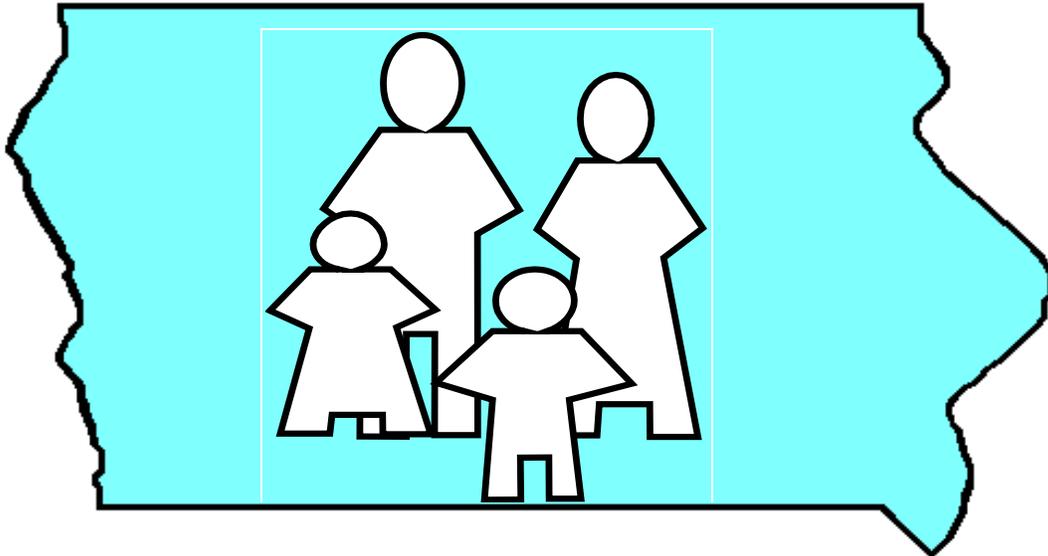


MEDICAID PATIENT ACCESS TO SERVICE SYSTEM

MediPASS



**PROCEDURE GUIDE FOR
PATIENT MANAGERS**

PROGRAM OVERVIEW

BACKGROUND

The Iowa Department of Human Services (DHS), with support from the Iowa Medical Society and the Iowa Osteopathic Medical Association, has developed a Managed Health Care (MHC) program. This program provides certain Medicaid members (families and children) residing in Iowa with a specified primary care provider/Patient Manager.

Implementation of this Managed Health Care program in Iowa Medicaid was mandated by the Iowa Legislature via House File 2447 in 1988 and Senate File 541 in 1989. Effective June 30, 2005, the Iowa Medicaid Enterprise (IME) assumed responsibility to administer the program.

The goals of Managed Health Care are to:

- Enhance quality and continuity of care
- Ensure appropriate utilization of health care services
- Ensure appropriate access to care
- Contain Medicaid costs

Patient management has been shown to enhance the continuity of care that comes from a strengthened provider-patient relationship. Research has also shown that a strong provider-patient relationship will encourage early diagnosis and intervention, promote good health outcomes, and support efforts to meet these goals.

CONCEPT

MediPASS is an option available in all of the counties in which the MHC program has been implemented. Members in the program choose a MHC provider to monitor and coordinate their health care services. In addition, some counties may have another option of one or more health maintenance organizations (HMOs) from which to choose. (As of 2009 there are no HMOs contracted with DHS to provide Medicaid services.) Family members within a household may choose different managed care options. If a member does not make a choice, a MHC provider is assigned.

In the MediPASS program, members select or are assigned to one primary care provider (doctor of medicine or osteopathy, nurse practitioner, or nurse midwife), a Federally Qualified Health Care Center (FQHC), or a Rural Health Center (RHC), known as a Patient Manager. The Patient Manager provides the member a medical home. This provider is responsible for providing primary care and for authorizing referrals for the member to specialists or other medical providers when appropriate.

The Patient Manager is responsible for authorizing all referrals with the exception of those services that do not require a referral. The list of services that members can receive without a referral includes:

- Emergent Services
- Home and Community Based Services (HCBS)
- Area Education Agency Services
- Skilled Care
- Intermediate Care Facility (ICF)
- ICF for the Mentally Retarded (ICF/MR)
- Dental Services
- Prescription Drugs
- Chiropractic Services
- Ambulance Services
- Family Planning Services
- Early Periodic Screening, Diagnosis & Treatment (EPSDT) for individuals under age 21
- Optometric Services
- Ophthalmology Services
- Rehabilitative Services/CACT
- Lead Investigation

Also, the Patient Manager has the responsibility of coordinating and monitoring necessary medical care. The Patient Manager acts as a monitor to assure appropriate utilization of services and also serves as an advocate for the member who might not otherwise seek appropriate medical care.

MEMBER PARTICIPATION

Only those members who receive medical assistance under the Temporary Assistance for Needy Families (TANF) program, previously known as the Aid to Families with Dependent Children (AFDC) program, and the TANF-related categories of assistance (families and children) are enrolled in MHC. Enrollment in MediPASS or another form of MHC (HMOs, if available) is mandatory for members in counties where MediPASS has been implemented.

SSI and SSI-related members (aged, blind, and disabled), those in Foster Care or the Medically Needy program, children with special health care needs accessing care from a Child Health Specialty Clinic (Title V providers), Native American Indians, and Alaskan Natives are not currently enrolled in MHC. Additionally, any Medicaid member who is a Medicare beneficiary is not enrolled in MHC regardless of their category of assistance.

PROVIDER PARTICIPATION

Physicians, nurse practitioners, and nurse midwives who practice primary care medicine may participate as MediPASS Patient Managers. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) may also serve as MHC providers. When an RHC or FQHC is the MHC provider, the clinic's name is whom the member is enrolled with in place of an individual provider's name. Other providers may be approved by DHS to be Patient Managers under extraordinary circumstances.

The following specialties may participate as MediPASS providers:

- General Practice
- Family Practice
- Pediatrics
- Internal Medicine
- Obstetrics/Gynecology

Some Medicaid providers have a special designation as a Federally Qualified Health Center (FQHC). These providers are clinic organizations that offer a wide variety of services at a single location. The FQHC services may be more extensive than at a typical provider's office or clinic. These services could include: better understanding of ethnic culture and customs relating to health care, foreign language translation, transportation to clinic/home, health and wellness education/training, dental, or pharmacy services.

PATIENT MANAGER RESPONSIBILITIES

The Patient Manager's overall role is to provide the members a medical home. The Patient Manager provides primary care and appropriate referrals for medical services from other providers. He or she assists the member in becoming a responsible user of medical services. He/she is responsible for either providing services, or issuing a referral for another provider to do so, for all members enrolled with them as their Patient Manager.

In managing the member's medical care, the Patient Manager must provide for or arrange for 24-hour per day, seven days per week provider coverage. The Patient Manager or designee must be available to the member because the member has no alternative but to go to the Patient Manager for non-emergent care. The Patient Manager should inform the member of normal office hours and explain the procedures to follow when the office is closed. A single 24-hour access telephone number must be provided by the Patient Manager to the IME. Consideration has been made to minimize the administrative burden for providers, but the Patient Manager is expected to keep complete and accurate patient records. While paper referrals and referrals are not required by DHS, all referrals must be documented by both the Patient Manager and treating provider. This documentation is no more detailed than the guidelines established by the Department of Health for complete patient records. See Chapter I in the All Medicaid Provider Manual for documentation policies.

QUALITY ASSURANCE/UTILIZATION REVIEW (QA/UR)

DHS is responsible for reviewing MediPASS to ensure that members are able to access quality care and that utilization patterns fall within acceptable norms. Providers are involved in this process through the Managed Health Care Advisory Committee (MHCAC).

The IME provides participating providers with information on the utilization of their MediPASS enrollees on a quarterly basis. Every MediPASS Patient Manager receives a MediPASS Patient Utilization Report quarterly.

Granting a referral, even retrospectively, does not mean the Patient Manager endorses or agrees with the course of treatment nor does it mean that the Patient Manager has any knowledge of the patient. Such referrals only authorize Medicaid payment to other providers.

In addition to the MediPASS Patient Utilization Report, a MediPASS Patient Manager **may** receive a Quarterly Member Utilization Exception Report. A cover letter explaining the Quarterly Member Utilization Exception Report is generated for all Patient Managers receiving this report.

IME Internal reports are generated for Quality Assurance/Utilization Review (QA/UR) from the quarterly exception reports. The following reviews are performed by IME Medical Services staff and reported to the Department of Human Services on a quarterly basis:

- MHC providers are randomly selected each month for audit of their 24-hour access (See 24-Hour Access under *Referral and Referral Process and Documentation*).
- MHC providers are also randomly selected each month for a short questionnaire on appointment access for urgent and routine care.
- Randomly selected paid claims are mailed to MediPASS Patient Managers to verify proper use of MediPASS Patient Managers referral numbers. This review is to assist Patient Managers in detecting inappropriate use of their referral numbers by other providers.

If quality of service issues are identified as a result of routine review or processing a member grievance, those issues are evaluated to determine if referral to other persons or agencies, such as the Board of Medical Examiners, is appropriate. IME Medical Services staff collects and analyzes utilization and quality assessment data.

PATIENT MANAGER REIMBURSEMENT

MediPASS providers continue to receive fee-for-service reimbursement from Medicaid for payable services provided to MediPASS members. In addition, an administrative fee of \$2.00 is paid per month for each eligible MediPASS patient enrolled with the Patient Manager. Maximum monthly reimbursement may not exceed \$3,000 per provider. This fee is paid each month regardless of whether the patient requires services from the Patient Manager. Payment is made the month following the month in which the member was enrolled with the provider. Federally Qualified health Centers are exempt from payment of the administrative fee.

MANAGED SERVICES

The following categories of service must either be provided by or be referred by the Patient Manager in order to be payable by Medicaid:

- Inpatient Hospital
- Outpatient Hospital
- Podiatric Services
- Home Health Services
- Clinic Services (Rural Health Centers, Federally Qualified Health Centers, maternal health clinics, ambulatory surgical centers, genetic consultation, and birthing centers)
- Lab and X-Ray
- Medical Supplies
- Physician Services (except Ophthalmologists)
- Other practitioners such as physical therapists, audiologists, rehabilitation agencies, and nurse anesthetists (except for mental health providers)

Services provided during a medical emergency and billed with an emergent diagnosis code do not require referral. After treatment of the medical emergency, the provider of the service is asked to inform the Patient Manager in a timely manner, during regular business hours, to maintain continuity of care. Additionally, follow-up treatment must be performed either by or through referral from the Patient Manager. The Patient Manager is responsible for issuing/denying referrals for all hospital admissions and services covered under pre-procedure review.

Members have the option of paying for services if the Patient Manager denies a referral. However, services may not be billed to the member unless the member was notified prior to the rendering of the service that he or she may be responsible for the bill and they agreed to be

responsible. This allows members to make the decision whether or not to continue to receive service if they will be held financially responsible.

Members enrolled in the MediPASS program (not HMOs) are exempt from pre-procedure and pre-admission review by Medical Services in most cases. The Patient Manager's referral replaces these reviews. Gastroplasty and transplants require referral from both the Patient Manager and Medical Services. If Medical Services denies referral, the Patient Manager's referral does not override the Medical Services denial. If the Patient Manager denies the referral when Medical Services approves the procedure, the procedure is not authorized.

FAMILY PLANNING

Family planning services are not managed care services and do not require Patient Manager referrals. Covered services include counseling, medical examinations, laboratory tests, and supplies furnished in connection with family planning.

Services performed for abortions, childbirth, or treatments of an illness or injury that have a secondary family planning relationship are not considered family planning services and do require Patient Manager referral.

MATERNAL HEALTH CENTERS

Patient Managers are required, as part of their MediPASS agreement, to refer pregnant enrollees requiring case management, enhanced services, prenatal, and postpartum services to maternal health centers when an enrollee:

- Requests such services
- Is receiving such services at the time of enrollment, or
- Attempts to obtain such services without prior referral

The referral is required when the risk assessment tool reflects a high-risk pregnancy or if requested by the pregnant enrollee (see Physicians Provider Manual, Chapter E).

THE IOWA PLAN FOR BEHAVIORAL HEALTH

Most Medicaid members under the age of 65 are enrolled in the Iowa Plan for Mental Health and Substance Abuse Services. Medicaid mental health providers coordinate services under the Iowa Plan, including notification of medication changes, with MediPASS Patient Managers. Patient Managers receive copies of referral letters for Iowa Plan mental health services received by their patients. Services for high need clients will be coordinated between the Iowa Plan and Patient Managers whenever possible.

HEALTH MAINTENANCE ORGANIZATION (HMO)

HMOs may be available in some counties as an alternative to MediPASS. DHS makes a capitated payment to the HMO, which is then responsible for providing the member's medical care. Providers may choose to participate in both MediPASS and the HMOs. Providers interested in participating in both programs must contact the HMO for instructions to become part of the HMO's provider network.

The member's medical benefits are the same whether they enroll in MediPASS or an HMO. However, the referral procedure and the provider's source of payment may differ.

The HMO in which members enroll may be an open access model or a Patient Manager (PM) model. In an open access HMO, members may receive services from any primary care provider who is on that HMO's provider panel without a referral. In a PM model, the member must choose or be assigned to a PM who monitors and coordinates the member's medical services. The PM must authorize services administered by other providers, including providers who are members of the HMO's provider panel. Appropriate referrals, if necessary, should be obtained through the HMO. Provider claims should be submitted to the HMO for payment.

The services that may be accessed outside of the HMO plan include those listed below. These services are covered by Medicaid fee-for-service reimbursement, so claims should be submitted to IME for payment.

- Home and Community Based Services (HCBS Waiver)
- Are Education Agency Services
- Skilled Care
- Longer Term Care – Skilled Nursing Facilities, Intermediate Care Facilities (ICF), Residential Care Facilities, State Hospital Schools, or Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
- Dental Services
- Prescription Drugs
- Rehabilitative Services/CACT
- Family Planning Services
- Lead Investigation

Chiropractor and Medical Supplies (Durable Medical Equipment) may or may not be covered by the HMO. Please check with the appropriate HMO for clarification on these services. If the HMO does not cover Chiropractor or Medical Supplies, then the services are covered by Medicaid fee-for-service reimbursement, as noted above.

MEMBER MANAGED HEALTH CARE **ENROLLMENT PROCESS**

Summary: New members are enrolled in Managed Health Care as they become eligible for Medicaid. In counties where MHC has been implemented, members in the Temporary Assistance for Needy Families (TANF) program and TANF-related programs are required to participate. Members are notified that they must choose a MHC patient manager and if they do not, a patient manager will be assigned to them.

An enhancement to the assignment process is the matching of a member with a previous MHC patient manager. If a Medicaid member starts through the MHC enrollment process, the enrollment system will look to see if the member has been in the MHC program during the past twelve months. If so (and the patient manager is open to new patients with enough openings and the patient manager is in the member's county of residence), the enrollment system will make the tentative assignment back to the same patient manager choice from the past.

Members may choose to change their patient manager during their open enrollment although the change will not take effect for two to six weeks. Enrollments and changes may be initiated at the patient manager's office, at the local DHS office, by mailing an enrollment form to the IME office, or calling the IME Member Services Line toll free 1-800-338-8366 or locally at 515-725-1003. The member must obtain medical services or referrals from the patient manager that they are enrolled with until the IME reflects the new patient manager choice.

DHS implemented the Extended Participation Program (EPP) effective July 1, 1998, requiring members to be continuously enrolled with a MHC patient manager for a period of six months. Members enrolled in MHC are given an initial 90 days to choose a MHC patient manager they wish to remain enrolled with for the six-month EPP period. Sixty days prior to the end of an EPP period, members receive a notice informing them of their next open enrollment period. Failure to change patient managers during an open enrollment period will result in members being enrolled for an additional six months with the same patient manager. This program does not guarantee Medicaid eligibility.

MANDATORY PARTICIPATION

Members are enrolled in MHC as they become eligible for Medicaid under one of the covered categories of assistance or if they move into a MHC county from a non-MHC county. Members who are required to enroll in MHC are those generally referred to as families and children. These members may be receiving a cash grant under the Temporary Assistance for Needy Families (TANF) program, formerly known as the Aid to Families with Dependent Children (AFDC), or may be members of TANF-related Medicaid funds.

EXCLUDED PARTICIPATION

Members in the aged, blind, and disabled categories of assistance, children with special health care needs accessing care from a Child Health Specialty Clinic (Title V provider), Native American Indians, Alaskan Natives, and any members who are also Medicare beneficiaries are excluded from participation in MHC. Additionally, members under the Medically Needy Program and those receiving Medicaid under foster care or subsidized adoption are not enrolled in MHC.

MEMBER ENROLLMENT/ASSIGNMENT

Members are encouraged to make their own selection of a Patient Manager. Patient Managers should feel free to discuss enrollment with their current Medicaid patients. New members are enrolled in MHC as they become eligible for Medicaid. Once Medicaid eligibility is approved, a computer-generated notice is sent to the member informing them that they must make a selection or be automatically assigned a MHC patient manager. Until members are enrolled in MHC they can access services from any provider enrolled with Iowa Medicaid without referral.

The member is instructed to select a MHC Patient manager who has contracted with DHS to be a Patient Manager. In counties where DHS has contracted with HMOs, the member may elect to enroll in an HMO as an alternative to MediPASS. If the member does not make a selection, he or she will be assigned to a MediPASS Patient Manager (or to an HMO if one is available in the member's county of residence). Once a member is enrolled with a MHC patient manager all covered medical care must be done by or through referral by that MHC patient manager.

PROVIDER SELECTION OF ENROLLEES

Patient Managers agree to accept all members who are enrolled with them, up to the maximum number that the Patient Manager designates. The Patient Manager may not discriminate on the basis of age, race, creed, color, national origin, sex, religion, political affiliation, physical or mental disability, or health status.

NOTICES SENT TO MEMBERS REGARDING MHC ENROLLMENT

A Notice of Decision (NOD) is sent to the member regarding the MHC enrollment process and the requirement to enroll. An informational brochure, an enrollment form, and a list of participating providers are included. The NOD indicates the tentative patient manager selection that the member will be assigned to if he or she does not select a patient manager by the date given in the letter. **Please Note:** These member NODs should not be used to verify a member's eligibility. Eligibility is established on a month-to-month basis. Eligibility may be verified by calling the Eligibility Verification System (ELVS) which is available 24-hours a day, seven days a week at 1-800-338-7752 or 515-323-9639.

ENROLLMENT FORMS

MHC enrollment forms are available in many provider offices and local offices of the Department of Human Services. Enrollments may be done by phone or enrollment forms may be mailed to the IME. The IME will provide enrollment forms to Patient Managers who wish to have patients complete enrollments in their office. Additional enrollment forms may be obtained by calling the IME Provider Services Line at 1-800-338-7909 or 515-256-4609, Monday through Friday between 7:30 A.M. and 4:30 P.M. or by writing to:

Iowa Medicaid Enterprise
P.O. Box 36450
Des Moines, IA 50315

MEMBER REQUESTS TO CHANGE ENROLLMENT

Members may change Patient Managers or switch between MediPASS and an HMO, if available, during their open enrollment period. Enrollment for eligible members is mandatory. If the member wishes to change patient manager, he or she must select another participating MHC provider.

To change patient managers, the member may mail an enrollment form as described above or call the IME Member Services Line at 1-800-338-8366 or locally at 515-256-4606. Changes in enrollment will take effect in two to six weeks. The effective date of the change is dependent upon when, during the month, the request for a change was received by the IME.

ENROLLMENT EFFECTIVE DATES

MHC enrollment and changes in enrollment are always effective on the first day of the month and neither is retroactive. Enrollments made after the middle of each month will not be effective the next month. Instead, the enrollment will become effective the following month. (e.g., if a MHC enrollment choice is received by July 19, the new choice will be effective for August. However, if the enrollment choice was received after July 19 the enrollment choice will be effective for September.

Members must obtain medical services from the patient manager listed on ELVS or by referral from that patient manager. Patient Managers are responsible to either provide services or issue referrals for treatment by another provider.

PATIENT MANAGER ENROLLMENT LIMITS

Each participating patient manager is allowed a maximum of 1500 enrollees under the MediPASS plan. For a Physician Assistant an additional 300 enrollees may be added to this

maximum enrollment. Exceptions to this limit may be granted under special circumstances at the discretion of DHS.

At the time the Agreement for Participation as a Patient Manager (470-2615) is signed, a provider can designate a lower maximum number of enrollees that they will accept; there is no minimum number of enrollees required. This limit can be changed with written notification.. Once a provider's enrollment limit is reached, the IME computer system will not allow further enrollments with that Patient Manager unless the patient manager's office notifies the IME Provider Services to approve additional enrollments.

The Patient Manager's medical service area consists of the county in which their practice is located and contiguous counties. A Patient Manager may serve members in his or her primary county and also may elect to serve members from contiguous counties. In order to enroll patients from contiguous counties, the counties must be added to the Patient Manager's agreement. Enrolling patients from outside the medical service area requires authorization from the MediPASS Patient Manager to Provider Services. Both provider and patient should be aware that, except for emergencies, the patient must access medical services from the Patient Manager and not from emergency rooms or other providers. DHS does not pay transportation costs if members choose a Patient Manager outside their county of residence.

MEDICAID CARD

Summary: Medicaid members, including those on Managed Health Care, receive an identification card from DHS when they first become eligible for Medicaid. In addition, HMOs may issue a separate card that indicates the member's HMO provider. Eligibility, managed care enrollment, lock-in status and other insurance information may be verified by calling the Eligibility Verification System (ELVS) at 1-800-338-7752 or 515-323-9639, or by visiting the web portal.

ISSUANCE OF THE MEDICAID CARD

The identification card is issued from the Central Office of the Department of Human Services. Members who indicate that they have not received their card should be instructed to call their Income Maintenance Worker at their county DHS office or to contact IME Member Services at 800-338-8699 or 515-256-4609.

Each individual member receives a card rather than one card listing all persons on the Medicaid case. Each member of the family may enroll with a different MediPASS provider or HMO (if available).

VERIFICATION OF ELIGIBILITY

If the member is enrolled in the Iowa Plan, mental health and substance abuse treatment must be accessed by calling the telephone number listed on the Medicaid card. MHC Patient Managers

are not responsible for issuing referrals for these services.

Eligibility may be verified by calling the Eligibility Verification System (ELVS) at 1-800-338-7752 or 515-323-9639. This computerized system is available 24-hours a day, seven days a week. ELVS uses either the member's Person ID number or both the date of birth and Social Security Number to access eligibility information. The web portal can also be used to verify eligibility and MHC enrollment.

A New Enrollment letter with a MHC tentative provider assignment, a Confirmation Letter, or MediPASS Patient Listing should never be used as verification of Medicaid eligibility.

REFERRAL PROCESS AND DOCUMENTATION

Summary: The Patient Manager's referral number is that provider's NPI provider number. Referrals for services may be given verbally and requires no special form. The Patient Manager decides the scope and duration of each referral. With the Patient Manager's approval, the referral number may be passed on to other providers. MediPASS referrals should be documented as completely as any other referral and in accordance with accepted medical practice.

Referrals between partners in the same clinic are assumed if, for example, the Patient Manager has a full schedule or is on vacation. The patient manager's referral number must still appear on the claim form. The provider designated by the Patient Manager to provide 24-hour coverage is authorized to make decisions on the Patient Manager's behalf and should use the Patient Manager's NPI number to issue referrals for services.

REFERRAL/REFERRAL PROCESS

Referrals for payment require no special referral forms under MediPASS. Referrals should be conducted according to accepted practice in the medical community. The Patient Manager's referral number is that provider's NPI provider number. This number must appear on CMS 1500 claim form in Item 17B or Locator 79 on the UB 04 claim form to allow a MediPASS member's claim to be paid.

When making a referral, Patient Managers must provide the specialist or other medical provider with the Patient Manager's NPI number to signify that the service is authorized. A referral indicates a Patient Manager's approval for another provider to receive payment for services and does not speak to quality or appropriateness of care delivered. All expectations, limitations, and restrictions that the provider is placing on the use of his or her number should be communicated with the referral (e.g., purposes, length of referral, involvement of other providers). At the Patient Manager's discretion, referrals may be made for a single visit or an extended period, such as the duration of an illness or a specific number of months.

With the Patient Manager's approval, the referral number may be relayed from one intermediate provider to another. For example, when a Patient Manager refers a patient to a specialist for testing and diagnosis of a particular condition, the specialist may order diagnostic tests as part of the evaluation of the patient. With the Patient Manager's approval, the specialist may in turn relay the referral number (e.g., radiologists, anesthesiologists, laboratories).

A referral by a provider on call or covering for a Patient Manager is considered to be the same as a referral by the Patient Manager. The covering provider should use the Patient Manager's referral number for such referrals. The covering provider does not have to be a MediPASS participating provider. He or she makes referrals and acts on the Patient Manager's behalf in referring services for MediPASS enrollees. Patient Managers should have procedures in place to ensure that referrals are documented.

Retroactive referrals are made at the discretion of the Patient Manager. Providers may contact the Patient Manager on behalf of a member to obtain referral for a service if referral was not obtained in advance. If the referral is granted, covered services may be reimbursed by Medicaid. If the referral is refused, no reimbursement will be made. If the patient persists in requesting service when the referral has been denied, then the provider from whom service is being requested is responsible for informing the member that the patient is in a private pay status. Members may not be billed for Medicaid covered services unless they are informed prior to receiving the service that they will be responsible for the bill.

Appropriate use of the Patient Manager's referral number is verified with the Patient Manager on a random basis (see Quality Assurance and Utilization Review). Unauthorized use of the number will result in action being taken by the Department of Human Services to recover unauthorized reimbursements from the billing provider.

DOCUMENTATION

The Patient Manager must document referrals in the patient's medical record. The extent and duration of referral should be included in this documentation. Documentation is essential when claims are audited. No special form is required for referrals, but the provider to whom the referral is given should also chart the referral. A percentage of paid claims for MediPASS enrollees are audited on a quarterly basis to detect and prevent misuse of a Patient Manager's provider number (see Quality Assurance and Utilization Review page 3).

ROUTINE, URGENT, AND EMERGENCY CARE

Medicaid members are educated on an ongoing basis regarding the proper way to seek medical services under MediPASS. The following guidelines are provided to members in written form, as well as to Medicaid providers via informational releases and provider manuals. The Patient Manager and office staff, assisted by staff at the IME, are encouraged to continually reinforce this information.

Routine Care is defined as care that can wait for a scheduled appointment. Routine care should be provided by the Patient Manager or authorized to an appropriate Medicaid provider by the

Patient Manager. The Patient Manager can refer routine care in an emergency room, but should only do so if the ER is the only feasible back-up provider after regular office hours or if there is any question about whether or not the care required can wait until a regularly scheduled appointment. MediPASS members who request and receive routine care without referral from their Patient Manager are responsible for paying the cost of such care only if properly notified by the provider rendering the service. Attending providers may contact the Patient Manager on behalf of the patient to obtain a referral, but the Patient Manager is in no way obligated to provide such referral.

Urgent medical condition is defined as care for a medical condition manifesting itself by acute symptoms that are of lesser severity (including pain) than that recognized for an emergent condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,
- Impairment to bodily functions, or
- Dysfunction of any bodily organ or part

If the member is assigned to a Patient Manager (e.g., MediPASS or HMO), the Patient Manager shall arrange for necessary care within 24 hours by either providing the care or issuing a referral to another appropriate provider for care.

Emergency Care is defined as care needed for an emergency medical condition. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Treatment in an emergency situation does not require a referral from the Patient Manager.

The Patient Manager referral number is not required on claims with an emergency diagnosis.

True medical emergencies are defined by the diagnosis codes available through the IME website at www.ime.state.ia.us. The provider of emergency services should contact the Patient Manager in a timely manner during regular business hours to advise the Patient Manager of the treatment that was rendered. **Follow-up treatment is to be provided by or through referral from the Patient Manager.**

24-HOUR ACCESS

The Patient Manager serves as the sole point of access into the health care system for MediPASS members. As part of the MediPASS agreement and to ensure compliance with federal regulations, Patient Managers are required to provide 24-hour access for their MediPASS members.

A single 24-hour access telephone number must be established by the Patient Manager for scheduling appointments, accessing information, and for use by members when the office is closed. Once a provider enrolls as a MediPASS Patient Manager, IME staff will verify the 24-hour access and work with the provider to ensure program requirements are met. DHS will have final approval of the 24-hour access system.

When the Patient Manager's office is closed, members must be able to call the 24-hour number to receive instructions on how to access non-emergent medical care. The Patient Manager (or qualified medical professional who is authorized to make decisions on behalf of the Patient Manager) must be available within 30 minutes to answer questions, give advice for non-emergent situations, or to refer for treatment.

On a random basis, staff at the IME will audit 24-hour access to ensure that the system is in place and functioning properly (see Quality Assurance and Utilization Review page 3).

INFORMATIONAL LINES AND GRIEVANCE PROCESS

Summary: The IME has established informational telephone lines for both members and providers to facilitate understanding of MediPASS and to assist in resolution of problems or grievances related to services provided under MediPASS, requests for enrollment choices, and changes in Patient Managers. The phone lines are staffed Monday through Friday 8:00 A.M. to 5:00 P.M. for members, and Monday through Friday 7:30 A.M. to 4:30 P.M. for providers, except for holidays. The Eligibility Verification System (ELVS) is a 24-hour number that can be used to verify eligibility and to obtain the MHC provider's name and phone number if the patient is in the MHC program.

- ELVS: 1-800-338-7752 or 515-323-9639
- IME Member Services 1-800-338-8366 or 515-256-4606
- IME Provider Services 1-800-338-7909 or 515-256-4609

ELIGIBILITY VERIFICATION TOOLS

The Eligibility Verification System (ELVS) is available 24-hours a day seven days a week to assist providers. ELVS will verify eligibility for current dates of services and for any date of service in the past 24 months. In addition, ELVS will provide information on primary insurance, applicable MHC provider and 24-hour phone number, and member enrollment in the Iowa Plan.

To access eligibility information, providers enter their Medicaid provider number, the member's Person ID number, and the date of service. If the Person ID number is not available, the system will relay the Person ID number when both the date of birth and Social Security Number of the

member are entered.

Providers can also use the IME Web portal to verify eligibility online. Registration is done through EDISS.

USES OF THE IME MEMBER LINE

Medicaid members utilize IME Member Services to make MHC enrollment choices, changes, and to request general information about the MHC program. They also use this line to express complaints or file grievances and to receive assistance with patient-provider communications. The Member Services is not intended to circumvent or interfere with the provider's decisions about medical practice regarding MediPASS patients or any other patients. (A brief description of the grievance process follows.) The Member Services is staffed Monday through Friday from 8:00 A.M. to 5:00 P.M. except holidays.

GRIEVANCE PROCESS

A formal written grievance that relates to any service covered under the MediPASS plan can be filed by a MediPASS member or a provider of service under MediPASS. IME staff participates in working with providers and members on resolution. An informal grievance may be initiated by a provider or a member through a telephone call.

The facts of the grievance are determined and recorded by asking questions of the complainant, contacting the other party or parties as appropriate and, if warranted, by conducting on-site visits and interviews. Based on the review of all available facts, a determination will be made as to the course of action necessary to respond to the grievance. Such determinations may include, but are not limited to, clarification of MediPASS policy to parties who have not acted in accordance with policy, advising members of methods for changing providers, and advising providers of procedures for disenrolling members.

Documentation is prepared on all grievances. When a formal grievance is filed, a written response is sent to the complainant and a copy is sent to the other involved parties. The complainant is advised in the letter about appeal rights through DHS. A written response is sent within fifteen (15) days of receipt of the complaint unless extraordinary circumstances dictate a longer time frame.

USES OF THE IME PROVIDER LINE

Medicaid providers, including participating MediPASS providers, utilize IME Provider Services to obtain assistance in identifying the member's correct MHC provider, clarification of program requirements and covered services, and other MHC questions.

Providers may also contact staff at this number to discuss patient-provider problems or grievances. If a provider is calling about a specific member, the member's State ID number must be available.

IME Provider Services is intended to improve provider access to information about the MHC program. To maintain immediate access for MHC providers, this number should not be given to members. IME Provider Services is staffed Monday through Friday 7:30 A.M. to 4:30 P.M. except state holidays.

Inquiries about billing, claims, or Medicaid covered services may also be obtained through this line. A list of telephone numbers follows.

ELIGIBILITY VERIFICATION SYSTEM (ELVS)

Eligibility Verification System (ELVS): 24-Hour Access

1-800-338-7752 (Toll Free)
1-515-323-9639 (Local)

IME PROVIDER SERVICES NUMBERS

Monday through Friday from 7:30 A.M. to 4:30 P.M.

IME Provider Line: 1-800-338-7909
1-515-256-4609 (Local)

IME MEMBER SERVICES NUMBERS

Monday through Friday from 8:00 A.M. to 5:00 PM

Member Line: 1-800-338-8366
1-515-256-4606 (Local)

DIENROLLMENT OF A MEMBER BY A MediPASS PROVIDER

Summary: Despite the best efforts of those involved, there are times when a satisfactory provider-patient relationship cannot be established or maintained. A mechanism is in place for patient managers to disenroll members in these situations. Disenrollment must be made only for good cause as determined by DHS and may not constitute a practice of discrimination. A Request for Disenrollment form 470-2169, available at www.ime.state.ia.us, must be completed and submitted along with the necessary documentation to IME Provider Services. The member will be given an opportunity to respond to the request for disenrollment before final determination.

DIENROLLMENT OF A MediPASS MEMBER

At times, a difficult or non-compliant patient may be enrolled with a MediPASS patient manager. At the manager's request, the staff at the IME will assist the manager in an attempt to educate the member and change inappropriate behavior. A referral may also be made to the Recipient Health Education Program (RHEP). These educational efforts may create positive changes rather than simply transferring the problem from one patient manager to another.

GOOD CAUSE FOR DIENROLLMENT OF A MEMBER

A member may only be disenrolled for good cause. Examples of good cause for disenrollment include but are not limited to: failure on the part of the patient to follow treatment plans, repeated failure to keep appointments, abusive behavior toward providers or office staff, drug-seeking behavior, seeking unauthorized care from others, and noncompliance with the medical plan of treatment.

Disenrollments must be based on behavioral issues and not monetary issues. Disenrollment of a member may not be based on discriminatory practices. Medicaid providers may not discriminate against Medicaid members on the basis of age, race, creed, color, national origin, sex, religion, political affiliation, physical or mental disability or health status. DHS makes the final determination of the criteria that constitute good cause.

DIENROLLMENT PROCESS

Request for Disenrollment, forms 470-2169 are available from the IME at www.ime.state.ia.us. The form is completed by the Patient Manager and forwarded to the IME. IME staff will process the request as quickly as possible, consulting with DHS when necessary.

The member is notified of the Patient Manager's request to disenroll and given five days to respond. If the member does not respond, processing of the disenrollment continues. If the member does respond, IME staff will work with the patient manager and the member in an attempt to reach a resolution.

The Patient Manager must continue to treat the member or issue a referral to another provider until the disenrollment becomes effective. Processing the disenrollment request may take from 30 to 45 days. A change in patient managers is effective only when ELVS reflects the change.

REPORTS PROVIDED TO MediPASS PROVIDERS

Summary: Informational reports are provided as tools for MediPASS Patient Managers to use in coordinating and monitoring the medical care of their MediPASS patients. A list of MediPASS enrollees is sent monthly. Patient Manager utilization rates and utilization exception reports are provided quarterly. The reports are provided for educational and informational purposes.

MONTHLY PATIENT LISTING

The Patient Listing is sent to each participating MediPASS patient manager at the beginning of each month listing the Medicaid members who are enrolled with the manager. It lists enrollees who are currently enrolled with the Patient Manager (indicated by a C next to their name), enrollees who are new to the Patient Manager as of that month (N), and enrollees who are either potential enrollees or previous enrollees (P). Potential enrollees are those who are currently in a non-eligible status in Medicaid but who could be reinstated during the month. If a member is reinstated, his or her enrollment with the Patient Manager is also reinstated. Previous enrollees are those who were enrolled with the Patient Manager the previous month but are not for the current month.

The \$2.00 administrative payment is made for members who show as a C or an N. Payment will also be made for members with a status of a P that have been reinstated during the month. The administrative payment is made at the end of the month following the month of the Patient Listing. A member who was disenrolled will show on the Patient Listing as a P in the month following the disenrollment.

A cover letter accompanies the monthly Patient Listing. The final page of the report is a summary sheet and shows the total number of N, C, and P MediPASS enrollees for the month. It also indicates the total number of patients enrolled with the Patient Manager.

MediPASS PATIENT UTILIZATION REPORT

This report identifies the average units of service and average dollars expended per enrollee served for each Patient Manager. For purpose of comparison, MediPASS utilization averages from each of the primary care practice specialties are listed as well as a statewide average.

QUARTERLY MEMBER UTILIZATION EXCEPTION REPORT

A MediPASS Patient Manager **may** also receive the Quarterly Member Utilization Exception Report. This report is sent to Patient Managers for each enrollee who has demonstrated utilization of medical services that are well outside established parameters (usually + or - [2] standard deviations) in any of the measured services. This report is for the Patient Manager's use in identifying patients with possible utilization problems and is to be used as an educational tool at the Patient Manager's discretion.

This report also includes **Pharmacy** and **Chiropractic** services, which **do not** require Patient Manager referral. These services are included to assist the Patient Manager in monitoring the overall care that members are receiving.

EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

The U.S. Department of Health and Human Services requires that the Medicaid program place special emphasis on early and periodic screening, diagnosis and treatment (EPSDT) for children to ascertain physical and mental problems and provide treatment for conditions discovered. In Iowa, this program is called Care for Kids. For children under 21 years of age, payment will be approved for early and periodic Care for Kids examinations. This includes all well-baby and routine physical examinations for children, as well as immunization updates. When a child is due for a Care for Kids screening examination, the Department of Public Health issues a reminder. The child's parent or guardian makes the appointment for the screening.

An EPSDT Care for Kids screening includes:

- * Unclothed physical exam
- * Vision screening
- * Comprehensive history
- * Hearing screening
- * Review of immunization status
- * Dental referrals for patients 1 year of age and older
- * Appropriate lab tests
- * Health education, including anticipatory guidance

RECOMMENDED CHILDHOOD SCREENING SCHEDULE

The recommended screening schedule is as follows:

Child=s Age	Number of Recommended Screenings	Recommended Ages for Screening
0-12 months	7	*2-3 days, by 1,2,4,6,9, and 12 months
13 months to 24 months	3	15,18, and 24 months
3 years to 6 years	4	3,4,5, and 6 years
7 years to 20 years	7	8,10,12,14,16,18, and 20 years

* For newborns discharged 24 hours or less after delivery.

Patient Managers must make every reasonable effort to provide or approve appropriate referrals for eligible patients needing EPSDT services identified through the screening.

We have attached a number of EPSDT screening forms to provide you with an easy-to-follow format of the frequency and content of EPSDT visits. Please include a copy of these forms as part of your patient=s chart and use it at the time of the screening examination.

EPSDT SCREENING: INFANCY							
Check when completed	2-3 days	By 1 month	2 months	4 months	6 months	9 months	12 months
History							
Unclothed Physical exam							
Height & weight							
Head circumference							
Blood Pressure							
Nutrition Assessment/education							
Oral Health Assessment							
Dental referral							
Vision Assessment	s	s	s	s	s	s	s
Hearing Assessment	o	s	s	s	s	s	s
Development/Behavior Assessment							
Immunization Review							
Immunizations Scheduled							
Anticipatory Guidance							

s= subjective, by history o= objective, by a standard testing method
 = not indicated at this age

- Hemoglobin/Hematocrit**....once during each stage of childhood
- Urinalysis**.....once during each stage of childhood (excluding infancy)
- Metabolic screening**.....newborn period; later if indicated
- Hemoglobinopathy**.....newborn period; at puberty for children born before 1987, or as indicated
- Tuberculin test**..... recommended for children from high risk groups
- Lead**.....assess children at 6 months; blood lead level at 6 month for high-risk children; other children at 12 months
- Gynecologic testing**.....as indicated
- STD=s**.....test for Chlamydia and gonorrhea as indicated

The information included in this checklist follows the American Academy of Pediatrics guidelines. Since the AAP guidelines are constantly under review. Health Care Professionals should be aware that the information included in these chart is subject to change.

EPSDT SCREENING: EARLY CHILDHOOD					
Check when completed	15 months	18 months	2 years	3 years	4 years
History					
Unclothed Physical exam					
Height & weight					
Head circumference					
Blood Pressure					
Nutrition Assessment/education					
Oral Health Assessment					
Dental referral					
Vision Assessment	s	s	s	s	o
Hearing Assessment	o	s	s	s	o
Development/Behavior Assessment					
Immunization Review					
Immunizations Scheduled					
Anticipatory Guidance					

s= subjective, by history
 = not indicated at this age

o= objective, by a standard testing method

EPSDT SCREENING: MIDDLE CHILDHOOD					
Check when completed	5 years	6 years	8 years	10 years	12 years
History					
Unclothed Physical exam					
Height & weight					
Head circumference					
Blood Pressure					
Nutrition Assessment/education					
Oral Health Assessment					
Dental referral				*	*
Vision Assessment	o	o	o	s	s
Hearing Assessment	o	s	s	s	o
Development/Behavior Assessment					
Immunization Review					
Immunizations Scheduled					
Anticipatory Guidance					

s= subjective, by history
 = not indicated at this age

o= objective, by a standard testing method
 *= every six months

EPSDT SCREENING: ADOLESCENCE				
Check when completed	14 years	16 years	18 years	20 + years
History				
Unclothed Physical exam				
Height & weight				
Head circumference				
Blood Pressure				
Nutrition Assessment/education				
Oral Health Assessment				
Dental referral	*	*	*	*
Vision Assessment	o	s	o	o
Hearing Assessment	s	s	o	s
Development/Behavior Assessment				
Immunization Review				
Immunizations Scheduled				
Anticipatory Guidance				

s= subjective, by history
 = not indicated at this age

o= objective, by a standard testing method
*****= every six months