MedicAide

An Informational Newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **June 2026**

In This Issue

The content of this guidance document is not new law but is an interpretation of existing law prepared by the Idaho Department of Health and Welfare to provide clarity to the public regarding existing requirements under the law. This document does not bind the public, except as authorized by law or as incorporated into a contract. For additional information or to provide input on this document, contact the Division of Medicaid by emailing medicaidcommunications@dhw.idaho.gov or by calling 888-528-5861.

Unacceptable Documentation Practices

The Medicaid Program Integrity Unit identified provider records used to support services rendered that didn't meet documentation requirements for Medicaid reimbursement. Documentation reviewed lacked member-specific information necessary to support the services rendered and/or was used across multiple service dates for the same or different members. These practices are commonly referred to as "cloned notes."

Examples identified included, but weren't limited to:

- The date of service and/or appointment time being the only change
- The rendering provider's signature, date, and/or time stamp being the only change
- Use of the exact same "canned" text to support medical necessity for services rendered

Electronic health record (EHR) systems often have the ability to generate documentation that has already been recorded elsewhere, insert "canned" text that isn't member-specific, use templates with preloaded documentation, and/or use artificial intelligence (AI) to create documentation. Providers are responsible for ensuring that all documentation accurately reflects the clinical work performed, is member-specific, and is relevant to the encounter.

Cloned and/or AI-generated notes aren't acceptable and may compromise the credibility of a member's medical and behavioral health records. This type of documentation often lacks the specificity needed to support medical necessity requirements. Members aren't expected to present with the exact same concerns, symptoms, responses, or interventions during every encounter.

All documentation in the medical record must be specific to the member's condition, concerns, needs, responses, and status at the time of the encounter.

IDAPA 16.05.07.101.01 outlines requirements for documentation of services and states:

> **01. Documentation of Services**. Providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must:
>
> **a.** Be legible and consistent with professionally recognized standards; and
>
> **b.** Be retained for a period of five (5) years from the date the item or service was provided.

Section 1.2 of General Information and Requirements for Providers in the Idaho Medicaid Provider Handbook addresses documentation. It states in pertinent part:

> **1.2. Documentation**
>
> All providers are required to generate records at the time the service is delivered and to maintain documentation to fully document the extent of services submitted for Medicaid reimbursement. Services which have not been sufficiently documented are not reimbursable.

The person delivering the services and any supervising providers must ensure all documentation is legible, complete, dated, time-stamped, and includes a written or electronic dated signature to attest that the records are a true and accurate account of the services delivered.

1.2.1. Additional Documentation

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

1.2.3. Artificial Intelligence

Documentation generated by artificial intelligence is not acceptable.

1.2.6. Retention of Records

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

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

Please be advised the department won't reimburse services supported by unacceptable documentation such as but not limited to cloned and/or AI generated documentation. Documentation that doesn't meet requirements may be subject to review, recoupment, and civil monetary penalties.

Billing Procedure for Date Spanning

The Medicaid Program Integrity Unit continues to identify providers who are incorrectly billing services using date spanning. Providers are reminded when billing with a date span, services must have been provided consecutively every day within that span. This information has been provided in subsequent MedicAide newsletters.

Section 1.2 of General Information and Requirements for Providers in the Idaho Medicaid Provider Handbook describes the correct billing procedure for date spanning and states:

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

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

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

Date(s) of Service	Procedure Code	Charges
12/11/2020 –12/11/2020	XXXXXX	$XXX.XX
12/13/2020 – 12/13/2020	XXXXXX	$XXX.XX

For UB-04 claims, non-consecutive dates may be spanned on a single claim. However, providers must exercise caution to ensure billing accuracy. Providers must ensure date spans don't result in overlapping claims and outpatient claims don't overlap inpatient stays. Outpatient claims that overlap an inpatient admission will be denied, unless otherwise specified in the Idaho Medicaid Provider Handbook.

Providers are responsible for ensuring all services are billed in accordance with Medicaid billing requirements. The Medicaid Program Integrity Unit will be assessing civil monetary penalties for services that are incorrectly billed with a date span.

Billing for Timed Activities

To receive payment, providers must fully document all services they deliver. Documentation must be complete, accurate, and easy to read.

Each record must include:
- The date and time of service
- Description of the service provided
- Written or electronic signature (dated) confirming the record is accurate

The person providing the services — and any supervising provider — are responsible for making sure documentation meets these requirements.

Records must be accurate. Any incorrect or misleading information (such as rounding up or down) is considered fraud. This may result in recoupment, civil monetary penalties, and referral to the Medicaid Fraud Control Unit.

Timed Services
Some services are paid on the amount of time spent. These may include:

- Evaluations
- Therapy services
- Procedures
- Supported living services
- Collateral contacts

For these services, unless otherwise specified, providers must document the exact start and end times and include a note describing what was done.

Unless otherwise stated, only time spent directly with the member counts toward billing.

15-Minute Timed Codes

Many CPT® codes are billed in 15-minute units. These codes follow the eight-minute rule:

- You can bill when at least eight minutes of service is provided in a day
- You can't bill an additional unit unless at least 23 minutes of service is provided

Allowed Billable Units for 15-Minute Timed Codes	
Number of Units	**Time Interval**
1 unit	≥ 8 minutes to < 22 minutes
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes

The pattern continues for services longer than one hour.

Providers are expected to average 15 minutes per unit. If a provider consistently bills for less time per unit, the department may require different billing practices.

Multiple Services on the Same Day

If more than one timed service is provided on the same day:

- Add all minutes together to determine the number of billable units
- Don't combine services into one billing code
- Assign units to each code based on time spent

Example 1			
Billing Code	Time Spent	Billed Units	Explanation
Code 1	36 minutes	3	According to the chart above, "Allowable Billable Units for 15-Minute Timed Codes," 71 minutes equals five units. Each of the codes was billed for 30 minutes so are billed at least a minimum of two units each. Since Code 1 took more time than Code 2 the remaining unit is assigned there even though by itself Code 1 wouldn't qualify for three units.
Code 2	35 minutes	2	
Total	71 minutes	5	

Example 2			
Billing Code	Time Spent	Billed Units	Explanation
Code 1	20 minutes	2	According to the chart above, "Allowable Billable Units for 15-Minute Timed Codes," 40 minutes equals three units. Each of the codes were provided for at least 15-minutes and must be billed at least one unit each. Since both services took the same amount of time, the provider can assign the remaining unit to either code they decide.
Code 2	20 minutes	1	
Total	40 minutes	3	

Example 3			
Billing Code	Time Spent	Billed Units	Explanation
Code 1	33 minutes	2	According to the chart above, "Allowable Billable Units for 15-Minute Timed Codes," 40 minutes equals three units. Code 1 was provided for two full units. Since Code 2 didn't meet the eight-minute threshold for one unit, compare the unassigned time from Code 1 (three minutes) with Code 2 (seven minutes). Bill the remaining unit with the code that has the largest unassigned time, i.e., Code 2.
Code 2	7 minutes	1	
Total	40 minutes	3	

Example 4			
Billing Code	Time Spent	Billed Units	Explanation
Code 1	16 minutes	1	According to the chart above, "Allowable Billable Units for 15-Minute Timed Codes," 44 minutes equals three units. All codes performed would qualify for a single unit on the chart above, but since they were performed on the same day the time is added up to determine the number of billable units. Since all the codes qualify for one unit, the units are divided equally among the codes with the most time performed. Although Code 4 isn't being reimbursed directly, it must still be documented since its time is being reimbursed in the other codes.
Code 2	10 minutes	1	
Code 3	10 minutes	1	
Code 4	8 minutes	0	
Total	44 minutes	3	

Example 5			
Billing Code	Time Spent	Billed Units	Explanation
Code 1	7 minutes	1	According to this, 21 minutes is eligible for one unit. As all the codes were performed for the same amount of time, the performing professional selects one to bill with the one unit. Although Codes 2 and 3 aren't being reimbursed directly, they must be documented since their time is being used to justify the reimbursement for Code 1.
Code 2	7 minutes	0	
Code 3	7 minutes	0	
Total	21 minutes	1	

For questions about this article or suggestions about the provider handbook, contact the Bureau of Policy.

Sterilization Consent Form

An updated Sterilization Consent Form is now available for providers to use for sterilization procedures. The new form is valid through July 31, 2028. Providers should begin using the updated form immediately.

Please note:

- The previous version of the form expired on 07/31/2025.
- Due to the timing of the updated federal form's release, Idaho Medicaid will continue to accept the previous version of the form for claims with dates of service through 06/30/2026.
- Claims for dates of service on or after 07/01/2026, won't be accepted if the previous version of the form is used. Providers must use the updated form for these dates of service.

Forms are available in both English and Spanish:

- Consent for Sterilization: Form HHS-687 (English)
- Consentimiento para la Esterilización (Spanish)

Attention Personal Care Service and Supported Employment Providers

Personal Assistance Agencies and providers of Supported Employment will need to update their National Provider Identifier's (NPI) taxonomy before conducting maintenance of their account or going through revalidation. It is recommended providers do this early to avoid delays in their account updates or enrollment.

Taxonomy Changes	
Service	**New Taxonomy**
Personal Care Services	In Home Care Supportive Care 253Z00000X
Supported Employment	Community/Behavioral Health Agency 251S0000X

Changes to Hospital Perspective Payment System: DRG

Acute Care Hospitals will be subject to updates to the Solventum All Patient Refined DRG (Solventum APR DRG) Software reimbursement methodology effective July 1, 2026. It's highly encouraged to refer to the published information that will outline the Idaho specific parameters in the Hospital, Idaho Medicaid Provider Handbook, and the Hospital Prospective Payment System DRG library. This update will result in changes to base rates, percentage add-on, weights, and policy adjusters. This change won't affect Idaho Critical Access hospitals or Idaho State-owned hospitals.

Expanded Quality Assurance Reviews for ResHab Providers for A&D Waiver members

The Bureau of Long Term Care (BLTC) Quality Assurance (QA) team will expand its current quality improvement reviews for Residential Habilitation (ResHab) providers this year. Reviews will now include service delivery for all Medicaid members receiving services authorized by the BLTC, including the Aged & Disabled Waiver and Personal Care Services.

As part of the review process, the BLTC QA team will review:

- Progress notes
- Service plans
- Staff training records

Reviewing service plans will give the QA team an opportunity to work collaboratively with ResHab providers to help ensure service plans meet requirements outlined in 42 C.F.R. § 441.301(c)(2) and Idaho Administrative Procedures Act (IDAPA) rules 16.03.26, sections 536, 543.01, and 544.15.

At a minimum, service plans must include:

- Individual goals and outcomes
- Services and supports
- Risk factors
- Clear and understandable language
- A designated plan monitor
- Required signatures

ResHab providers will be notified when their review is scheduled and will have three weeks to submit the required documentation. The BLTC QA team looks forward to working with providers as this new service delivery review process begins.

Provider Handbook Updates

Several Idaho Medicaid Provider Handbooks have recently been updated. Providers are encouraged to review the latest changes and upcoming publications.

New and Upcoming Handbooks

- Publication of the **Children's Habilitation Intervention Services** handbook has been delayed until July.

Podiatry Services Updates

The ***Podiatry Services*** Handbook now includes:

- New information about coverage and requirements for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)
- Removal of the "site of service" requirement

Rewritten Handbooks

The following handbook has been significantly revised:

- Home and Community-Based Services (HCBS) and Long-Term Support Services (LTSS)
  A draft version will be available for public review, with final publication expected in **July 2026**.

Drafts can be reviewed in our policies and standards library on the department's website.

Therapy Services Updates

The Therapy Services handbook has been updated to:

- Clarify which services require prior authorization from Telligen
- Better explain when services and evaluations are appropriate
- Add a new appeals section
- Clarify how often progress reports are required
- Add disclaimers to appendices

Questions or Feedback

For questions or suggestions, please contact the Bureau of Policy.

CPT® and HCPCS Coverage Update

The following CPT® and HCPCS codes are now covered by Idaho Medicaid. These codes are associated with services and items already approved under the Idaho Medicaid State Plan and waivers.

Please allow time for system updates. Once updates are complete, any affected claims will be automatically reprocessed — providers don't need to resubmit them.

All applicable statutes, rules, and provider handbook requirements still apply.

Covered Codes			
Codes	**Description**	**Effective Date**	**Prior Authorization**
A4318	Female external urinary collection cup, with or without ring attachment, per day	4/1/2026	No
A4479	Electronic transanal irrigation system, includes electronic pump, water reservoir, tubing, and accessories, without catheter, any type	4/1/2026	Medical Care Unit
A6548	Accessory to custom gradient compression garment, silicone band, any size	4/1/2026	Medical Care Unit
C1743	Scaffold, endovascular non-coronary, resorbable drug eluting, with delivery system (implantable)	4/1/2026	Medical Care Unit
C8007	Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring insertion of a separate distal respiratory sensor electrode or electrode array	4/1/2026	Medical Care Unit
C8008	Revision or replacement of hypoglossal nerve neurostimulator array including connection to existing pulse generator	4/1/2026	Medical Care Unit
C8009	Removal of hypoglossal nerve neurostimulator array and pulse generator	4/1/2026	Medical Care Unit

Covered Codes			
Codes	**Description**	**Effective Date**	**Prior Authorization**
C8010	Percutaneous placement of permanent common carotid embolic protection device, including all system components and imaging guidance; bilateral	4/1/2026	Medical Care Unit
C8011	Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including external power source and all system components	4/1/2026	Medical Care Unit
C8012	Revision or replacement of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver	4/1/2026	Medical Care Unit
C8013	Removal of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver	4/1/2026	Medical Care Unit
C9309	Injection, onasemnogene abeparvovec-brve, per treatment	5/1/2026	Telligen
C9818	Suzetrigine, oral, 1 mg	4/1/2026	No
G0680	Detection and quantification of coronary artery calcium and/or aortic valve calcification from algorithmic analysis of computed tomography of the chest with report	4/1/2026	Medical Care Unit
J0463	Injection, atropine sulfate (fresenius and therapeutically equivalent), 0.01 mg	4/1/2026	No
J1098	Articaine ophthalmic, 8% solution, 0.4 ml	4/1/2026	No
J1164	Injection, diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg	4/1/2026	No
J1553	Injection, immune globulin (yimmugo), 100 mg	5/1/2026	Telligen
J3404	Injection, zopapogene imadenovec-drba suspension, per therapeutic dose	5/1/2026	Telligen
J8502	Injection, aprepitant (aponvie), 1 mg	4/1/2026	No
J9003	Leuprolide injectable (camcevi etm), 1 mg	5/1/2026	Telligen
J9183	Gemcitabine intravesical system, 225 mg	4/1/2026	No
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph	4/1/2026	No
J9278	Injection, carboplatin (avyxa), 1 mg	4/1/2026	No
J9601	Injection, linvoseltamab-gcpt, 1 mg	5/1/2026	Telligen
L5992	All lower extremity prosthesis, foot shell for modular foot/non-solid ankle cushion heel (sach) replacement only	4/1/2026	Medical Care Unit
Q0238	Injection, tocilizumab-aazg, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, 1 mg	4/1/2026	No

Covered Codes			
Codes	**Description**	**Effective Date**	**Prior Authorization**
Q5161	Injection, denosumab-kyqq (aukelso/bosaya), biosimilar, 1 mg	5/1/2026	Telligen
Q5162	Injection, denosumab-nxxp (bildyos/bilprevda), biosimilar, 1 mg	5/1/2026	Telligen

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Information Releases

Medicaid has recently published the following IRs:

- MA 26-11 Residential Habilitation Rates
- MA 26-12 Swing-bed and AND Rates 2026
- MA 26-13 Update to Medicaid Provider Agreements
- MA 26-14 Ambulance Claims For Mileage
- MA 26-15 Service Animal Benefit

Provider Training Opportunities

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

July: Long Term Care - This training will show Long Term Care providers how to submit for admissions, discharges, and ICF/ID preadmissions, how to upload, fax, and mail supporting documentation, how to use the LTC case status, and how to verify eligibility.

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

	July	August	September
	Long Term Care	**Revalidation**	**PEA Maintenance**
10-11:00 AM MT	7/21/2026	8/18/2026	9/15/2026
	7/15/2026	8/19/2026	9/16/2026
	7/16/2026	8/20/2026	9/17/2026
2-3:00 PM MT	7/8/2026	8/12/2026	9/9/2026
	7/9/2026	8/13/2026	9/10/2026
	7/21/2026	8/18/2026	9/15/2026
	7/16/2026	8/20/2026	9/17/2026

If you would prefer one-on-one training in your office with your Regional Provider Relations Consultant, please feel free to contact them directly. Contact information for Provider Relations Consultants can be found on page 16 of this newsletter.

DHW Resource and Contact Information

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

Insurance Verification

HMS PO Box 2894 Boise, ID 83701	1 (800) 873-5875 1 (208) 375-1132 Fax: 1 (208) 375-1134

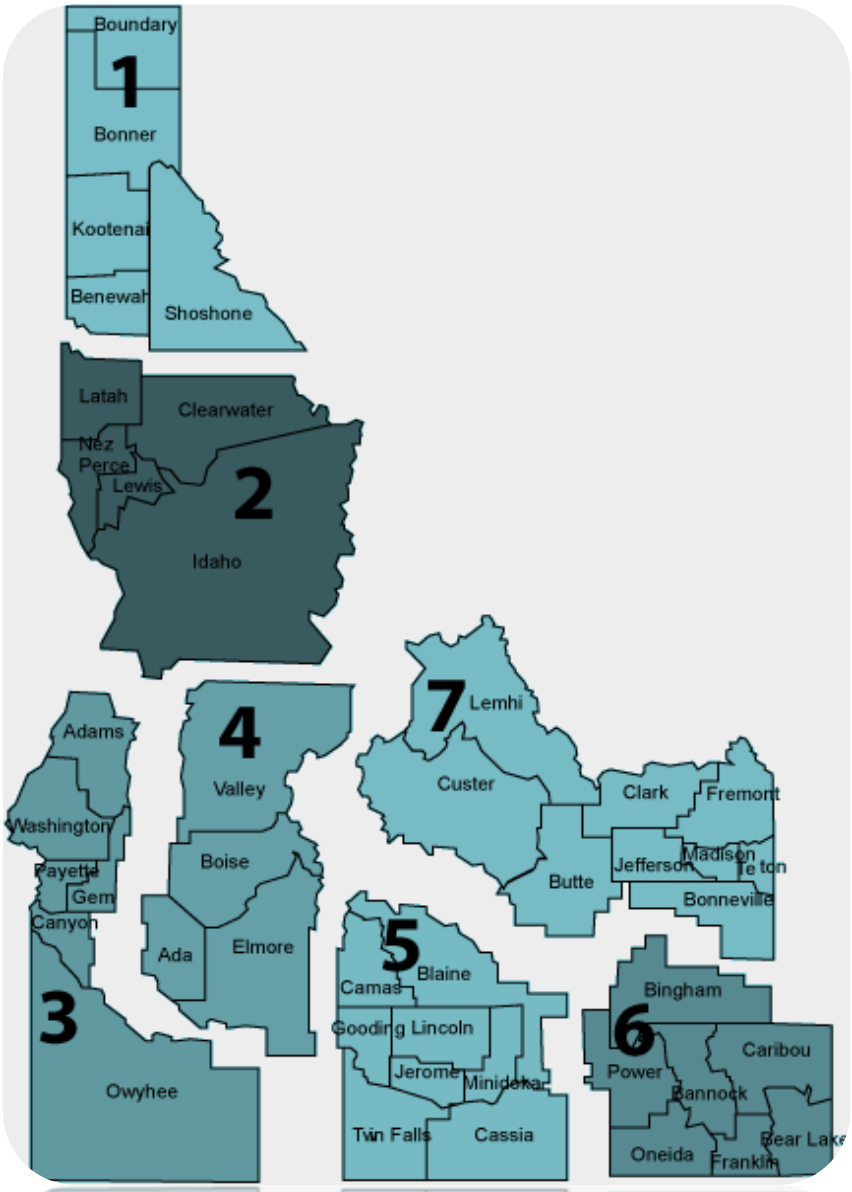
Gainwell Technologies Provider and Participant Services Contact Information

Provider Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4272 1 (208) 373-1424
Provider Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4272 1 (208) 373-1424
E-mail	idproviderservices@gainwelltechnologies.com idproviderenrollment@gainwelltechnologies.com
Mail	P.O. Box 70082 Boise, ID 83707
Participant Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4752 1 (208) 373-1432
Participant Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4752 1 (208) 373-1424
E-mail	idparticipantservices@gainwelltechnologies.com
Mail – Participant Correspondence	P.O. Box 70081 Boise, ID 83707
Medicaid Claims	
Utilization Management/Case Management	P.O. Box 70084 Boise, ID 83707
CMS 1500 Professional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional Crossover/CMS 1500/Third-Party Recovery (TPR)	P.O. Box 70084 Boise, ID 83707
Financial/ADA 2006 Dental	P.O. Box 70087 Boise, ID 83707

Gainwell Technologies Provider Services Fax Numbers

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

Provider Relations Consultant (PRC) Information



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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