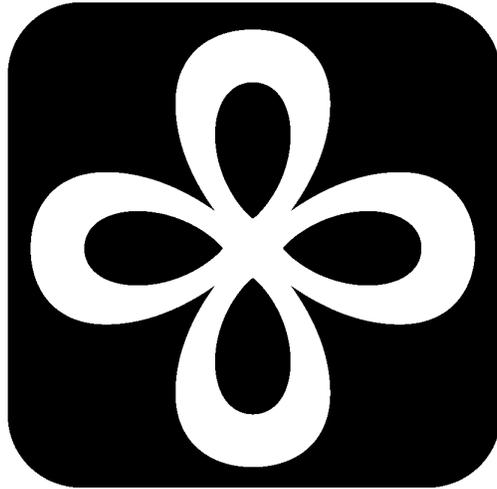


**STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES**

MEDICAID



Provider Manual
MR/CMI/DD Case Management



CHAPTER E. COVERAGE AND LIMITATIONS

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Iowa
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CHAPTER SUBJECT:

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I. ORGANIZATIONS ELIGIBLE TO PARTICIPATE

Case management provider organizations are eligible to participate in the Medicaid program provided that:

- ◆ They meet the standards in 441 IAC Chapter 24:
 - Division I, “Core Standards for All Providers on MH/MR/DD Services” and
 - Division II, “Standards for Individual Case Management Services,” **and**
- ◆ They are:
 - A county or consortium of counties,
 - The Department of Human Services, or
 - An agency or provider under subcontract to a county or consortium of counties or to the Department.

II. COVERAGE OF CASE MANAGEMENT SERVICES

Case management is a service provided by human service agencies to manage multiple resources effectively for the benefit of Medicaid clients. Case management services assist recipients in gaining access to appropriate and needed medical and interrelated social and educational services. The goal of case management is to ensure that:

- ◆ Necessary evaluations are conducted.
- ◆ Individual services and treatment plans are developed, implemented, monitored, and modified as necessary.
- ◆ Reassessment of client needs and service provision occurs on an ongoing and regular basis (but no less frequently than annually).

The Iowa Legislature has appropriated special funds for partial hospitalization, day treatment, and case management provided to persons with a primary diagnosis of mental retardation, chronic mental illness, or developmental disability.



To ensure proper allocation of funds, the Department must receive a report on each Medicaid recipient receiving one of these services who falls in one of the above three diagnostic categories. This includes information as to the diagnostic category applicable to the client and information concerning the client's legal settlement. (See Chapter F, Section I.)

A. Eligible Recipients

Payment will be approved for case management services to:

- ◆ Medicaid recipients who are 18 years of age or over and have a primary diagnosis of:
 - Mental retardation,
 - Developmental disabilities, or
 - Chronic mental illness.
- ◆ Medicaid recipients under 18 years of age receiving HCBS/MR waiver services.
- ◆ Medicaid recipients under 18 years of age with a primary diagnosis of mental retardation or developmental disabilities who reside in a child welfare decategorization county when the following conditions are met:
 - The county has entered into an agreement with the Department of Human Services certifying that the state match for case management is available within funds allocated for the purpose of decategorization.
 - The county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation, and developmental disabilities services fund administered by the Department.
 - The county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.
 - The person has been authorized for MR/CMI/DD case management in accordance with rule 441 Iowa Administrative Code 90.3(249A). (See section 4, below.)



Residents of ICF/MRs are **not** eligible to receive case management services, except for qualified discharge planning activities provided within 30 days of discharge.

Definitions for the three categories of primary diagnosis follow.

1. **Mental Retardation**

“Person with mental retardation” means a person who meets the following three conditions:

- ◆ The person has significantly subaverage intellectual functioning, meaning an intelligence quotient (IQ) of approximately 70 or below on an individually administered IQ test, or for an infant, a clinical judgment of significantly subaverage intellectual functioning.
- ◆ The person has concurrent deficits or impairments in present adaptive functioning, that is, the person’s effectiveness in meeting the standards expected for the person’s age and cultural group. The person must have a deficit or impairment in at least two of the following areas:
 - Communication
 - Self care
 - Home living
 - Social and interpersonal skills
 - Use of community resources
 - Self-direction
 - Functional academic skills
 - Work
 - Leisure
 - Health
 - Safety
- ◆ The onset of this condition is before age 18.



These criteria are from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM IV), 1994 revision, American Psychiatric Association.

2. Chronic Mental Illness

A person with chronic mental illness means a person who is 18 years of age or over and has a persistent mental or emotional disorder that seriously impairs the person's functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

Such persons typically meet at least one of the following criteria:

- ◆ They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime.
- ◆ They have experienced at least one episode of continuous, structured, supportive residential care other than hospitalization.

Additionally, these persons typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

- ◆ They are unemployed, are employed in a sheltered setting, or have markedly limited skills and a poor work history.
- ◆ They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- ◆ They show severe inability to establish or maintain a personal social support system.
- ◆ They require help in basic living skills.
- ◆ They exhibit inappropriate social behavior which results in demand for intervention by the mental health or judicial system.



In atypical instances, a person may vary from the above criteria and could still be considered a person with chronic mental illness. Persons with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

This definition is adapted from the National Institute of Mental Health's *Definition and Guiding Principles for Community Support Systems*, revised May 1983.

3. **Developmental Disabilities**

A person with developmental disabilities means a person with a severe, chronic disability which:

- ◆ Is attributable to mental or physical impairment, or a combination of mental and physical impairment.
- ◆ Is manifested before the person attains the age of 22.
- ◆ Is likely to continue indefinitely.
- ◆ Results in substantial functional limitation in three or more of the following areas of life activities:
 - Self care
 - Receptive and expressive language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living
 - Economic self-sufficiency
- ◆ Reflects the person's need for a combination and sequence of services which are of lifelong or extended duration.



4. Need for Service

The Department shall determine the initial and ongoing need for service based on evidence presented by the provider, including diagnostic reports, documentation of provision of services, and information supplied by the consumer and other appropriate sources. The evidence shall demonstrate that all of the following criteria are met:

- ◆ The consumer has a need for MR/CMI/DD case management to manage multiple resources pertaining to medical and interrelated social and education services for the benefit of the consumer.
- ◆ The consumer has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.
- ◆ The consumer is not receiving other paid benefits under the Medicaid program or under a Medicaid managed health care plan that serve the same purpose as MR/CMI/DD case management.

Medicaid rules at 441 IAC 90.3(1) require that case managers must request authorization for case management services for Medicaid-enrolled consumers to verify their need for case management. This process will assist the DHS Division of Results-Based Accountability in conducting quality assurance reviews of eligibility for Medicaid case management.

Case managers must complete form 470-3956, *MR/CMI/DD Service Authorization*, at the time of the initial assessment and at the annual review. This form serves as a means for authorizing MR/CMI/DD case management for the length of the proposed annual plan. See Chapter F, section II, for instructions.



B. Covered Services

Payment will be approved on a monthly, per enrollee basis for case management functions required in 441 Iowa Administrative Code Chapter 24, including:

- ◆ Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements.
- ◆ Assurance that a service plan is developed which addresses consumer's total needs for services and living arrangements.
- ◆ Assistance to the consumer in obtaining the services and living arrangements identified in the service plan.
- ◆ Coordination and facilitation of decision-making among providers to ensure consistency in the implementation of the service plan.
- ◆ Monitoring of the services and living arrangements to ensure their continued appropriateness for the consumer.
- ◆ Crisis assistance to facilitate referral to the appropriate providers for resolution.

Payment will be made for discharge planning activities for institutionalized persons:

- ◆ For a period not to exceed 30 days before the date of discharge.
- ◆ For discharge activities of the case manager which do not duplicate the discharge planning activities of the institution.

Case management services are the responsibility of a specific case manager whose primary responsibility to the client is case management. Case management is provided for an indefinite period of time and at a level of intensity determined by the individual client's needs. However, face-to-face contact with the client must occur no less often than quarterly.

At a minimum, contact with or on behalf of a client must occur once each month to support the monthly payment. This may include activities such as telephone calls to a provider or to the client's legal representative, visits by the case manager to a service provider, or conferences with members of the interdisciplinary team.



III. BASIS OF PAYMENT FOR SERVICES

The basis of payment for case management services is a monthly payment per enrollee. The monthly payment is established on the basis of cost information submitted to the Medicaid fiscal agent, and is an average cost per recipient.

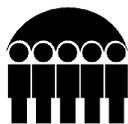
Providers are required to submit a projected cost report by July 1 of each year. This form is used to establish a projected rate for the new fiscal year, thus, avoiding underpayment or overpayment. A cost report showing actual costs shall be submitted 90 days after each state fiscal year end. Providers may contact the fiscal agent for a copy of the cost report form and instructions for completion.

State and local government entities that enroll in the Medicaid program as case management providers must establish their rates in accordance with the cost principles contained in the Office of Management and Budget Circular No. A-87, "Cost Principles for State and Local Governments."

IV. PROCEDURE CODES AND NOMENCLATURE

Payment will begin for case management services rendered in the first full month in which the provider meets the conditions of participation. Providers shall submit one billing per recipient served per month at the end of each month of service.

<u>Code</u>	<u>Description</u>
W0578	Case management, one unit of service per recipient served per calendar month
W0574	Case management, one unit of service per child in the waiver program served per calendar month
W0579	Case management, one unit of service per recipient served per calendar month, special circumstances (CMI)



I. ENHANCED SERVICES REPORTING AND INSTRUCTIONS

To ensure that funds are properly allocated, case management providers shall report certain information to the Department of Human Services. Providers shall submit this report on form 470-2464, *Report for Enhanced Services*. This report contains information concerning the diagnostic category into which the recipient falls, and the recipient's county of legal settlement.

A. Instructions for Completing Report for Enhanced Services

Form 470-2464 shall be completed when a Medicaid recipient in one of the three diagnostic categories is accepted for case management services. Definitions for the three categories of primary diagnosis are provided in Chapter E, **II. COVERAGE OF CASE MANAGEMENT SERVICES**.

Section A of this form is completed by the provider of services.

Enter the name and number of the recipient's county of legal settlement or "00" when the state is responsible for funding services. Maintain verification of legal settlement or state case verification.

Enter the date on which the county assumed financial responsibility for the recipient for whom the form is being submitted. This may be the date services were initiated by the provider. Enter a check in the box preceding the primary diagnosis and in the box preceding the service. Providers should retain the yellow copy of the completed form for their records.

Forward the original of the completed form to the local Department office.

Section B of the form is completed by the Department of Human Services.

B. Facsimile of Form 470-2464, Report for Enhanced Services

See the following page for a facsimile of form 470-2464, *Report for Enhanced Services*.

Iowa Department of Human Services

REPORT FOR ENHANCED SERVICES**Section A.** Completed by provider.

Recipient Name (Last, First, M.I.)		Birth Date		State I.D. Number	
Street		City		State	Zip Code
County of Legal Settlement (name and number)			Date Legal Responsibility Was Assumed		
Primary Diagnosis <input type="checkbox"/> Mental Retardation (M) <input type="checkbox"/> Chronic Mental Illness (I) <input type="checkbox"/> Developmental Disability (S)					
Provider Name		Provider Number		Telephone Number	
Street		City		State	Zip Code
Service <input type="checkbox"/> Case Management <input type="checkbox"/> Day Treatment <input type="checkbox"/> Partial Hospitalization					
Director or Designee Signature					

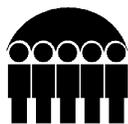
Section B. Completed by Department of Human Services.

Date Received	Date Entered	Signature
---------------	--------------	-----------

470-2464 (4/90)

Copy 1: Local Department of Human Services Office

Copy 2: Provider



C. General Information Regarding Legal Settlement

“**Legal Settlement**” is a status defined in Iowa law as acquired by a person when a specific county is identified as having a financial responsibility for that person.

“**Residence**” is defined as where the person is currently living. The courts have interpreted residence very broadly. Residence can be established without regard to length of time. Example:

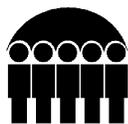
Ms. A arrives in Des Moines today from another state, rents an apartment, and moves in. As of today, she is a resident of the city of Des Moines, the county of Polk, and the state of Iowa. Residence does not require living in Des Moines for any specific reason.

The question of intent is frequently raised. The only intent required is, “This is where I intend to live for now.” A person can be a resident of Des Moines today and Omaha tomorrow. Some interpretations state that a person may have more than one residence simultaneously.

“**Continuously**” means a person has maintained a residence in the same county without interruption. It does not necessarily mean never being absent from the county. The Department currently defines a period of hospitalization in a state institution as an interruption in the continuous period. When the continuous period is interrupted, the period starts again from the beginning when the person returns to reside in the county.

Example:

Mr. J has legal settlement in County X, but six months ago moved and established residence in County Y. Mr. J is hospitalized at a MHI and discharged five months later. Under this definition, Mr. J does not acquire legal settlement in County Y until one continuous year after his discharge from the MHI, provided there are no further hospitalizations or services received.



“**Durational residency**” is having residence in a particular place for a specific length of time. Legal settlement is a durational residency because it requires continuous residency within the county for a one-year period of time.

“**State case**” is a phrase used to identify the condition where a person has no county of legal settlement. This condition does not automatically create a state financial responsibility.

“**Institution**” has been defined by the Iowa Supreme Court as “an established society or corporation, which may be private in character and designed for profit, or it may be public and charitable in purpose.” As a rule of thumb, this means any entity licensed as a health care facility under Iowa Code Chapter 135C, or approved by the Department of Human Services, i.e., community supervised living arrangement.

1. **Legal Settlement Determination**

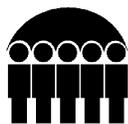
Counties determine whether a person has legal settlement and is, therefore, the financial responsibility of that county.

The basic Code provision for determining legal settlement is Iowa Code section 252.16(1), which states: “A person continuously residing in a county in this state for a period of one year acquires a settlement in that county except as provided in subsection 7 or 8.”

The only other way for an adult to acquire legal settlement is at the time a minor achieves majority (legally becomes an adult). Upon achieving majority, persons acquire, as their own legal settlement, the legal settlement of their parents or legal guardian.

Basically, a minor child takes the legal settlement of the parent or a court-appointed legal guardian. When a child’s parents are not residing together, the child takes the legal settlement of the custodial parent.

A blind person acquires legal settlement after only six months of continuous residence in a county.



Iowa Code section 252.16(6) states: “Subsections 1, 2, 3, and 7 do not apply to a blind person who is receiving assistance under the laws of this state. A blind person receiving assistance who has resided in one county of this state for a period of six months acquires legal settlement for support as provided in this Chapter.”

Military personnel receive special attention on establishing or losing legal settlement. Iowa Code section 252.16(5) states:

“A person with settlement in this state who becomes a member on active duty of an armed services of the United States retains the settlement during the period of active duty. A person without settlement in this state who is a member on active duty of an armed service of the United States within the borders of this state does not acquire legal settlement during the period of active duty.”

A person who is living in or is being supported by an institution cannot acquire or change legal settlement.

2. Host County

The 1987 Legislature added a new paragraph (8) to Iowa Code section 252.16, effective July 1, 1987, which states:

“A person receiving treatment or support services from any community-based provider of treatment or services for mental retardation, developmental disabilities, mental health, or substance abuse does not acquire legal settlement in the host county unless the person continuously resides in the host county for one year from the date of the last treatment or support services received by the person.”

To change legal settlement from one county to another, an adult has to follow the same process for originally acquiring legal settlement. The person has to continuously reside in the new county for one year.



A person does not lose legal settlement in the original county until legal settlement is acquired in a new county. A person with legal settlement in a county may live outside that county for years and still retain legal settlement in that county by never leaving the state and never living in another county for one continuous year.

II. SERVICE AUTHORIZATION REQUEST AND INSTRUCTIONS

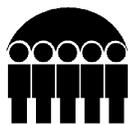
Case managers must request authorization for case management services for Medicaid-enrolled consumers. Complete form 470-3956, *MR/CMI/DD Case Management Service Authorization Request*, at the time of the initial assessment and at the annual review. This form serves as a means for authorizing MR/CMI/DD case management for the length of the proposed annual plan.

Submit forms for Medicaid consumers who have a primary diagnosis of CMI and are enrolled in the Iowa Plan to MBC of Iowa. Submit forms for all other consumers to the DHS Division of Results-Based Accountability

This process will assist the DHS Division of Results-Based Accountability in conducting quality assurance reviews of eligibility for Medicaid case management.

DHS will use the current certification process as a part of a retrospective review process to ensure that information submitted through the authorization process is accurate and is reflected in the record.

MBC of Iowa staff will use this form as part of the prior authorization process for recipients enrolled in the Iowa Plan. MBC will ensure the need for case management, as set forth in rules, using this form, individual information available to MBC and, in certain cases, additional information from the case manager.



A. Instructions for Completing Request

Case managers shall complete form 470-3956, *MR/CMI/DD Case Management Service Authorization Request*, for ongoing and new consumers within ten working days of the consumer's annual review. See specific instructions in the following sections. Be sure that all information is documented in the consumer's file.

For new consumers under the Iowa Plan, you are encouraged to call MBC's TCM Service Desk at 515-223-0306 or 800-638-8820 to gather more information to assist in making a full assessment.

After completing the form, check "Yes" or "No" to the certification statement. On the signature line, type the name of the person verifying that the information is true and accurate. After making a copy for the file, have the person verifying initial or sign under the typed name.

Submit the form by e-mail, as follows:

- ◆ For consumers with a primary diagnosis of MR, CMI, or DD who are funded through fee-for-service Medicaid, e-mail the form to tcmauth@dhs.state.ia.us. The internal e-mail address within DHS is tcmauth.
- ◆ For consumers with a primary diagnosis of CMI funded through the Iowa Plan, e-mail the form to: (iowaplantcm@magellanhealth.com)

1. Individual/Case Manager Identification

In the identification section of the form, enter:

- ◆ The name of the case manager submitting form.
- ◆ The name of the consumer who will receive case management services.
- ◆ The case manager's e-mail address.
- ◆ The consumer's Medicaid state identification number.
- ◆ The phone number of case manager submitting form.



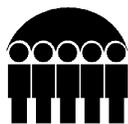
- ◆ The name of the county in which the consumer has legal settlement.
- ◆ The case management agency provider number.
- ◆ The consumer’s date of birth, using the format MM/DD/YY.
- ◆ The name of the person in the agency who should be contacted regarding authorization decisions.
- ◆ The e-mail address of the contact person.
- ◆ The months of authorization requested, using the format (beginning date) MM/YY to (end date) MM/YY.
- ◆ The date the case manager completed and submitted the form, using the format MM/DD/YY.

2. Primary Disability

Check one box to indicate the consumer’s primary disability (MR, DD or CMI). For consumers whose primary diagnosis is CMI, enter the applicable primary psychiatric diagnosis using DSM coding.

Common Diagnoses Associated With Chronic Mental Illness

- 295.10 Schizophrenia, disorganized type
- 295.20 Schizophrenia, catatonic type
- 295.30 Schizophrenia, paranoid type
- 295.60 Schizophrenia, residual type
- 295.70 Schizoaffective disorder
- 295.90 Schizophrenia undifferentiated type
- 296.30 Major depression, recurrent, unspecified
- 296.31 Major depression, recurrent, mild
- 296.32 Major depression, recurrent, moderate
- 296.33 Major depression, recurrent, severe without psychosis
- 296.34 Major depression, recurrent with psychosis
- 296.35 Major depression, recurrent, partial remission
- 296.36 Major depression, recurrent, full remission
- 296.40 Bipolar I disorder, manic, hypomanic



Common Diagnoses Associated With Chronic Mental Illness

- 296.41 Bipolar I disorder, manic, mild
- 296.42 Bipolar I disorder, manic, moderate
- 296.43 Bipolar I disorder, manic, severe without psychosis
- 296.44 Bipolar I disorder, manic, with psychosis
- 296.45 Bipolar I disorder, manic, partial remission
- 296.46 Bipolar I disorder, manic, full remission
- 296.50 Bipolar I disorder, depressed, unspecified
- 296.51 Bipolar I disorder, depressed, mild
- 296.52 Bipolar I disorder, depressed, moderate
- 296.53 Bipolar I disorder, depressed, severe without psychosis
- 296.54 Bipolar I disorder, depressed, with psychosis
- 296.60 Bipolar I disorder, mixed, unspecified
- 296.61 Bipolar I disorder, mixed, mild
- 296.62 Bipolar I disorder, mixed, moderate
- 296.63 Bipolar I disorder, mixed, severe without psychosis
- 296.64 Bipolar I disorder, mixed, severe with psychotic features
- 296.65 Bipolar I disorder, mixed, partial remission
- 296.70 Bipolar I disorder, unspecified
- 296.80 Bipolar disorder NOS
- 296.89 Bipolar II disorder
- 300.21 Panic disorder with agoraphobia
- 300.22 Agoraphobia without history of panic disorder
- 300.30 Obsessive compulsive disorder
- 300.40 Dysthymic disorder
- 301.22 Schizotypal personality disorder
- 301.40 Obsessive-compulsive personality disorder
- 301.82 Avoidant personality disorder
- 301.83 Borderline personality disorder

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Consult the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) for diagnoses not listed. You can also call the MBC of Iowa TCM Service Desk for assistance at 515-223-0306 or 800-638-8820.



Enter the date of documentation by a qualified professional verifying disability.

- ◆ For consumers with a diagnosis of CMI, use the most recent psychiatric diagnosis from an evaluation or report from qualified professional.
- ◆ For consumers with a diagnosis of MR, use HCBS guidelines.
- ◆ For consumers with a diagnosis of DD, use the DD checklist, with back-up documentation from the physician.

Enter the date of most the recent social history or update: Use the format: MM/DD/YY.

Enter the date of initial assessment or annual review. Use the format: MM/DD/YY. You may contact MBC of Iowa to gather information to develop the assessment for consumers with CMI, if needed.

3. Documentation of Need for Case Management Services

Check all that apply. Guidance for the options is as follows.

- ◆ There is a need for case management to manage multiple resources pertaining to medical and interrelated social and educational services for the benefit of the person served. Case management communication is required to manage the services and natural supports for the following:
 - The person is in the HCBS/MR or BI waiver program. (If this item is checked, you must list the person's functional limitations below.)
 - The person needs or receives help with schooling, vocational support, or day program. (Examples: adult day care, day program skill development, day program for skills training workshop, supported employment)
 - The person needs or receives respite.
 - The person needs or receives health services. (Examples: outpatient services, interim medical monitoring and treatment, in-home health related care, nursing)



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- The person needs or receives assistance in daily living skills. (Use the drop-down box to check **all** of the services that apply: supported community living, payee, meals on wheels, homemaker services, transportation)
- The person needs support or coordination to engage or maintain mental health treatment: (Examples: outpatient services, community support services, day treatment services, day program skill development, day program skills training, in-home health related care, employment related services)
- The person needs/receives assistance in Medication management.
- The person needs or receives assistance in housing. (Examples: residential care facility/MR, residential care facility/persistent mental illness, supported community living, homeless and Section 8 applications)
- The person needs or receives assistance to access and maintain eligibility and services, including assistance with applications for services benefits and funding.
- ◆ The person has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.
 - The assessment demonstrates the person's functional limitations that impair daily life. (Examples: The disorder prevents the consumer from daily work; or the disorder has prevented the consumer from learning community living skills.)
 - Documentation, including social history, assessment, and narrative information, of a lack of ability to independently access services. (Examples: The disorder prevents the consumer from making appropriate contact; or the disorder prevents the consumer from making and keeping appointments.)



Iowa
Department
of
Human
Services

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- Documentation, including social history, assessment and narrative information, of a lack of ability to sustain necessary services.
(Examples: The disorder prevents the consumer from making and keeping appointments; or the disorder prevents the consumer from following through with the service provider.)
- ◆ This person is receiving the following Medicaid benefits that serve the same purpose as case management at this time, such as:
 - The person resides in a medical institution (hospital, mental health institute, nursing facility) with no plan to discharge within 30 days.
 - The person is currently served in an approved assertive community treatment program and therefore is not eligible for case management.

B. Facsimile of Form 470-3956, MR/CMI/DD Case Management Service Authorization Request

See the following page for a facsimile of from 470-3956, *MR/CMI/DD Case Management Service Authorization Request*.

Iowa Department of Human Services

MR/CMI/DD CASE MANAGEMENT SERVICE AUTHORIZATION REQUEST

Case Manager Name	Client Name
Case Manager E-mail	Client Medicaid ID
Case Manager Phone Number	County of Legal Settlement
Case Management Provider Number	Client Date of Birth
Agency Contact Person	Agency Contact Person's E-mail
Months of authorization requested (mm/yy – mm/yy) – <input type="checkbox"/> New <input type="checkbox"/> Renewal	Date Authorization Requested

Select the client's primary disability that includes a need for services requiring case management (check only one):

MR DD CMI Primary Psychiatric Diagnosis Code for CMI: _____

Date of written documentation verifying disability from a qualified professional: _____

Social History and Assessment Information

Date of social history/update: _____ Date of initial assessment or annual review verifying need for CM: _____

Documentation included in the client's case file indicates a need for Case Management services to address the following areas: (Check all that apply)

1. There is a need for CM to manage multiple resources pertaining to medical and interrelated social and educational services for the benefit of the person served. CM communication is required to manage the services and natural supports for the following:

- The person is in the HCBS/MR/BI waiver program. If checked move on to item 2.
- The person needs help with schooling, vocational support, or day program.
- The person needs respite.
- The person needs health services.
- The person needs assistance in daily living skills. Check all that apply.
 - SCL Payee Meals on Wheels Transportation Homemaker
- The person needs support or coordination to engage/maintain mental health treatment.
- The person needs assistance in medication management.
- The person needs assistance in housing.
- The person needs assistance to access and maintain eligibility and services.

2. The person has functional limitation(s) and lacks the ability to independently access and sustain involvement in necessary services.

- The assessment demonstrates the person's functional limitations that impair daily life.
- Documentation of lack of ability to independently access services.
- Documentation of lack of ability to sustain necessary services.

3. The person is receiving the following Medicaid benefits that serve the same purposes as case management at this time.

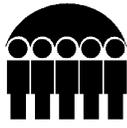
The person resides in a medical institution (hospital, mental health institute, intermediate care facility) with no plan to discharge within 30 days. Yes No

The person is currently served in an approved Assertive Community Treatment program. Yes No

I certify that the information I am submitting in this *Service Authorization Request* is true and accurate and is based upon documentation contained in the person's file at the time of this submission in accordance with state policy and rules. I agree to provide updated information or more detailed information as may be requested. I recognize that all cases are subject to quality control eligibility reviews and/or audits which are conducted by DHS and/or its agent. These reviews/audits can result in retroactive denial of payment for case management services based on a negative determination of client eligibility. A negative determination of eligibility for case management services does not mean that services must be stopped but rather that the Title 19 program managed through DHS will not pay for such case management services. A negative determination may be appealed in accordance with state policy and rules.

Yes No Signature: _____ Date: _____

Note: Keep a copy of this form in the client's file.



1. DHS Requests

When DHS requests additional information, the information must be submitted by e-mail within 30 days of the request. Faxes and hard copy of the documentation are not needed and will not be accepted. Verification of the appropriate documentation will be done at the time of the retrospective review.

Examples of additional information might include information from the following documents in the consumer's file:

- ◆ The summary of the services and providers from the service plan that identifies all of the services and supports that a person is receiving or being referred to.
- ◆ Proof of a primary diagnosis of mental retardation, developmental disability, or chronic mental illness as defined in Chapter E, Section II.A.
- ◆ Verification of a need for Medicaid case management as defined in Chapter E, Section II.A.4.
- ◆ The person resides in a medical institution or is within 30 days of a discharge from a medical institution as defined in Chapter E, Section II.A.
- ◆ The person receives only one service so there is not a need to manage resources for the benefit of the consumer as defined in Chapter E, Section II.A.4..

2. MBC Requests

The following information must be included in the consumer's case management file and included in discussions with MBC of Iowa staff. The summary of the services and providers from the case manager's service plan should be a useful resource.

MBC of Iowa staff will review Iowa Plan documentation on case management recipients before calling case management providers. This may eliminate the need to call the case manager.



When there is a stated need for case manager to manage multiple resources pertaining to medical and interrelated social and education services for benefit of the consumer, documentation is needed to show:

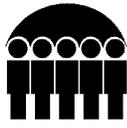
- ◆ That the consumer is accessing multiple services requiring communication to ensure the consumer's stability, including the identities of the current service providers, OR
- ◆ That the consumer requires the services of a case manager to engage in necessary mental health services because the consumer is not currently accessing services and requires close follow-up in the community.

Examples of situations where the consumer has functional limitation and lacks ability to independently access and sustain involvement in necessary services include:

- The consumer's current need and history shows poor access to needed mental health services.
- The consumer misses necessary medical appointments, including mental health visits.
- The consumer's daily life (such as eating, sleeping, thinking, mood, or self-care) is impaired due to a chronic mental illness.
- The consumer is not engaged in needed services, as outlined by service plan.
- The consumer needs assistance in becoming involved in needed services.
- The service or the treatment plan is not fully implemented (e.g., the consumer is not taking medications as prescribed).

D. Notification Process

Within ten working days following the submission of the requested information, the case manager will receive the final decision.



1. DHS Decisions

For a DHS request, within ten working days from receipt of form 470-3956, the case manager will receive one of three letters:

- ◆ Acceptance
- ◆ Level 1 rejection (request for more information)
- ◆ Level 2 rejection (decertification from case management)

Level 2 rejections will be notified by e-mail with an attached letter. The case management provider can request a hearing conducted by an administrative law judge. Make this request by hard-copy mail within 30 calendar days of the date of the Level 2 rejection letter.

2. MBC of Iowa Decisions

Case management providers requesting authorization from MBC of Iowa will receive an authorization confirmation by mail within ten working days if information is sufficient to meet the three criteria Chapter E, Section II.A.4.

When the request is assessed as not meeting one or more of the three criteria, MBC will send a non-authorization letter by mail within ten working days of the receipt of necessary information.

Case management providers have the option of appealing MBC's non-authorization by submitting a letter requesting a Level 1 appeal by mail to MBC of Iowa within 60 calendar days of the date of the non-authorization letter.

Written confirmation of a decision will be received by mail within 14 calendar days of the request for a Level 1 decisions.

For Level 1 requests that are upheld by MBC of Iowa, notification will be by mail. The case management provider can request a hearing conducted by an administrative law judge. Make this requesting by mail within 30 calendar days of the date of the Level 1 decision letter.



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III. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

Submit billings for all case management services to ACS on the *Claim for Targeted Medical Care*, Iowa Medicaid program, form 470-2486. Copies of this form may be obtained from ACS at (515) 327-5120 or (800) 338-7909.

Bill ACS for each service rendered to each consumer (recipient) using applicable charges or the rate determined by the Division of Medical Services. The cost limits are presented in Chapter E, Section **IV: PROCEDURE CODES AND NOMENCLATURE**. The maximum Medicaid rates are reviewed annually by the state legislature and, with the Governor's approval, are established effective July 1 for each state fiscal year.

Submit claims to ACS on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for the month's service by the tenth of the month following the month of service.

The following table contains information to aid in the completion of the *Claim for Targeted Medical Care*, form 470-2486. The table matches field numbers and names on the form, giving a brief description of what information is needed, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.



For Electronic Media Claim (EMC) submitters, refer to your EMC specifications for appropriate claim completion instructions.

LOCATOR #/FIELD REQUIREMENTS		LOCATOR NAME	TARGETED MEDICAL CARE CLAIM FORM DESCRIPTION AND INSTRUCTIONS
1	R	STATE ID	Enter the recipient's <u>Medicaid</u> identification number found on the <i>Medical Assistance Eligibility Card</i> . This number consists of seven numeric characters and an ending alphabetic character. (For example, 1234567A)
1a	R	CONSUMER ACCOUNT #	Enter the patient account number assigned by you.
2	R	CONSUMER'S NAME	Enter the last name, first name, and middle initial of the recipient. Use the <i>Medical Assistance Eligibility Card</i> for verification.
3	R	TREATING PROVIDER NUMBER	Enter your seven-digit Medicaid identification number.
4	R	TREATING PROVIDER NAME	Enter the provider's name.
5	R	TREATING PROVIDER ADDRESS	Enter the provider's address.
6	R	PAY-TO PROVIDER NUMBER*	Enter your seven-digit Medicaid identification number.
7		PAY-TO PROVIDER NAME	No entry required.
8	C	OTHER INSURANCE: YES	If the medical resource codes indicate there is other insurance coverage, or if you are aware of other coverage that will pay, check YES. Enter the amount the other insurance paid in box 12.
		OTHER INSURANCE: NO	Leave blank.



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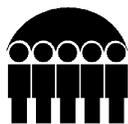
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9	C	OTHER INSURANCE DENIED: YES	If the other insurance denied, check YES. Be sure to also check YES in box 8.
		OTHER INSURANCE DENIED: NO	Leave blank.
10		SERVICES:	
10A	R	PROCEDURE CODE	Enter the appropriate five-digit procedure code.
10B			Leave blank.
10C	O	PROCEDURE DESCRIPTION	Enter a complete description of the service performed.
10D	R	PLACE OF SERVICE	<p>* Enter one of the two-digit codes as follows:</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room - hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance - land 42 Ambulance - air or water 51 Inpatient psychiatric facility 52 Psychiatric facility partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State of local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility



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10E	R	FIRST DATE OF SERVICE	If there is client participation, only one calendar month can be billed per claim form. For the first month of service, enter the first date of service. In subsequent months, enter the first date of the calendar month for which the charge was incurred. The entry must be six digits (MM/DD/YY).
10F	R	LAST DATE OF SERVICE	If there is client participation, only one calendar month can be billed on each claim form. Enter the last day of the calendar month that was entered in 10E. For the last month of service, enter the last date service was provided. The entry must be six digits (MM/DD/YY).
10G	R	TOTAL CHARGES	Enter your usual and customary charge for the calendar month being billed.
10H	R	UNITS	Enter the appropriate number of units of service depending upon the procedure code billed. Refer to Chapter E for procedure code descriptions. Round units for the entire month to the nearest whole number.
11	R	TOTAL CHARGE	Enter the total charge.
12	C	THIRD PARTY LIABILITY	Enter the third-party insurance payment when applicable.
13		CLIENT PARTICIPATION	Do not enter.
14	R	BALANCE DUE	Subtract the amounts in box 12 from the amount in box 11 and enter the amount due from the Medicaid program.
	R	PROVIDER SIGNATURE	The signature of the authorized representative must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
	R	DATE	Enter the date that this claim form is originally signed.

MEDICAID PAYMENTS
(PROVIDER CERTIFICATION)

I hereby agree:

- ◆ To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.
- ◆ To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.
- ◆ To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment, and spenddown.
- ◆ To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I certify that:

- ◆ The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.
- ◆ The charges for these services are just, unpaid, actually due according to law and program policy and not in excess of regular fees.
- ◆ The information provided on the front of this claim is true, accurate, and complete.

I understand that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES

11 Office	51 Inpatient psychiatric facility
12 Home	53 Community mental health center
21 Inpatient hospital	54 Intermediate care facility/MR
22 Outpatient hospital	55 Residential substance abuse treatment facility
23 ER room hospital	56 Residential psychiatric treatment facility
24 Ambulatory surgical center	61 Comp inpatient rehab facility
31 Skilled nursing facility	62 Comp outpatient rehab facility
32 Nursing facility	71 Public health clinic
33 Custodial care facility	99 Other
34 Hospice	



B. Facsimile of Form 470-2486, Claim for Target Medical Services

(See the preceding pages.)

C. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ Staple the additional information to form 470-3969, *Claim Attachment Control*. (See the page following the claim form for an example of this form.)
- ◆ Complete the “attachment control number” with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- ◆ Do not attach a paper claim.
- ◆ Mail the *Claim Attachment Control* with attachments to:

ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Provider Name _____

Pay-to-Provider Number

--	--	--	--	--	--	--	--

Recipient Name _____

Recipient State ID Number

--	--	--	--	--	--	--	--

Date of Service ____ / ____ / ____

Type of Document

**RETURN THIS DOCUMENT WITH ATTACHMENTS TO:
ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422**



IV. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.

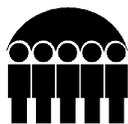
PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the *Medicaid Provider Application* at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.



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If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit - the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

When contacting the fiscal agent with questions regarding the *Remittance Advice*, refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following page.)

REMITTANCE A D V I C E

1. TO: [REDACTED] 2. R.A. NO.: 0000022 3. DATE PAID: 05/19/97 PROVIDER NUMBER: [REDACTED] 4. PAGE: 1

**** PATIENT NAME **** RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /
LAST FIRST MI LINE SVC-DATE PROC/MODS UNITS AMT. SOURCES MCAID AMT. PERF. PROV. S EOB EOB

*** CLAIM TYPE: WAIVER

*** CLAIM STATUS: PAID

ORIGINAL CLAIMS:

5.	6.	7.	8.	9.	10.	11.	12.	13.	14.
[REDACTED]	[REDACTED]	4-96326-00-131-0055-00	18.	9359.15	0.00	9359.15	0.00	[REDACTED]	000 000
	01	08/01/95 W1300	31	1519.31	0.00	1519.31	0.00	[REDACTED]	B 000 000
	02	09/01/95 W1300	30	1470.30	0.00	1470.30	0.00	[REDACTED]	B 000 000
	15. 03	16. 10/01/95 W1300	17. 31	1862.79	0.00	1862.79	0.00	[REDACTED]	B 000 000
	04	11/01/95 W1300	30	1802.70	0.00	1802.70	0.00	[REDACTED]	B 000 000
	05	12/01/95 W1300	31	1862.79	0.00	1862.79	0.00	[REDACTED]	B 000 000
	06	01/01/96 W1300	14	841.26	0.00	841.26	0.00	[REDACTED]	B 900 000
[REDACTED]	[REDACTED]	4-96340-00-102-0034-00		5197.71	0.00	0.00	0.00	[REDACTED]	000 000
	01	09/09/96 W1300	22	2157.54	0.00	0.00	0.00	[REDACTED]	K 000 000
	02	10/01/96 W1300	31	3040.17	0.00	0.00	0.00	[REDACTED]	K 000 000

REMITTANCE T O T A L S

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	14,556.86	9,359.15
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	0.00	0.00
AMOUNT OF CHECK:				9,359.15

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

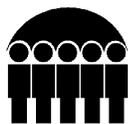
900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.



C. Remittance Statement Field Description

1. Pay-to provider name as specified on the *Medicaid Provider Enrollment Application*.
2. *Remittance Advice* number.
3. Date claim paid.
4. Medicaid (Title XIX) pay-to provider number.
5. Recipient last and first name.
6. Recipient Medicaid ID number.
7. Transaction control number assigned by fiscal agent to each claim. Please use this number when making inquiries about claims.
8. Total charges submitted by provider.
9. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
10. Total amount paid by Medicaid for this claim.
11. Total amount of recipient copayment deducted from this claim.
12. Medical record number as assigned by provider/Medicaid ID number of provider performing services.
13. Allowed charge source code.

B	Billed charge	F	Fee schedule
K	Denied	N	Provider charge rate
P	Group therapy	Q	EPSDT total screen over 17 years
R	EPSDT total under 18 years	S	EPSDT partial over 17 years
T	EPSDT partial under 18 years	U	Gynecology fee
V	Obstetrics fee	W	Child fee



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14. Explanation of benefits code indicates the reason for claim denial. Refer to explanation at end of the remittance for each EOB code in the *Remittance Advice*.
15. Line item number.
16. The first date of service for the procedure billed.
17. The procedure code for the service billed.
18. The number of units of service rendered.
19. Remittance totals (found at the end of the *Remittance Advice*).
 - ◆ Number of paid original claims, amount billed, and amount allowed and paid.
 - ◆ Number of paid adjusted claims, amount billed, and amount allowed and paid.
 - ◆ Number of denied original claims, amount billed, and amount allowed and paid.
 - ◆ Number of denied adjusted claims, amount billed, and amount allowed and paid.
 - ◆ Number of pended claims (in process), amount billed, and amount allowed.
 - ◆ Amount of check.
20. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.



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V. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *Remittance Advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: Claim copy Remittance copy
 Other pertinent information for possible claim reprocessing.

1. 17-DIGIT TCN	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td><td style="width: 5%;"></td> </tr> </table>																		
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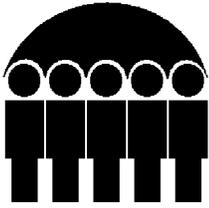
Provider Signature/Date:	MAIL TO: ACS P. O. BOX 14422 DES MOINES IA 50306-3422	ACS Signature/Date:
Provider Please Complete:	7-digit Medicaid Provider ID# _____ Telephone _____	(FOR ACS USE ONLY) PR Inquiry Log # _____
Name _____ Street _____ City, St _____ Zip _____		Received Date Stamp:

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.														
<input type="checkbox"/> CLAIM ADJUSTMENT ♦ Attach a complete copy of claim. (If electronic, use next step.) ♦ Attach a copy of the Remittance Advice with corrections in red ink . ♦ Complete Sections B and C.	<input type="checkbox"/> CLAIM CREDIT ♦ Attach a copy of the Remittance Advice. ♦ Complete Sections B and C.	<input type="checkbox"/> CANCELLATION OF ENTIRE REMITTANCE ADVICE ♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ♦ Attach the check and Remittance Advice. ♦ Skip Section B. Complete Section C.												
SECTION B:														
1. 17-digit TCN														
2. Pay-to Provider #:							4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)							
3. Provider Name and Address:														
5. Reason for Adjustment or Credit Request:														
SECTION C:		Provider/Representative Signature:												
		Date:												
FISCAL AGENT USE ONLY: REMARKS/STATUS														
Return All Requests To: <div style="float: right; text-align: right;"> ACS PO Box 14422 Des Moines, IA 50306-3422 </div>														



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-76
Employees' Manual, Title 8
Medicaid Appendix

July 20, 1998

CASE MANAGEMENT MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Case Management Manual*, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, pages 1 through 5, revised; pages 6 and 7, new; and Chapter F, *Billing and Payment*, pages 1 through 18, revised.

Chapter E is revised to incorporate billing code W0574 for children in the waiver program and to delete language referring to case management as a waiver.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

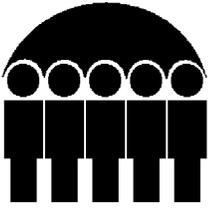
Material Superseded

Remove the following pages from the *Case Management Manual* and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 4)	October 1, 1989
Contents (page 5)	January 1, 1989
Chapter E	
1-5	January 1, 1989
Chapter F	
1	October 1, 1989
2	10/89
3, 3a-3f, 4	October 1, 1989
5, 6	10/89
7, 8	October 1, 1989
9-11	January 1, 1989
12	Undated
13-15	09/30/79
16-18	January 1, 1989

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-86
Employees' Manual, Title 8
Medicaid Appendix

October 30, 1998

CASE MANAGEMENT MANUAL TRANSMITTAL NO. 98-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Case Management Manual*, Chapter F, *Billing and Payment*, page 2, revised.

Chapter F is revised to correct the instructions for submitting the *Report for Enhanced Services*, form 470-2464. Rather than send the white copy to Quality Assurance in Central Office it is to be sent to the county office of the Department.

Date Effective

Upon receipt.

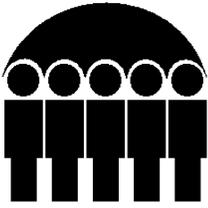
Material Superseded

Remove the following page from the *Case Management Manual* and destroy it:

<u>Page</u>	<u>Date</u>
Chapter F 2	July 1, 1998

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-236

Employees' Manual, Title 8

Medicaid Appendix

October 20, 2003

MR/CMI/DD CASE MANAGEMENT MANUAL TRANSMITTAL NO. 03-1

ISSUED BY: Bureau of Long-Term Care, Division of Medical Services

SUBJECT: ***MR/CMI/DD CASE MANAGEMENT MANUAL***, Title page, revised; Table of Contents, page 4, revised; Table of Contents, page 5, new; Chapter E, *Coverage and Limitations*, pages 1 through 7, and page 8, new; Chapter F, *Billing and Payment*, pages 1 through 18, revised; and pages 19 through 32, new.

Chapter E is revised to:

- ◆ Add requirements for service authorization.
- ◆ Incorporate billing code W0579 for CMI special circumstances.

Chapter F is revised to:

- ◆ Update form 470-2486, *Claim for Targeted Medical Care*.
- ◆ Add form 470-3756, *MR/CMI/DD Case Management Service Authorization Request*.
- ◆ Add instructions for form 470-3969, *Claim Attachment Control*, used to submit paper attachments for an electronic claim.
- ◆ Add form 470-3744, *Provider Inquiry*. Complete this form if you wish to inquire about a denied claim or if claim payment was not as expected.
- ◆ Add form 470-0040, *Credit/Adjustment Request*. Complete this form to notify ACS that.
 - A paid claim amount needs to be changed; or
 - Funds need to be credited back; or
 - An entire *Remittance Advice* should be canceled.

Both chapters are revised to change references from “Consultec” to “ACS.”

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from *CASE MANAGEMENT MANUAL* and destroy them:

<u>Page</u>	<u>Date</u>
Title page	Undated
Table of Contents (page 4)	July 1, 1998
Chapter E	
1-7	July 1, 1998
Chapter F	
1	July 1, 1998
2	October 1, 1998
3	4/90
5-10	July 1, 1998
11, 12	4/98
13, 14	July 1, 1998
15	6/12/97
17, 18	July 1, 1998

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.