base Units	Code	Base Units	Code	Base Units	Code	Base Units	Code	Base Units
00100	75	00400	45	00625	195	00846	120	00948	60
00102	90	00402	75	00626	225	00848	120	00950	75
00103	75	00404	75	00630	120	00851	90	00952	60
00104	60	00406	195	00632	105	00860	90	01112	75
00120	75	00410	60	00635	60	00862	105	01120	90
00124	60	00450	75	00640	45	00864	120	01130	45
00126	60	00454	45	00670	195	00865	105	01140	225
00140	75	00470	90	00700	60	00866	150	01150	150
00142	60	00472	150	00702	60	00868	150	01160	60
00144	90	00474	195	00730	75	00870	75	01170	120
00145	90	00500	225	00731	75	00872	105	01173	180
00147	60	00520	90	00732	90	00873	75	01180	45
00148	60	00522	60	00740	75	00880	225	01190	60
00160	75	00524	60	00750	60	00882	150	01200	60
00162	105	00528	120	00752	90	00902	75	01202	60
00164	60	00529	165	00754	105	00904	105	01210	90
00170	75	00530	60	00756	105	00906	60	01212	150
00172	90	00532	60	00770	225	00908	90	01214	120
00174	90	00534	105	00790	105	00910	45	01215	150
00176	105	00537	105	00792	195	00912	75	01220	60
00190	75	00539	270	00794	120	00914	75	01230	90
00192	105	00540	180	00796	450	00916	75	01232	75
00210	165	00541	225	00797	165	00918	75	01234	120
00211	150	00542	225	00800	60	00920	45	01250	60
00212	75	00546	225	00802	75	00921	45	01260	45
00214	135	00548	255	00810	75	00922	90	01270	120
00215	135	00550	150	00811	60	00924	60	01272	60
00216	225	00560	225	00812	45	00926	60	01274	90
00218	195	00561	375	00813	75	00928	90	01320	60
00220	150	00562	300	00820	75	00930	60	01340	60
00222	90	00563	375	00830	60	00932	60	01360	75
00300	75	00566	375	00832	90	00934	90	01380	45
00320	90	00567	270	00834	75	00936	120	01382	45
00322	45	00580	300	00836	90	00938	60	01390	45
00326	105	00600	150	00840	90	00940	45	01392	60
00350	150	00604	195	00842	60	00942	60	01400	60
00352	75	00620	150	00844	105	00944	90	01402	105

Code	Base Units		Code	Base Units		Code	Base Units		Code	Base Units		Code	Base Units
01404	75		01610	75		01742	75		01920	105		01960	75
01420	45		01620	60		01744	75		01922	105		01961	105
01430	45		01622	60		01756	90		01924	75		01962	120
01432	90		01630	75		01758	75		01925	105		01963	120
01440	120		01634	135		01760	105		01926	120		01965	60
01442	120		01636	225		01770	90		01930	75		01966	60
01444	120		01638	150		01772	90		01931	105		01967	75
01462	45		01650	90		01780	45		01932	90		01968	30
01464	45		01652	150		01782	60		01933	105		01969	75
01470	45		01654	120		01810	45		01935	75		01990	105
01472	75		01656	150		01820	45		01936	75		01991	45
01474	75		01670	60		01829	45		01937	60		01992	75
01480	45		01680	45		01830	45		01938	60		01996	45
01482	60		01682	60		01832	90		01939	60		01999	0
01484	60		01710	45		01840	90		01940	60			
01486	105		01712	75		01842	90		01941	75			
01490	45		01714	75		01844	90		01942	75			
01500	120		01716	75		01850	45		01951	45			
01502	90		01730	45		01852	60		01952	75			
01520	45		01732	45		01860	45		01953	15			
01522	75		01740	60		01916	75		01958	75			

Appendix C. Physician and Non-Physician Practitioner, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date.

Physician and Non-Physician Practitioner, Provider Handbook Modifications				
Version	Section/ Column	Modification Description	Date	SME
58.0	All	Published version	05/01/2024	TQD
57.6	5.7. Hysterectomy	Incorporated form requirements.	05/01/2024	W Deseron S Fox
57.5	5.5.3. Obstetrical Anesthesia	Removed requirement to bill all anesthesia on the date of delivery.	05/01/2024	W Deseron S Fox
57.4	4.43. Wellness Examinations	Added information about depression screenings.	05/01/2024	W Deseron S Fox
57.3	4.30.7. Lactation Counseling	Added lactation classes and additional codes.	05/01/2024	W Deseron S Fox
57.2	4.26. Mammography Services	Added language for procedure in other states.	05/01/2024	W Deseron S Fox
57.1	2.6. Pharmacists	Updated codes.	05/01/2024	W Deseron S Fox
57.0	All	Published version	02/02/2024	TQD
56.23	Appendix B. Anesthesia Base Units	Added codes and units.	02/02/2024	W Deseron E Garibovic
56.22	Appendix B. Periodicity Schedule	Deleted section.	02/02/2024	W Deseron E Garibovic
56.21	8. Documentation Requirements	Renamed section Documentation. Clarified policy.	02/02/2024	W Deseron E Garibovic
56.20	5.10.2. Informed Participant Consent	Updated preferred form to most recent version. Removed requirement for details of premature delivery.	02/02/2024	W Deseron E Garibovic
56.19	5.7. Hysterectomy	Clarified date of signature can be electronically populated.	02/02/2024	W Deseron E Garibovic
56.18	5.5.6. Office-Based Pediatric Dental Anesthesia	Section deleted. MCNA handles service now.	02/02/2024	W Deseron E Garibovic
56.17	4.43.3. Child Wellness Exams	Updated policy.	02/02/2024	W Deseron E Garibovic
56.16	4.43.2. Adult Wellness Exams	Updated limitation and added co-pay exclusions.	02/02/2024	W Deseron E Garibovic
56.15	4.43. Wellness Examinations	Updated policy.	02/02/2024	W Deseron E Garibovic
56.14	4.41. Virtual Care Services	New section.	02/02/2024	W Deseron E Garibovic
56.13	4.38 Telehealth	Section deleted. Replaced with Virtual Care Services section.	02/02/2024	W Deseron E Garibovic
56.12	4.34.3. Psychiatric Crisis via Telehealth	Renamed section Psychiatric Crisis via Virtual Care. Updated terminology.	02/02/2024	W Deseron E Garibovic
56.11	4.27. National Diabetes Prevention Program	Changed verbiage for virtual care services.	02/02/2024	W Deseron E Garibovic
56.10	4.26. Mammography Services	Corrected biannual to biennial.	02/02/2024	W Deseron E Garibovic
56.9	4.25. Lung Cancer Screening	Updated preapproved diagnoses.	02/02/2024	W Deseron E Garibovic
56.8	4.21.2. Stand-Alone Vaccine Counseling	New section.	02/02/2024	W Deseron E Garibovic
56.7	4.21. Immunization and Vaccines	Clarified policy.	02/02/2024	W Deseron

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				E Garibovic
56.6	4.14. Evaluation and Management	Added pharmacists to eligible providers.	02/02/2024	W Deseron E Garibovic
56.5	2.6. Pharmacists	Clarified billing for services and services that can be provided.	02/02/2024	W Deseron E Garibovic
56.4	2.1.2. Residents	New section.	02/02/2024	W Deseron E Garibovic
56.3	2.1.1. International Medical Graduate	New section.	02/02/2024	W Deseron E Garibovic
56.2	2.1.2. Bridge Year Physician	New section.	02/02/2024	W Deseron E Garibovic
56.1	2.1. Physicians	Relocated residents, bridge physicians and international medical graduates to their own sections.	02/02/2024	W Deseron E Garibovic
56.0	All	Published version	08/16/2023	TQD
55.33	7.8. Transferring a Prior Authorization	New section.	08/08/2023	W Deseron A Welch
55.32	7.7.1. References: Prior Authorization Appeals	New section.	08/08/2023	W Deseron A Welch
55.31	7.7. Prior Authorization Appeals	New section.	08/08/2023	W Deseron A Welch
55.30	7.6. Prior Authorization Reconsiderations	New section.	08/08/2023	W Deseron A Welch
55.29	7.5. Status of a Prior Authorization	New section.	08/08/2023	W Deseron A Welch
55.28	7.4. Modifying a Prior Authorization	New section.	08/08/2023	W Deseron A Welch
55.27	7.3.1. References: Telligen, Inc.	New section.	08/08/2023	W Deseron A Welch
55.26	7.3. Telligen, Inc.	Update process.	08/08/2023	W Deseron A Welch
55.25	7.2. The Medical Care Unit	Update process.	08/08/2023	W Deseron A Welch
55.24	7. Prior Authorizations	Update process.	08/08/2023	W Deseron A Welch
55.23	5.10.2. Informed Participant Consent	Clarify when corrections can be made on form.	08/08/2023	W Deseron A Welch
55.22	5.5.4.(C)(v) State Regulations	Update references.	08/08/2023	W Deseron A Welch
55.21	4.30.12. Surrogates	New section.	08/08/2023	W Deseron A Welch
55.20	4.29.4.30. Obstetric Care	Added reference to Surrogates section.	08/08/2023	W Deseron A Welch
55.19	4.27.4.(a) References: Reimbursement - NDPP	New section.	08/08/2023	W Deseron A Welch
55.18	4.27.4. Reimbursement: NDPP	New section.	08/08/2023	W Deseron A Welch
55.17	4.27.3.(a) References: Eligible Participants - NDPP	New section.	08/08/2023	W Deseron A Welch
55.16	4.27.3. Participant Eligibility: NDPP	New section.	08/08/2023	W Deseron A Welch
55.15	4.27.2.(a) References: Provider Qualifications – NDPP	New section.	08/08/2023	W Deseron A Welch
55.14	4.27.1. References: National Diabetes Prevention	New section.	08/08/2023	W Deseron A Welch

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	Program4.27.2. Provider Qualifications: NDPP			
55.13	4.27. National Diabetes Prevention Program	New section.	08/08/2023	W Deseron A Welch
55.12	4.26. Mammography Services	Update coverage to bi-annual screening.	08/08/2023	W Deseron A Welch
55.11	4.11.4.(a) References: Reimbursement – Diabetes Education and Training	New section.	08/08/2023	W Deseron A Welch
55.10	4.11.3.(a)(i) State Regulations	Update references.	08/08/2023	W Deseron A Welch
55.9	4.11.2.(a)(ii) State Regulations	Update references.	08/08/2023	W Deseron A Welch
55.8	4.11.2. Provider Qualifications: Diabetes Education and Training	Add ADCES programs.	08/08/2023	W Deseron A Welch
55.7	4.11.1. (b) State Regulations	Update references.	08/08/2023	W Deseron A Welch
55.6	4.11. Diabetes Education and Training	Updated language to correct grammar.	08/08/2023	W Deseron A Welch
55.5	4.1.3. Spontaneous Abortion	Clarify that dilation and curettage is included.	08/08/2023	W Deseron A Welch
55.4	4.1.1. Induced Abortion	Included allowance for reporting to child protective services.	08/08/2023	W Deseron A Welch
55.3	2.1.1.(a) Idaho Medicaid Publications	Update references.	08/08/2023	W Deseron A Welch
55.2	2.1. Physicians	Updated to include additional physician types.	08/08/2023	W Deseron A Welch
55.1	1.4. Telligen, Inc.	Removed fax number.	08/08/2023	W Deseron A Welch
55.0	All	Published version	06/02/2023	TQD
54.13	5.10.1. References: Sterilization Procedures	Updated.	05/26/2023	W Deseron K Duke
54.12	5.10. Sterilization Procedures	Clarify coverage and documentation.	05/26/2023	W Deseron K Duke
54.11	5.7.1. References: Hysterectomy	Updated.	05/26/2023	W Deseron K Duke
54.10	5.7. Hysterectomy	Clarification of form requirements.	05/26/2023	W Deseron K Duke
54.9	4.42.3. Child Wellness Exams	Removed codes for cesarean section.	05/26/2023	W Deseron K Duke
54.8	4.35.1. EpiCord® and EpiFix®	Clarify Telligen is reviewer for prior auths.	05/26/2023	W Deseron K Duke
54.7	(a) References: Multiple Deliveries	New section.	05/26/2023	W Deseron K Duke
54.6	4.29.8. Multiple Deliveries	Clarification of billing multiple deliveries.	05/26/2023	W Deseron K Duke
54.5	4.29.7. Lactation Counseling	Clarification of billing.	05/26/2023	W Deseron K Duke
54.4	4.26.1. References: Mammography Services	New section.	05/26/2023	W Deseron K Duke
54.3	4.26. Mammography Services	New section. Incorporate policy.	05/26/2023	W Deseron K Duke
54.2	4.21.1. References: Immunization and Vaccines	Updated.	05/26/2023	W Deseron K Duke
54.1	4.21. Immunization and Vaccines	Clarifications on $0 vaccines, co-pays and COVID-19 vaccinations.	05/26/2023	W Deseron K Duke
54.0	All	Published version	05/05/2022	TQD

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53.1	2.6 Pharmacists	Clarified that pharmacists cannot be rendering providers	05/05/2022	M Payne K Duke
53.0	All	Published version	01/26/2022	TQD
52.1	4.28.3 Cesarean Section	Updated the claim review to Medical Review (DHW Review)	01/25/2022	M Payne K Irby C Beal E Garibovic
52.0	All	Published version	08/30/2021	TQD
51.1	4.25 Lung Cancer Screening	Removed ICD-9 diagnosis code, per CR69912.	08/30/2021	M Payne Configuration Team E Garibovic
51.0	All	Published version	06/04/2021	TQD
50.27	8.1. References: Documentation Requirements	Updated.	06/01/2021	W Deseron E Garibovic
50.26	5.7.1. References: Hysterectomy	Updated.	06/01/2021	W Deseron E Garibovic
50.25	5.7. Hysterectomy	Clarified that example in book cannot be used as a consent form.	06/01/2021	W Deseron E Garibovic
50.24	4.41.3. Child Wellness Exams	Clarified time period for wellness visits.	06/01/2021	W Deseron E Garibovic
50.23	4.41. Wellness Examinations	Clarified time period for wellness visits in adults. Updated coding.	06/01/2021	W Deseron E Garibovic
50.22	4.40.1. References: Vitamin Injections	New section.	06/01/2021	W Deseron E Garibovic
50.21	4.40. Vitamin Injections	New section.	06/01/2021	W Deseron E Garibovic
50.20	4.37. Therapy Services	New section.	06/01/2021	W Deseron E Garibovic
50.19	4.31. Prolonged Services	Updated code list.	06/01/2021	W Deseron E Garibovic
50.18	4.26.1. References: Naturopathic Services	New section.	06/01/2021	W Deseron E Garibovic
50.17	4.26. Naturopathic Services	New section.	06/01/2021	W Deseron E Garibovic
50.16	4.25.1. References: Lung Cancer Screening	Updated.	06/01/2021	W Deseron E Garibovic
50.15	4.23.5(a) References: Newborn Screening	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.14	4.23.5 Newborn Screening	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.13	4.23.4(a) References: Blood Lead Screening	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.12	4.23.4 Blood Lead Screening	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.11	4.23.3 Pathology Laboratory Procedures	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.10	4.23.2 Specimen Collection	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.9	4.23.1 Physician Office Laboratories	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.8	4.24. Laboratory Coverage	Removed language and directed to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.7	4.22.1 References: International Normalized Ratio Monitoring Services	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic

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50.6	4.22 International Normalized Ratio Monitoring Services	Section deleted. Moved to Laboratory Services Handbook.	06/01/2021	W Deseron E Garibovic
50.5	4.16.1. References: Fertility Services	New section.	06/01/2021	W Deseron E Garibovic
50.4	4.16. Fertility Services	New section.	06/01/2021	W Deseron E Garibovic
50.3	4.7. Cervical Cancer Screening	Clarified reimbursement for sample collection.	06/01/2021	W Deseron E Garibovic
50.2	4.2.1. References: Acupuncture	New section.	06/01/2021	W Deseron E Garibovic
50.1	4.2. Acupuncture	New section.	06/01/2021	W Deseron E Garibovic
50.0	All	Published version	04/02/2021	TQD
49.114	9.2. Site of Service Differential	Updated name of fee schedule. Added POS 62 to list.	03/30/2021	W Deseron E Garibovic
49.113	Appendix A. ICD-10 Diagnosis Codes Accepted by Idaho Medicaid Supporting Medical Necessity for Cesarean Section	New section. Moved from Hospital handbook.	03/30/2021	W Deseron E Garibovic
49.112	8.6. References: General	Section deleted.	03/30/2021	W Deseron E Garibovic
49.111	9.6.1. References: Locum Tenens and Reciprocal Billing Arrangements	New section.	03/30/2021	W Deseron E Garibovic
49.110	8.5.2 Reciprocal Billing Arrangements.	Deleted section. Content moved to Locum Tenens and Reciprocal Billing Arrangements .	03/30/2021	W Deseron E Garibovic
49.109	8.5.1 Locum Tenens Arrangements	Deleted section. Content moved to Locum Tenens and Reciprocal Billing Arrangements .	03/30/2021	W Deseron E Garibovic
49.108	9.4. Misrepresentation of Services	Clarified misrepresentation.	03/30/2021	W Deseron E Garibovic
49.107	9.2.1. References: Site of Service Differential	Added references.	03/30/2021	W Deseron E Garibovic
49.106	9.1. References: Reimbursement	New section.	03/30/2021	W Deseron E Garibovic
49.105	9. Reimbursement	Clarified reimbursement structure.	03/30/2021	W Deseron E Garibovic
49.104	8.1. References: Documentation Requirements	New section.	03/30/2021	W Deseron E Garibovic
49.103	8. Documentation Requirements	New section.	03/30/2021	W Deseron E Garibovic
49.102	7.3. Telligen, Inc	New section.	03/30/2021	W Deseron E Garibovic
49.101	7.2. The Medical Care Unit	New section.	03/30/2021	W Deseron E Garibovic
49.100	7.1. References: Prior Authorizations	New section.	03/30/2021	W Deseron E Garibovic
49.99	7. Prior Authorizations (PA)	Renamed section Prior Authorizations. Updated and clarified section.	03/30/2021	W Deseron E Garibovic
49.98	5.13.1 References: Transplants	Section deleted. Content moved to Hospital handbook.	03/30/2021	W Deseron E Garibovic
49.97	5.12. Transplants	Content moved to Hospital handbook.	03/30/2021	W Deseron E Garibovic
49.96	5.11.5 Physician Statement	Section deleted. Content moved to Informed Participant Consent.	03/30/2021	W Deseron E Garibovic

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49.95	5.11.4 Statement of Person Obtaining Consent	Section deleted. Content moved to Informed Participant Consent.	03/30/2021	W Deseron E Garibovic
49.94	5.11.3 Mandatory Waiting Time	Section deleted. Content moved to Sterilization.	03/30/2021	W Deseron E Garibovic
49.93	5.10.3(a) References: Interpreter's Statement	New section.	03/30/2021	W Deseron E Garibovic
49.92	5.10.3. Interpreter's Statement	Clarified interpreter requirements.	03/30/2021	W Deseron E Garibovic
49.91	5.10.2(a) References: Informed Participant Consent	New section.	03/30/2021	W Deseron E Garibovic
49.90	5.10.2. Informed Participant Consent	Clarified Form requirements.	03/30/2021	W Deseron E Garibovic
49.89	5.10.1. References: Sterilization Procedures	Added references.	03/30/2021	W Deseron E Garibovic
49.88	5.10. Sterilization Procedures	Clarified coverage and requirements.	03/30/2021	W Deseron E Garibovic
49.87	5.7.1. References: Hysterectomy	Added references.	03/30/2021	W Deseron E Garibovic W Deseron E Garibovic
49.86	5.8.2. Sample Consent For Hysterectomy Form	Deleted section. Content moved to Hysterectomy.	03/30/2021	W Deseron E Garibovic
49.85	5.8.1. Retroactive Eligibility -- Hysterectomy	Deleted section. Content moved to Hysterectomy.	03/30/2021	W Deseron E Garibovic
49.84	5.7. Hysterectomy	Clarified coverage and form requirements. Incorporated Sample Consent and retroactive eligibility sections.	03/30/2021	W Deseron E Garibovic
49.83	5.5.3(a) References: Obstetrical Anesthesia	New section.	03/30/2021	W Deseron E Garibovic
49.82	5.5.3. Obstetrical Anesthesia	New section incorporating newsletter.	03/30/2021	W Deseron E Garibovic
49.81	5.6.2 Modifiers	Section deleted. Content moved to Anesthesiology.	03/30/2021	W Deseron E Garibovic
49.80	5.5.2(a) References: Certified Registered Nurse Anesthetist	New section.	03/30/2021	W Deseron E Garibovic
49.79	5.5.2. Certified Registered Nurse Anesthetist (CRNA)	Renamed section Certified Registered Nurse Anesthetist. Minor, non-substantive word change.	03/30/2021	W Deseron E Garibovic
49.78	5.5.1. References: Anesthesiology	Added references.	03/30/2021	W Deseron E Garibovic
49.77	5.5. Anesthesiology	Incorporated modifier section.	03/30/2021	W Deseron E Garibovic
49.76	5.3.22. Toe Modifiers	New section.	03/30/2021	W Deseron E Garibovic
49.75	5.3.21. Right and Left Side Modifiers	New section.	03/30/2021	W Deseron E Garibovic
49.74	5.3.20. Modifier XU: Unusual Non-Overlapping Service	New section.	03/30/2021	W Deseron E Garibovic
49.73	5.3.19. Modifier XS: Separate Structure	New section.	03/30/2021	W Deseron E Garibovic
49.72	5.3.18. Modifier XP: Separate Practitioner	New section.	03/30/2021	W Deseron E Garibovic
49.71	5.3.17. Modifier XE: Separate Encounter	New section.	03/30/2021	W Deseron E Garibovic

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49.70	5.3.16. Modifier 59: Separate Encounters and Distinct Procedures	New section.	03/30/2021	W Deseron E Garibovic
49.69	5.3.15. Modifier 58: Staged or Related Procedure	New section.	03/30/2021	W Deseron E Garibovic
49.68	5.3.14(a) References: Modifiers – Surgical 57	Renamed References: Modifier 57.	03/30/2021	W Deseron E Garibovic
49.67	5.3.14. Modifier 57	Renamed Modifier 57: Decision for Surgery.	03/30/2021	W Deseron E Garibovic
49.66	5.3.13(a) References: Modifier 56	New section.	03/30/2021	W Deseron E Garibovic
49.65	5.3.13. Modifier 56: Preoperative Management Only	New section.	03/30/2021	W Deseron E Garibovic
49.64	5.3.12 (a) References: Modifier 55	New section.	03/30/2021	W Deseron E Garibovic
49.63	5.3.12. Modifier 55: Postoperative Care Only	New section with appropriate use.	03/30/2021	W Deseron E Garibovic
49.62	5.3.11(a) References: Modifier 54	New section.	03/30/2021	W Deseron E Garibovic
49.61	5.3.11. Modifier 54: Surgical Care Only	New section with appropriate use.	03/30/2021	W Deseron E Garibovic
49.60	5.3.10. Modifier 53: Discontinued Procedure	New section.	03/30/2021	W Deseron E Garibovic
49.59	5.3.9. Modifier 51: Multiple Surgical Procedures	New section.	03/30/2021	W Deseron E Garibovic
49.58	5.3.8. Modifier 50: Bilateral Procedure	New section.	03/30/2021	W Deseron E Garibovic
49.57	5.3.7(a) References: Modifiers 25	New section.	03/30/2021	W Deseron E Garibovic
49.56	5.3.7. Modifier 25	Renamed Modifier 25: Separately Identifiable Service. Updated appropriate use.	03/30/2021	W Deseron E Garibovic
49.55	5.3.6(a) References: Modifier 24	New section.	03/30/2021	W Deseron E Garibovic
49.54	5.3.6. Modifier 24: Unrelated Evaluation and Management	New section with correct use.	03/30/2021	W Deseron E Garibovic
49.53	5.3.5. Modifier 22: Increased Procedural Services	New section.	03/30/2021	W Deseron E Garibovic
49.52	5.3.4. Finger Modifiers	New section.	03/30/2021	W Deseron E Garibovic
49.51	5.3.3. Eyelid Modifiers	New section.	03/30/2021	W Deseron E Garibovic
49.50	5.3.2. Coronary Artery Modifiers	New section.	03/30/2021	W Deseron E Garibovic
49.49	5.3.1. References: Surgical Modifiers	New section.	03/30/2021	W Deseron E Garibovic
49.48	5.3 Modifiers -- Surgical	Renamed section Surgical Modifiers. Added additional modifiers and reimbursement amounts.	03/30/2021	W Deseron E Garibovic
49.47	5.2.1. References: Provider-Preventable Conditions	New section.	03/30/2021	W Deseron E Garibovic
49.46	5.2 Health-Acquired Conditions (HAC)	Renamed Provider Preventable Conditions. Clarified language.	03/30/2021	W Deseron E Garibovic
49.45	5.1. References: Surgical Global Fee Concept	Renamed section References: Covered Services and Limitations – Surgery. Added references.	03/30/2021	W Deseron E Garibovic

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49.44	5. Covered Services and Limitations – Surgery	Incorporated Surgical Global Fee Concept section. Clarified global fee concept.	03/30/2021	W Deseron E Garibovic
49.43	4.34.4. Reimbursement for Examinations	Deleted section. Incorporated into Wellness Examinations.	03/30/2021	W Deseron E Garibovic
49.42	4.37.3. Child Wellness Exams	Updated requirements.	03/30/2021	W Deseron E Garibovic
49.41	4.37.1. References: Wellness Examinations	Added reference.	03/30/2021	W Deseron E Garibovic
49.40	4.37. Wellness Examinations	Updated requirements. Incorporated billing section.	03/30/2021	W Deseron E Garibovic
49.39	4.36.1. References: Transcranial Magnetic Stimulation	New section.	03/30/2021	W Deseron E Garibovic
49.38	4.36. Transcranial Magnetic Stimulation	New section incorporating newsletter article.	03/30/2021	W Deseron E Garibovic
49.37	4.35.1. References: Tobacco Cessation	New section.	03/30/2021	W Deseron E Garibovic
49.36	4.35. Tobacco Cessation	Updated coverage to incorporate newsletter article.	03/30/2021	W Deseron E Garibovic
49.35	4.29.1. References: Prolonged Services	New section.	03/30/2021	W Deseron E Garibovic
49.34	4.29. Prolonged Services	Updated coding.	03/30/2021	W Deseron E Garibovic
49.33	4.28. Physician-Administered Drugs (PDA)	Renamed Physician-Administered Drugs.	03/30/2021	W Deseron E Garibovic
49.32	4.26.9(a) References: Postpartum Care	Added references.	03/30/2021	W Deseron E Garibovic
49.31	4.26.9. Postpartum Care	Updated content of code.	03/30/2021	W Deseron E Garibovic
49.30	4.26.4(a) References: Delivery of the Placenta	New section.	03/30/2021	W Deseron E Garibovic
49.29	4.26.4. Delivery of the Placenta	New section incorporating newsletter article.	03/30/2021	W Deseron E Garibovic
49.28	4.26.3.(a) References: Cesarean Section	New section incorporating policy from Hospital handbook.	03/30/2021	W Deseron E Garibovic
49.27	4.26.3. Cesarean Section	New section incorporating policy from Hospital handbook.	03/30/2021	W Deseron E Garibovic
49.26	4.26.2(a) References: Antepartum Care	New section.	03/30/2021	W Deseron E Garibovic
49.25	4.26.1. References: Obstetric Care	Added references.	03/30/2021	W Deseron E Garibovic
49.24	4.24. Lung Cancer Screening	Updated age limitations to latest guidance.	03/30/2021	W Deseron E Garibovic
49.23	4.23.5(a) References: Blood Lead Screening	New section.	03/30/2021	W Deseron E Garibovic
49.22	4.17.3 Vaccines and Third-Party Liability	Section deleted. Incorporated into Immunization and Vaccines.	03/30/2021	W Deseron E Garibovic
49.21	4.17.2 Vaccines for Children Under 19	Section deleted. Incorporated into Immunization and Vaccines.	03/30/2021	W Deseron E Garibovic
49.20	4.19.1. References: Immunization and Vaccines	Added references.	03/30/2021	W Deseron E Garibovic
49.19	4.19. Immunization and Vaccines	Incorporated VFC program section and TPL section. Added information about certain age limits.	03/30/2021	W Deseron E Garibovic
49.18	4.18.1. References: Hyperbaric Oxygen Therapy	New section.	03/30/2021	W Deseron E Garibovic

Physician and Non-Physician Practitioner, Provider Handbook Modifications				
Version	Section/ Column	Modification Description	Date	SME
49.17	4.17. Forensic Examinations and Interviews	New section. Incorporating existing policy.	03/30/2021	W Deseron E Garibovic
49.16	4.10.2. Provider Qualifications: Diabetes Education and Training	Non-substantive, minor word change.	03/30/2021	W Deseron E Garibovic
49.15	4.7. Clinic Services	New section. Describing clinic services.	03/30/2021	W Deseron E Garibovic
49.14	4.1.5. References: Abortions	Added references.	03/30/2021	W Deseron E Garibovic
49.13	2.7.1. References: Physician Assistants	Added references.	03/30/2021	W Deseron E Garibovic
49.12	2.7. Physician Assistants	Clarify status when contracting.	03/30/2021	W Deseron E Garibovic
49.11	2.6.1. References: Pharmacists	Added references.	03/30/2021	W Deseron E Garibovic
49.10	2.5.1. References: Nurse Practitioners	Added references.	03/30/2021	W Deseron E Garibovic
49.9	2.5. Nurse Practitioners	Clarify status when contracting.	03/30/2021	W Deseron E Garibovic
49.8	2.4.1. References: Clinical Nurse Specialists	Added references.	03/30/2021	W Deseron E Garibovic
49.7	2.4. Clinical Nurse Specialists	Clarify status when contracting.	03/30/2021	W Deseron E Garibovic
49.6	2.3.1. References: Certified Registered Nurse Anesthetist	Added references.	03/30/2021	W Deseron E Garibovic
49.5	2.3. Certified Registered Nurse Anesthetists	Clarify status when contracting.	03/30/2021	W Deseron E Garibovic
49.4	2.2.1. References: Certified Nurse Midwives	Added references.	03/30/2021	W Deseron E Garibovic
49.3	2.2. Certified Nurse Midwives	Clarify status when contracting.	03/30/2021	W Deseron E Garibovic
49.2	2.1.1 References: Physicians	Added references.	03/30/2021	W Deseron E Garibovic
49.1	2.1. Physicians	Clarify status when contracting.	03/30/2021	W Deseron E Garibovic