



# Iowa Department of Human Services

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## GENERAL LETTER NO. 8-M-44

ISSUED BY: Bureau of Financial, Health and Work Supports  
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 8, Chapter M, **MEDICAID SERVICES**, pages 4, 5, 6, 20, 24, and 43, revised.

### Summary

Chapter 8-M is revised to:

- ◆ Update the 300% of SSI benefit amount.
- ◆ Update the HMA amount for the month of discharge.
- ◆ Update the amount of the waiver personal needs allowance.
- ◆ Update the manual with the ICD-10 changes.
- ◆ Update all links due to the Department's new website.

### Effective Date

The ICD-10 changes were effective October 1, 2014.

All other changes are effective January 1, 2015.

### Material Superseded

This material replaces the following pages from Employees' Manual, Title 8, Chapter M:

<u>Page</u>	<u>Date</u>
4-6	November 18, 2011
20, 24, 43	August 2, 2013

### Additional Information

Refer questions about this general letter to your area income maintenance administrator.

To begin the enrollment and certification process, the provider must submit form 470-4990, *Application for Authorization to Make Presumptive Eligibility Determinations for Children*, which is available on line at <http://dhs.iowa.gov/ime/providers/forms>.

After receiving form 470-4990, the Department will determine if the applicant meets the criteria to become a qualified entity. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants.

See ***Medicaid All Providers Manual***, [Chapter II](#), for copies of these forms.

### **Qualifying to Determine Presumptive Eligibility for Pregnant Women**

**Legal reference:** 441 IAC 75.1(30)“a”

For the purposes of determining presumptive Medicaid eligibility for pregnant women, a “qualified provider” is a Medicaid provider who has made application and has been specifically designated by the Department in writing.

To be designated, a provider must:

- ◆ Provide one or more of the following services:
  - Outpatient hospital services
  - Rural health clinic services
  - Clinic services furnished by or under the direction of a physician
- ◆ Participate or receive funds under one of the following:
  - The state perinatal program
  - The Migrant Health Centers or Community Health Centers Program
  - The Maternal and Child Health Services Program
  - The Health Services for Urban Indians Program
  - The Special Supplemental Food Program for Women, Infants, and Children
  - The Commodity Supplemental Food Program
  - The Indian Health Service or health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act

In Iowa, these providers are primarily maternal and child health centers operated under the Department of Public Health. However, other providers, such as migrant health centers and rural health clinics, may also meet the criteria.

Refer anyone asking about applying to be a qualified provider to the IME Provider Enrollment Unit at 1-800-338-7909 (option 2), or locally (Des Moines) at 515-256-4609 (option 2) or by e-mail at [imeproviderservices@dhs.state.ia.us](mailto:imeproviderservices@dhs.state.ia.us).

To begin the enrollment and certification process, the provider must submit form 470-2579, *Application for Authorization to Make Presumptive Eligibility Determinations*, which is available on line at <http://dhs.iowa.gov/ime/providers/forms>.

After receiving form 470-2579, the Department will determine if the applicant meets the criteria to become a qualified provider. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants.

See ***Medicaid All Providers Manual***, [Chapter II](#), for copies of these forms.

### **Qualifying to Determine Presumptive Eligibility for BCCT**

**Legal reference:** 441 IAC 75.1(40)“c”(1)

For the purposes of determining presumptive Medicaid eligibility for women who need treatment for breast or cervical cancer, a “qualified provider” is a Medicaid provider who has made application and has been specifically designated by the Department in writing.

To be qualified to do presumptive eligibility determinations, a provider must be eligible for payment under the Medicaid program and either:

- ◆ Have been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the Department of Public Health; or
- ◆ Have a cooperative agreement with the Department of Public Health to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the “Care for Yourself” breast and cervical cancer early detection program.

Refer anyone asking about applying to be a qualified provider to the Bureau of Financial, Health and Work Supports in the Division of Adult, Children and Family Services.

To begin the enrollment process, a provider must submit form 470-3864, *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)*, to the Bureau of Financial, Health and Work Supports for approval.

After receiving form 470-2579, the Department will determine if the applicant meets the criteria to become a qualified provider. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants.

See *Medicaid All Providers Manual*, [Chapter II](#), for copies of these forms.

### **Nonemergency Medical Transportation**

**Legal reference:** 441 IAC 78.13(249A)

The Department pays for the Medicaid member's transportation to receive medical care, including prescribed drugs, if the requirements in this section are met. Effective October 1, 2010, the Department has hired a transportation broker to manage the nonemergency medical transportation program.

TMS Management Group, Inc. (TMS) is the vendor the Department has contracted with to provide the brokerage service. TMS is responsible for arranging and reimbursing for all nonemergency medical transportation for dates of service on and after October 1, 2010. TMS also responsible for appeals associated with the nonemergency medical transportation program.

If members have questions regarding scheduling their trips or seeking travel reimbursement, direct them to call 1-866-572-7662. Members must contact TMS to make travel arrangements at least 72 hours **before** they travel to a medical provider, unless the need is urgent.

### **Client Participation for Enrollee Living at Home**

**Legal reference:** 42 CFR 460.152-156; 42 CFR 435.725; 441 IAC 88.84(249A)

Client participation is the amount a PACE enrollee is required to contribute to the cost of PACE services. The PACE provider arranges directly with the enrollee to collect client participation.

To calculate client participation for PACE enrollees who are receiving services in their homes:

1. Determine the total gross monthly income of the enrollee only, according to [8-I, Income Available for Client Participation](#).
2. Subtract 300% of the SSI benefit for one person. See [8-E, SSI-Related Income Limits](#).
3. Add in the following:
  - ◆ Veteran's aid and attendance,
  - ◆ Veteran's housebound allowance, and
  - ◆ Third-party medical payments.

The result is the client participation amount.

Mr. J, age 60, lives alone and applies for PACE services on October 2. His gross monthly income includes \$843 Social Security benefit, \$250 private pension, and \$100 VA aid and attendance. The worker determines client participation as follows:

$\$843 \text{ Social Security} + 250 \text{ pension} = \$1,093 \text{ total gross monthly income}$

$\$1,093 - \$2,199 \text{ (300\% of SSI benefit)} = \$0$

$\$0 + \$100 \text{ VA aid and attendance} = \$100 \text{ client participation}$

See 14-B(9), [SSI-RELATED MEDICAID AND FACILITY CASE ACTIONS](#), for the necessary case actions for the ABC system. ISIS will notify the PACE provider of the amount of client participation to be paid, if any.

### **Members With a Medical Assistance Income Trust**

To calculate client participation for PACE enrollees with a medical assistance income trust, see [8-I, Trust Payments](#).

Mr. S, a PACE enrollee, enters a nursing facility from his home on April 16. His gross income is \$838 monthly and his PACE client participation while living at home is \$0.

The IM worker recalculates his client participation effective May 1 as follows:

\$	838	Income
-	<u>50</u>	Personal needs allowance
\$	788	Client participation

Mr. S is discharged from the nursing facility and returns to his home on June 5. The worker recalculates his client participation for June and July as follows:

<u>June</u>		<u>July</u>	
\$	838	Income	\$ 838
-	733	HMA month of discharge	- <u>2,199</u>
-	<u>50</u>	Personal needs allowance	\$ 0
\$	55	Client participation to NF	Client participation

### **Client Participation for Medicare Skilled Stays**

When a PACE enrollee enters a medical institution as skilled and Medicare will be participating in the cost of care, do not assess client participation until after the first 20 days.

Determine if client participation for a Medicare skilled stay should be split by following these steps:

1. Determine the number of days remaining for the month after the first 20 days of a Medicare skilled stay.
2. Multiply the days remaining by the nursing facility's per diem rate.
3. Determine the monthly client participation based on gross monthly income and allowing the deductions.
4. Compare the calculation in #2 with the calculation in #3. The client participation will be the lesser of the two amounts.
5. For the month following the month the enrollee entered a nursing facility as Medicare skilled, determine client participation based on the enrollee's gross monthly income.

System codes that indicate pay and chase for coverage by absent parents are located on the SSNI or MMIS screen.

The absent parent indicator is located in the second position of the medical resource code on the SSNI screen. The codes are H, K, and 8. Field 10 on the MMIS screen has an indicator of absent parent insurance for the insurance coverage that is described on the page open for viewing. Each page has information on a different health insurance policy.

### **Review of Trauma Claims**

**Legal reference:** 441 IAC 75.2(1)

The IME Revenue Collection Unit screens Medicaid claims indicating an accidental injury or "trauma" in order to pursue potential third-party liability for the costs of treatment. The Unit reviews all Medicaid claims over \$250 submitted with an ICD diagnosis code indicating an accident or injury.

When additional information is needed regarding the accident or injury, the Revenue Collection Unit worker sends computer-generated form 470-0398, *Priority Leads Letter* (also called the "trauma leads letter"), to the injured person. The form asks the person to supply details of the accident or injury.

Upon receipt of the completed letter, the Revenue Collection Unit worker:

- ◆ Reviews the member's response to determine if a third party is available to pay for part or all of the medical expenses.
- ◆ Follows up with the third-party resources identified to substitute the Department's claim for that of the injured person. (This process is called "subrogation.")