



Iowa Department of Human Services

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INFORMATIONAL LETTER NO.1226

DATE: March 21, 2013

TO: Iowa Medicaid Case Managers, Targeted Case Managers, Department of Human Services (DHS) Service Workers, Service Supervisors, Service Area Administrators (SAMS), Child Health Specialty Clinics (CHCS), Central Point of Coordination (CPCs), Home and Community Based Services (HCBS) and Individual Consumer Directed Attendant Care Providers

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

RE: Details of Atypical Conversion Documentation and Billing

EFFECTIVE: July 1, 2013

This letter is the fourth of several Informational Letters explaining all facets of the Atypical Conversion. Prior Informational Letters [1215](#), [1216](#) and [1222](#) explained the highlights of the conversion and the implementation process. This letter will address documentation and billing.

Documentation of HCBS Services:

Providers will continue to document services in accordance with Iowa Administrative Code 441-Chapter 79.3. There are no changes in documentation requirements. Services should be documented to support the entire time period to be billed and to substantiate the services being provided. There is no need to create documentation to coincide with the billing code definition. For example: the billing code for respite will be 15 minutes. The documentation for a two hour time period of respite will be one narrative that supports the two hours; the documentation will not be eight different 15-minute narratives. The change in service code unit definition should not have an impact on how a provider, who is currently properly documenting services, continues to document provided services.

Rounding Rules:

For codes that will use a 15-minute unit definition, providers will utilize the following rounding rules:

- Add together the minutes spent on all billable activities during a calendar day for a daily total.
- For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
- Round the remainder using these guidelines: round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
- Add the number of full and rounded units to determine the total number of units to bill for that day.
- Providers will not determine daily units by the number of encounters they have with the member during a day, but by the total amount of time spent with the member.

- Units will not be determined by adding the number of minutes of service for the month and then dividing; units are to be determined on a daily basis.

Example 1: Respite is provided for 2 hours and 34 minutes on Monday:

- This equals 154 minutes (2 hours X 60 minutes = 120 minutes + 34 minutes = total of 154 minutes).
- 154 minutes divided by 15 minutes = 10 full units + a remainder of 4 minutes.
- 4 minutes is rounded down and does not become an additional full unit.
- The total units to bill for this day = 10 units.

Example 2: Respite is provided for 2 hours and 40 minutes one day on Tuesday:

- This equals 160 minutes (2 hours X 60 minutes = 120 minutes + 40 minutes = total of 160 minutes).
- 160 minutes divided by 15 minutes = 10 full units + a remainder of 10 minutes.
- 10 minutes is rounded up to a full unit.
- 10 full units + 1 rounded unit = 11 units
- The total units to bill for this day = 11 units.

Providers who complete the claim form using one line per month will total each day's rounded units for a monthly unit total. Those providers who bill each day on a separate line on the claim form will enter each day's rounded units onto each line. There is no change in whether one line or multiple lines are used on a claim form.

Claim Form Completion:

All HCBS claims will continue to be billed on the claim forms currently used. If a diagnosis code is currently required on the claim form, then V00.01 will continue to be entered into the claim. The instructions for completing claim forms have not changed, with the exception of use of a modifier. Current paper claim forms and electronic claim formats allow for use of a modifier. Please refer to claim form instructions regarding entry of a modifier. These instructions can be found on the IME website at:

<http://www.ime.state.ia.us/Providers/ClaimsPage.html>.

Effective for services rendered on July 1, 2013, the new billing codes plus applicable modifiers must be used to bill for services. In addition, providers must make sure they are using the new rate (if applicable) and the new unit definition (if applicable). Services provided before July 1, 2013, will continue to be billed and adjusted using the old "W" codes, units, and rates regardless of when the claim is submitted or adjusted.

Failure to bill the correct codes, units and rates will result in claim denials or incorrect payments. Providers would then be responsible for correcting and resubmitting valid claims.

Webinar:

The IME will be hosting a webinar to explain the implementation process involved with the Atypical Conversion. Providers, case managers, and service workers are invited to participate in this webinar. If you have specific issues that you would like to see included in this webinar, please send your issues to lhowlan@dhs.state.ia.us. The webinar is scheduled for the following time:

Date: March 27, 2013

Time: 1:00-3:00 PM

Reserve your Webinar seat now at: <https://www2.gotomeeting.com/register/563026946>.

After registering you will receive a confirmation email containing information about joining the Webinar.

Contacts for the Atypical Conversion:

For questions about the codes and modifiers to be used for the conversion: refer to the IME website <http://www.ime.state.ia.us/Providers/AtypicalCode.html>.

For questions regarding the conversion process please contact HCBS specialists at HCBSwaivers@dhs.state.ia.us or Le Howland @ lhowlan@dhs.state.ia.us.

For questions regarding claim form completion please contact the IME Provider Services Unit at 1- 800-338-7909 or locally in Des Moines at 515-256-4609.