Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

For Human Services use only:

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Employees' Manual, Title 8
Medicaid Appendix

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ALL PROVIDERS MANUAL TRANSMITTAL NO. 16-3

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***ALL PROVIDERS MANUAL***, Chapter I, ***General Program Policies***, Contents (pages 1, 2, and 3), revised; and pages 1 through 48, revised.

Summary

ALL PROVIDERS MANUAL Chapter I. *General Program Policies*, is revised to:

- Align with current IA Health Link policies, procedures, and terminology.
- Align with current ICD-10 policies, procedures, and terminology.
- Update links due to the Department's new website.

Effective Date

January 1, 2016

Material Superseded

This material replaces the following pages in the ***ALL PROVIDERS MANUAL***:

Page	Date
Chapter I	
Contents (pages 1-3)	May 1, 2014
1-50	May 1, 2014

Additional Information

The updated provider manual containing the revised pages can be found at: https://dhs.iowa.gov/sites/default/files/All-I.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

TABLE OF CONTENTS

Page

CHAPTER I. GENERAL PROGRAM POLICIES 1

A. ORGANIZATION AND ADMINISTRATION OF MEDICAID 1
1. Eligibility 1
2. Benefits 3
3. Iowa Medicaid Enterprise Addresses and Telephone Numbers 5
4. Provider Services 7
a. Provider Manuals 7
b. Change of Provider Enrollment Status 8

B. COVERAGE OF MEDICAL AND HEALTH SERVICES 9
1. Acute Hospitals 9
2. Advanced Registered Nurse Practitioners (ARNP) 9
3. Ambulance Services 10
4. Ambulatory Surgical Centers 10
5. Area Education Agencies 10
6. Assertive Community Treatment 10
7. Audiologists and Hearing Aid Dealers 11
8. Behavioral Health Services 11
9. Behavioral Health Intervention Services (BHIS) 11
10. Birth Centers 11
11. Case Managers 11
12. Child Care Medical Services 12
13. Chiropractors 12
14. Community Mental Health Centers 12
15. Community-Based Neurobehavioral Rehabilitation Services 12
16. Dentists 13
17. Family Planning Clinics 13
18. Federally Qualified Health Centers (FQHC) 13
19. Habilitation Services 13
20. Health Home Services 14
21. Home- and Community-Based Service Providers (HCBS) 15
a. AIDS/HIV Waiver 15
b. Brain Injury Waiver 15
c. Children's Mental Health Waiver 16
d. Elderly Waiver 16
e. Health and Disability Waiver 17
f. Intellectual Disabilities Waiver 17
g. Physical Disability Waiver 17

Page

22. Home Health Agencies 18
23. Hospice 18
24. Independent Laboratories 19
25. Indian Health Services 19
26. Infant and Toddler Services 19
27. Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) 19
28. Lead Investigation Agencies 19
29. Local Education Agencies 20
30. Managed Health Care Providers 20
31. Maternal Health Centers 20
32. Medical Equipment and Supply Dealers 20
33. Non-Emergent Medical Transportation 21
34. Nursing Facilities 21
35. Occupational Therapists 21
36. Optometrists and Opticians 21
37. Orthopedic Shoe Dealers 22
38. Pharmacies 22
39. Pharmaceutical Case Management 22
40. Physical Therapy Services 22
41. Physicians 23
42. Podiatrists 23
43. Program of All Inclusive Care for Elderly (PACE) 23
44. Psychiatric Medical Institutions 23
45. Psychologists 24
46. Public Health Agency 24
47. Rehabilitation Agencies 24
48. Rural Health Clinics 24
49. Screening Centers 24
50. Speech-Language Pathology 25

C. GENERAL REQUIREMENTS FOR SERVICES 25
1. Service Delivery 25
2. Determination of Coverage 27
3. Determining Member Status 28
4. Prior Authorization 29
a. Requests for Prior Authorization 31
b. Review of Request 33
c. Denial of Request 33
5. Records 34

Page

D. REIMBURSEMENT FOR SERVICES 36
1. Claims 36
a. Procedure Coding 37
b. Claim Submission 37
2. Third-Party Liability 37
3. Eligibility Under Both Medicare and Medicaid 39
a. Services Provided to Traditional Medicare Beneficiaries 40
b. Traditional Medicare with Other Insurance 41
c. Medicare Advantage Plans and Crossover Invoices 41
4. Copayment 42
a. Drugs 43
b. Other Services 43
c. Exemptions 44
5. Problems with Submitted Claims 45
a. Provider Inquiry, Form 470-3744 45
b. Adjustment Request, Form 470-0040 45
c. Recoupment Request, Form 470-4987 46
6. Appeals 46
7. Reviews and Audits 47
8. Overpayments 48
9. Penalties 48

CHAPTER I. GENERAL PROGRAM POLICIES

A. ORGANIZATION AND ADMINISTRATION OF MEDICAID

Medicaid is a public assistance medical care program administered by states and financed jointly through federal and state funds. The purpose of the Medicaid program is to help ensure that people of low income have available to them medical and health care of good quality. The legal basis for the program is Title XIX of the Social Security Act.

At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS) in the U. S. Department of Health and Human Services. In order to participate in Medicaid, the state legislature must appropriate funds and designate a state agency to administer the program. Iowa's Medicaid program is administered by the Division of Medical Services in the Iowa Department of Human Services.

To obtain federal funds, the state's program must meet federal requirements. These requirements are designed to ensure that states are administering Medicaid programs of good quality, both in terms of the people covered under the program and the medical and health services for which the program makes payment.

States must submit a plan declaring how they meet these requirements. If CMS approves a state's Medicaid plan, then federal matching funds for program expenditures are available at a rate based on a formula for each state that takes into account the per capita income for the state.

1. Eligibility

Eligibility for Medicaid is based primarily on a person's financial situation. The federal government requires states that participate in the Medicaid program to provide coverage for:

- A child under the age of 21.
- A parent living with a child under the age of 18.
- A woman who is pregnant.
- A person who is elderly (age 65 or older).
- A person is disabled according to Social Security standards.

- A woman in need of treatment for breast or cervical cancer.
- Others may qualify. (See below.)
  - Iowa Health and Wellness Plan: On January 1, 2014, Medicaid began to offer a new health care coverage option to adults aged 19 to 64 with income up to and including 133 percent of the Federal Poverty Level. To learn more about Iowa Health and Wellness Plan view the IA Health Link webpage.
  - Medically Needy: If your income is too high for Medicaid but your medical costs are so high that it uses up most of your income, you may qualify for some payment help through the Medically Needy plan. If you qualify, you are responsible for paying some of the costs of your medical expenses.
  - Medicare Assistance: If your income is low and you have a hard time paying Medicare premiums, Medicaid may be able to help pay the premiums.
  - Iowa Family Planning Network (IFPN): If you are between the ages of 12 to 54, Iowa's family planning waiver program may be able to help you with the cost of your family planning related services.
  - State Supplementary Assistance: If you are 65 or older, blind, or disabled and have a special financial need not met by Social Security, you may be eligible for an additional benefit through this program.

To be eligible for Medicaid programs you must:

- Live in Iowa.
- Be a U.S. citizen or an alien who is in this country legally.
- Provide a Social Security number or proof that you have applied for one.
- Provide other information (such as financial and size of family).

States have the option of covering members of state-funded public assistance programs and various groups of people whose situations are similar in some respects to recipients of public assistance, but who do not meet all the requirements. The Iowa Legislature specifies what groups can be covered in Iowa Code Chapter 249A.

The Bureau of Financial, Health and Work Supports in the Department's Division of Adult, Children and Family Services is responsible for formulating Medicaid eligibility policy and procedure within the framework of state and federal law and regulations.

Eligibility determination is done by staff in the Department's local offices, by the Centralized Facility Unit or, for certain groups, by staff of the Social Security Administration or by qualified providers. The Department has local offices throughout Iowa. Click here to view the directory of Department offices.

Income maintenance workers are responsible for maintaining the Medicaid eligibility records for all members. Each member's eligibility information is entered into a centralized automated system.

Click here to view a more detailed description of the groups covered by the Iowa Medicaid program as found in Chapter II, ***Member Eligibility***.

2. Benefits

The Division of Iowa Medicaid Enterprise (IME) is responsible for formulating Medicaid policy and procedure within the framework of state and federal law and regulations. The IME, together with other units of the Department, has the additional responsibility of overseeing the operation of the program to ensure that it is effectively and efficiently administered throughout the state.

The Department has contracted with several private firms to handle administrative duties for the program. These contractors, together with staff, collectively form the IME.

The address for the IME is:

Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315

- The Division's Bureau of Long-Term Care is responsible for the development of policies about coverage and payment for nursing facilities, intermediate care facilities, home- and community-based services waivers, habilitation, and PACE, as well as, quality oversight of those programs.
- The Division's Bureau of Adult and Children's Medical Programs is responsible for the development of policies about coverage and payment for all other services. This bureau also manages the Health Insurance Premium Payment (HIPP) program and the Healthy and Well Kids in Iowa (***hawk-i***) program.

- The IME Core Unit is responsible for operating the Medicaid Management Information System (MMIS) and the automated eligibility reporting system, known as ELVS. The core unit is also responsible for processing and payment of claims, mail handling, and reporting.
- The IME Medical Service Unit houses the medical review staff and affiliated staff that provide medical opinions on specific areas, such as coverage and benefits, as well as assisting with exceptions to policy and appeals.
- The IME Member Services Unit is a call center that assists Medicaid members in accessing services or explains how services can be provided, including help in enrolling in managed care.
- The IME Pharmacy Medical Services Unit is responsible for pharmacy prior authorization (PA), drug utilization review (DUR), and the preferred drug list (PDL).
- The IME Pharmacy Point of Sale Unit is responsible for maintaining a real-time system for pharmacies to submit prescription drug claims for Iowa Medicaid members and receive a timely determination regarding payment.
- The IME Provider Cost Audit and Rate Setting Unit is responsible for helping policy staff to develop payment rates that are consistent and appropriate for services being provided to members.
- The IME Provider Services Unit is responsible for provider training, provider enrollment, and the provider call center.
- The IME Revenue Collection Unit is responsible for capture of payments that are to be made to the Medicaid program through other third-party insurance, estate recovery, and liens.
- The IME Program Integrity Unit is responsible for routine inspection of claims submitted to the IME to assure that Medicaid is paying appropriately for covered services.

3. Iowa Medicaid Enterprise Addresses and Telephone Numbers

Direct inquiries by telephone, email or in writing to the following sources:

Unit Name	Phone Numbers / Hours (as applicable)
IME Medicaid Claims PO Box 150001 Des Moines, IA 50315	7:30 AM – 4:30 PM (800) 338-7909 (515) 256-4609 (Des Moines)
IME Provider Services Iowa Medicaid Enterprise PO Box 36450 Des Moines, IA 50315	7:30 AM – 4:30 PM (800) 338-7909 (515) 256-4609 (Des Moines) (515) 725-1155 (Fax) imeproviderservices@dhs.state.ia.us
Iowa Medicaid Portal Access	https://secureapp.dhs.state.ia.us/IMPA/
Eligibility Verification System (ELVS)	24 hours a day, 7 days a week (800) 338-7752 (515) 323-9639 (Des Moines)
EDI Support Services	8:00 AM – 7:00 PM (800) 967-7902
IME Member Services PO Box 36510 Des Moines, IA 50315	8:00 AM – 5:00 PM (800) 338-8366 (515) 256-4606 (Des Moines) (515) 725-1351 (Fax) imememberservices@dhs.state.ia.us
IME Medical Services	8:00 AM – 4:30 PM (800) 383-1173 (515) 256-4623 (Des Moines) (515) 725-1355 (Fax – General) (515) 725-1349 (Fax – Long-Term Care) (515) 725-0931 (Fax – CMH Documentation) (515) 725-0420 (Fax – Swing Bed Review)
IME Medical Prior Authorization PO Box 36478 Des Moines, IA 50315	8:00 AM – 4:30 PM (888) 424-2070 (515) 256-4624 (Des Moines) (515) 725-1356 (Fax) (515) 725-0938 (Fax – Dental PA)

Unit Name	Phone Numbers / Hours (as applicable)
Pharmacy **Point-of-Sale Help Desk**	8:00 AM – 5:00 PM (after hours on-call available) (877) 463-7671 (515) 256-4608 (Des Moines)
Pharmacy **Prior Authorization Hotline**	8:00 AM – 5:00 PM (after hours on-call available) (877) 776-1567 (515) 256-4607 (Des Moines) (800) 574-2515 (Fax)
IME Provider Cost Audits and Rate Setting PO Box 36478 Des Moines, IA 50315	8:00 AM – 5:00 PM (866) 863-8610 (515) 256-4610 (Des Moines) (515) 725-1353 (Fax)
IME Revenue Collection **Estate Recovery** **Miller Trust** PO Box 36445 Des Moines, IA 50315	7:30 AM – 5:30 PM (888) 513-5186 (515) 246-9841 (Des Moines) (515) 246-0155 (Fax)
IME Lien Recovery PO Box 36446 Des Moines, IA 50315	8:00 AM – 4:30 PM (888) 543-6742 (515) 256-4620 (Des Moines)
IME Third Party Liability and Refunds PO Box 36475 Des Moines, IA 50331-0202	8:00 AM – 4:30 PM (866) 810-1206 (515) 256-4619 (Des Moines) (515) 725-1352 (Fax)
IME Refund Checks PO Box 310202 Des Moines, IA 50331-0202	
IME Program Integrity Unit PO Box 36390 Des Moines, IA 50315	8:00 AM – 5:00 PM (877) 446-3787 (515) 256-4615 (Des Moines) (515) 725-1354 (Fax)

4. Provider Services

a. Provider Manuals

The Iowa Medicaid Provider Manual contains basic information concerning Iowa's Medical Assistance Program (Medicaid). It is intended for use by all providers of medical and health services participating in the program.

Use of the manual will do much to eliminate misunderstandings concerning the coverage status of services, member eligibility, and proper billing procedures, which can result in delays in payment, incorrect payment, or denial of payment.

However, when the medical claims are to be submitted to a managed care organization for payment of a covered service, the instructions for billing are established by the managed care organization. The claim must adhere to the managed care organization's guidelines and not the guidelines in this manual. Contact the managed care organization for assistance and questions.

The manual contains sections dealing with:

- The organization, administration, and financing of the Medicaid program, including program policies and procedures applicable to all providers (Chapter I)
- Member eligibility (Chapter II)
- Coverage policies and billing instructions procedures applicable to each particular provider group (Chapter III)
- Directories of offices involved in administering the program (Appendix)

Click here to access the provider manuals online. This website contains all the published policy manuals that pertain to Iowa Medicaid policies and procedures.

Chapters I and II and the Appendix are published as separate documents in the category "all providers." Chapter III for each provider type is published as a separate document.

The current version of Adobe® Reader® software is required to view provider manuals online. A link to download the software is on the website.

The transmittal letter identifies and locates the changes being made and provides instructions for filing the revised material. These transmittal letters are numbered consecutively for each provider type, with a separate series for changes to the chapters that are identical for all providers.

The transmittal letters and their revised pages are also published as separate documents on the Internet and can be accessed through the table labeled "General Letters." When the revised pages are issued in advance of their effective date, they will be available only through the "General Letters" file. The chapter files are not updated until the week of the effective date.

Printed pages of the manual may be requested by contacting Provider Services at (800) 338-7909; locally in Des Moines at (515) 256-4609.

Occasionally, information may be released to providers through "informational letters." These do not update manual pages.

b. Change of Provider Enrollment Status

All providers must keep the IME Provider Services Unit informed concerning:

- Any change in licensure status (if subject to state licensure); or
- Any changes in certification status as a provider of service under Part A or Part B of Medicare.

A provider may amend the provider file by submitting a revised copy of the provider enrollment form or a letter to the Provider Services Unit. Submit a revised copy to add a Medicaid service that requires special certification or approval to provide the service or to receive additional reimbursement for the service. Submit additional information that meets the criteria for the service or additional payment.

The Provider Services Unit will review the documents and will respond within 30 days of receipt if the criteria for approval are met. Approval of an amendment is retroactive to the date requested or the date all applicable criteria is met, whichever is later, not to exceed 30 days before the IME receives the amendment.

A provider may appeal denial of an amendment using the same procedures as for appealing the denial of a claim (see Appeals).

No payment shall be made for care or services provided before the effective date of the approval of an application.

B. COVERAGE OF MEDICAL AND HEALTH SERVICES

Following is a list of medical and health services within the scope of the Medicaid program and the principal conditions and restrictions that apply to each.

This information is included so all providers may be aware of the medical benefits to which Medicaid members are entitled. A detailed statement of coverage policies for any particular provider group is found in Chapter III of the provider manual.

1. Acute Hospitals

Legal reference: 441 IAC 78.3(249A), 78.31(249A)

Medicaid covers both inpatient and outpatient hospital care. All inpatient care is covered for the length of stay when the stay is determined to meet the criteria for inpatient hospital care. Select admissions and procedures are subject to prior approval by the IME Medical Services Unit. Outpatient services are limited to specific outpatient programs. Limits are placed on certain outpatient programs.

2. Advanced Registered Nurse Practitioners (ARNP)

Legal reference: 441 IAC 78.40(249A)

Medicaid covers services provided by advanced registered nurse practitioners who are duly licensed and registered as advanced registered nurse practitioners with certification pursuant to Board of Nursing rules at 655 Iowa Administrative Code (IAC) Chapter 7. This includes nurse-midwives, certified registered nurse anesthetists, and other specialties recognized by the Board of Nursing.

Payment will be approved for services provided within the nurse practitioner's scope of practice and the limitations of state law, including advanced nursing and physician-delegated functions under a protocol with a collaborating physician.

Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth for physicians.

3. Ambulance Services

Legal reference: 441 IAC 78.11(249A)

For ambulance services to be covered, the member's condition must be such that the member can be transported only by ambulance, and the transportation must be to the nearest hospital with appropriate facilities, from one hospital to another, or to a nursing facility. Ambulance services must be medically necessary and not merely for the convenience of the member.

4. Ambulatory Surgical Centers

Legal reference: 441 IAC 78.26(249A)

Medicaid covers services furnished by ambulatory surgical centers in connection with a covered surgical procedure or dental procedure. Covered procedures are those medically necessary procedures that are eligible for payment under the same circumstances as physician or dental services.

5. Area Education Agencies

Legal reference: 441 IAC 78.32(249A)

Medicaid covers services provided by area education agencies in connection with physical therapy, occupational therapy, speech-language therapy, psychological services, nursing social work, vision services, and audiological services. Screening, assessment, and direct services are covered.

6. Assertive Community Treatment

Legal reference: 441 IAC 78.45(249A)

Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

7. **Audiologists and Hearing Aid Dealers**
Legal reference: 441 IAC 78.14(249A)

Payment is made for testing services to establish the need for a hearing aid. When needed, payment is made for hearing aids, repairs of hearing aids, and maintenance items. Some types of aids require prior approval by the IME Medical Services Unit.

8. **Behavioral Health Services**
Legal reference: 441 IAC 78.29(249A)

Covered behavioral health services include medically necessary mental health examinations, evaluation, individual therapy, family therapy, and group therapy.

9. **Behavioral Health Intervention Services (BHIS)**
Legal reference: 441 IAC 78.12(249A)

Covered services include skill building services that have been ordered by a licensed mental health practitioner. The skill building services are designed to reduce or eliminate the symptoms or behaviors resulting from the psychological disorder that interfere with the member's ability to function.

10. **Birth Centers**
Legal reference: 441 IAC 78.30(249A)

Medicaid covers prenatal care, delivery, and postpartum care provided in a birth center that is enrolled as a Medicaid provider.

11. **Case Managers**
Legal reference: 441 IAC 78.33(249A)

Case management services are covered when provided by case management provider organizations certified eligible to participate in the Medicaid program. To be eligible for case management services, a member must have a primary diagnosis of intellectual disability, developmental disability, chronic mental illness, or serious emotional disturbance. Case management services are not available to members residing in an ICF/ID or those enrolled in an Integrated Health Home.

12. Child Care Medical Services

Legal reference: 441 IAC 77.51

Medicaid covers child care medical services when provided by a child care center that complies with the standards of 441 IAC Chapter 109. The provider implements a comprehensive protocol of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psycho-social, and developmental therapies required by the medically dependent or technologically dependent child served. Nursing services must be provided.

13. Chiropractors

Legal reference: 441 IAC 78.8(249A)

The Medicaid program covers services of a chiropractor performed in the office or home. The only covered service is manual manipulation of the spine for treatment of a subluxation demonstrated to exist by an x-ray.

14. Community Mental Health Centers

Legal reference: 441 IAC 78.16(249A)

Medicaid pays for the services of a psychiatrist, psychologist, social worker, or psychiatric nurse on the staff of a mental health center, subject to certain conditions.

15. Community-Based Neurobehavioral Rehabilitation Services

Legal reference: 441 IAC 77.52(249A)

Medicaid covers community-based neurobehavioral rehabilitation services when provided by a multidisciplinary team that have been trained in, and deliver, services individually designed to address cognitive, medical, behavioral, and psychosocial challenges, as well as the physical manifestations of acquired brain injury.

Services concurrently work to optimize functioning at personal, family, and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors, and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in their home and community.

16. Dentists

Legal reference: 441 IAC 78.4(249A)

Payment is made for dental services, including cleaning of teeth, fillings, extractions, dental surgery, dentures, and orthodontia. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by Doctors of Medicine, Osteopathy, Dental Surgery, or Dental Medicine and would be covered if furnished by Doctors of Medicine or Osteopathy. Some dental services require prior approval by the IME Medical Services Unit.

17. Family Planning Clinics

Legal reference: 441 IAC 78.22(249A)

Covered family planning services include counseling, medical examination, laboratory tests, drugs, and supplies that are furnished by a clinic in connection with family planning.

18. Federally Qualified Health Centers (FQHC)

Legal reference: 441 IAC 78.39(249A)

Medicaid covers services provided by federally qualified health centers that are within the scope of practice of the health professional rendering the service and are within the exclusions and coverage limitations under the Medicaid program.

19. Habilitation Services

Legal reference: 441 IAC 78.27(249A)

Habilitation services are designed to assist members who have functional deficits typically seen in persons with a chronic mental illness. These home- and community based services assist in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

20. Health Home Services

Legal reference: 441 IAC 78.53(249A)

Health home services are provided to eligible Medicaid members with chronic or mental health conditions. Payment shall be made only for health home services provided to a Medicaid member who:

- Has at least two chronic conditions,
- Has one chronic condition and is at risk of having a second chronic condition,
- Has a serious mental illness, or
- Has a serious emotional disturbance.

Chronic condition means:

- A mental health disorder
- A substance use disorder
- Asthma
- Diabetes
- Heart disease
- Being overweight

Serious mental illness means:

- A psychotic disorder,
- Schizophrenia,
- Schizoaffective disorder,
- Major depression,
- Bipolar disorder,
- Delusional disorder, or
- Obsessive-compulsive disorder.

Serious emotional disturbance means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders and that results in a functional impairment.

Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner:

- Comprehensive care management,
- Care coordination,
- Health promotion,
- Comprehensive transitional care
- Member and family support
- Referral to community and social support services

21. Home- and Community-Based Service Providers (HCBS)

Under the home- and community-based services waiver programs, Medicaid provides services to maintain persons in their own homes or communities who would otherwise require care in medical institutions.

Services are limited to certain target member groups from whom the federal government agrees to waive some federal requirements for eligibility and for amount, duration, and scope of services. Thus, these programs are referred to as "Medicaid waivers."

Iowa currently has the following home- and community-based services waivers:

a. AIDS/HIV Waiver

Legal reference: 441 IAC 78.38(249A)

The AIDS/HIV waiver serves members who have been diagnosed with AIDS or HIV. Members must also require the level of care available in a hospital or nursing facility. The services offered under the AIDS/HIV waiver are: adult day care, consumer choices option, consumer-directed attendant care, counseling, home-delivered meals, home health aide, homemaker, nursing, and respite.

b. Brain Injury Waiver

Legal reference: 441 IAC 78.43(249A)

The brain injury waiver serves members who are under 65 years of age and have a diagnosis of brain injury. To be eligible, a member must require the level of care provided in a nursing facility or an intermediate care facility for the intellectually disabled (ICF/ID).

The services available under the brain injury waiver are: adult day care, behavioral programming, case management, consumer choices option, consumer-directed attendant care, family counseling and training, home and vehicle modifications, interim medical monitoring and treatment, personal emergency response system, prevocational services, respite, specialized medical equipment, supported community living, supported employment, and transportation.

c. Children's Mental Health Waiver

Legal reference: 441 IAC 78.52(249A)

The children's mental health waiver provides funding and individualized supports that allow eligible children and youth up to the age of 18 to live in their own homes.

Eligible children and youth must have a current diagnosis of "serious emotional disorder" as determined by a mental health professional. "Serious emotional disorder" does not include developmental disorders or substance-related disorders. All eligible children and youth must be assessed to meet hospital level of care.

The services available under the children's mental health waiver are: family and community support services, environmental modifications and adaptive devices, respite, and in-home family therapy.

d. Elderly Waiver

Legal reference: 441 IAC 78.37(249A)

Members who are at least 65 years old may qualify for the elderly waiver program if they meet an intermediate or skilled nursing level of care.

The services available under the elderly waiver are: adult day care, assistive devices, case management, chore service, consumer choices option, consumer-directed attendant care, home and vehicle modification, home-delivered meals, home health aide, homemaker, mental health outreach, nursing, nutritional counseling, personal emergency response, respite, senior companion, and transportation.

e. Health and Disability Waiver
Legal reference: 441 IAC 78.34(249A)

To be eligible for the health and disability waiver, a member must be under age 65 and must be determined to need a nursing facility or ICF/ID level of care.

The services available under the ill and handicapped waiver are: adult day care, consumer choices option, consumer-directed attendant care, counseling, home and vehicle modification, home-delivered meals, home health aide, homemaker, interim medical monitoring and treatment, nursing care, nutritional counseling, personal emergency response, and respite.

f. Intellectual Disabilities Waiver
Legal reference: 441 IAC 78.41(249A)

The intellectual disabilities waiver provides services for members with a primary diagnosis of intellectual disability who require the level of care available in an ICF/ID. Members can choose to live at home or in assisted living arrangements. This program encourages total community integration.

Services provided under the intellectual disabilities waiver are: adult day care, consumer choices option, consumer-directed attendant care, day habilitation, home and vehicle modifications, home health aide, interim medical monitoring and treatment, nursing, personal emergency response, prevocational service, respite, supported community living, residential-based supported community living, supported employment, and transportation.

g. Physical Disability Waiver
Legal reference: 441 IAC 78.46(249A)

The physical disability waiver serves members ages 18 through 64 who have a physical disability, determined according to the criteria used for Supplemental Security Income (SSI). Members must require the skilled nursing or intermediate level of care. Members with intellectual disability are **not** eligible for this waiver.

The services available under the physical disability waiver are: consumer choices option, consumer-directed attendant care, home and vehicle modification, personal emergency response system, specialized medical equipment, and transportation.

22. Home Health Agencies

Legal reference: 441 IAC 78.9(249A)

Services provided by the home health services program are covered if the agency has been certified to participate in the Medicare program. To be covered, services must be medically necessary in the treatment of an illness or an injury.

Covered services can include skilled nursing care, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services.

Personal care and private duty nursing are available for children aged 20 and under through the EPSDT program. These services require prior authorization.

23. Hospice

Legal reference: 441 IAC 78.36(249A)

Medicaid hospice provides care to members who are terminally ill and elect hospice rather than active treatment for the illness. Services are aimed at controlling pain and providing support to the member to continue life with as little disruption as possible.

The four core services are: nursing care, medical social services, physician services, and counseling. Supplemental services include short inpatient care, medical appliances, supplies and medication, home health, homemaker services, physical therapy, occupational therapy, and speech-language pathology. Members eligible for Medicare hospice must use that benefit.

24. Independent Laboratories

Legal reference: 441 IAC 78.20(249A)

Medicaid can pay for medically necessary laboratory services provided by independent laboratories. The laboratory must be certified by Medicare and Medicaid for all of the services for which it requests payment.

25. Indian Health Services

Legal reference: 441 IAC 78.51(249A)

Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441 IAC 77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth 441 IAC 78.1(1).

26. Infant and Toddler Services

Legal reference: 441 IAC 78.49(249A)

Medicaid covers services provided by the Early Access program in connection with physical therapy, occupational therapy, speech-language therapy, psychological services, developmental, health and nursing, medical transportation, nutritional counseling, social work, vision, and audiological services. Assessment and direct services are covered.

27. Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)

Legal reference: 441 IAC Chapter 82

Medicaid covers care and services in an ICF/ID if prescribed and certified by the attending physician and supported by an interdisciplinary evaluation. The member served must be intellectually disabled or otherwise developmentally disabled, and be able to benefit from an active treatment program.

28. Lead Investigation Agencies

Legal reference: 441 IAC 78.44(249A)

Payment will be made for medically necessary lead inspection services in order to identify the sources of lead poisoning. The provider must be certified as an elevated blood level (EBL) agency by the Iowa Department of Public Health.

29. Local Education Agencies

Legal reference: 441 IAC 78.50(249A)

Medicaid covers services provided by local education agencies in connection with audiological services, physical therapy, occupational therapy, speech therapy, psychological services, behavior services, consultation services, medical supplies, medical transportation and escort service, nursing, nutrition counseling, personal health services, social work and counseling, vision, and primary and preventive care services.

30. Managed Health Care Providers

Legal reference: 441 IAC Chapter 73 and Chapter 88

These rules make provision for the following managed health care options:

- Health maintenance organizations (HMOs),
- Prepaid health plans (PHPs),
- Programs of all-inclusive care for the elderly (PACE).

The rules cover eligibility of a provider to participate, reimbursement methodologies, record-keeping requirements, grievance procedures, and member enrollment and disenrollment procedures. Services covered or requiring authorization and member access to services are specified.

31. Maternal Health Centers

Legal reference: 441 IAC 78.25(249A)

Payment is made to maternal health centers for prenatal and postpartum care, including nutritional counseling and social services, provided by a licensed dietician, bachelor-degree social workers, physicians, physician assistants, and nurse practitioners employed or under contract with the center.

32. Medical Equipment and Supply Dealers

Legal reference: 441 IAC 78.10(249A)

Medicaid covers durable medical equipment, prosthetics, orthotics, and supplies prescribed by a physician, physician assistant, or advanced registered nurse practitioner. Only equipment whose use is primarily medical in nature is payable under the program. Items that have only an incidental medical use in individual cases are not covered.

33. Non-Emergent Medical Transportation

Legal reference: 441 IAC 78.13(249A)

The Department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

34. Nursing Facilities

Legal reference: 441 IAC Chapter 81

Medicaid covers care and services in nursing facilities if prescribed by the attending physician, and if the physician certifies that nursing care is required.

Medicaid pays for skilled care if the facility has been certified for participation in the Medicare program. In order to be medically eligible for such care, the member must require nursing care under the 24-hour supervision of licensed nursing personnel.

35. Occupational Therapists

Legal reference: 441 IAC 78.35(249A)

Occupational therapy services are covered in accordance with Medicare criteria when provided by an occupational therapist employed by a hospital, home health agency, rural health clinic, nursing home, rehabilitation agency, or physician or by an independently practicing occupational therapist.

36. Optometrists and Opticians

Legal reference: 441 IAC 78.6(249A)

Covered services include the examination determining the need for glasses, the glasses, necessary repairs, visual aids for subnormal vision, and certain other optical appliances, if medically necessary. No payment is made for photogray or gradient-tinted cosmetic lenses. Payment for contact lenses is for certain conditions only.

37. Orthopedic Shoe Dealers

Legal reference: 441 IAC 78.15(249A)

Orthopedic shoes are covered only if prescribed in writing by a physician, podiatrist, physician assistant, or advanced registered nurse practitioner. Payment is approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to definitions and conditions.

38. Pharmacies

Legal reference: 441 IAC 78.42(249A)

Medicaid covers drugs that by law can be dispensed only by a pharmacy on a physician's prescription. Insulin is covered, although not a prescription drug. Also covered are medical and sickroom supplies. A limited number of nonprescription drugs are covered. Some types of drugs are covered only if approved in advance by the IME Pharmacy Medical Services Unit. Payments will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children program.

39. Pharmaceutical Case Management

Legal reference: 441 IAC 78.47(249A)

Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid members determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

40. Physical Therapy Services

Legal reference: 441 IAC 78.17(249A)

Physical therapy services are covered in accordance with Medicare criteria when provided by a physical therapist employed by a hospital, home health agency, rural health clinic, nursing home, rehabilitation agency, physician, or by an independently practicing physical therapist.

41. Physicians

Legal reference: 441 IAC 78.1(249A)

Medicaid covers medical and surgical services performed in the office, clinic, hospital, home, or other location by a doctor of medicine or osteopathy. The following exclusions from coverage apply: cosmetic surgery, routine foot care, and experimental or unproven medical and surgical procedures.

Abortion and sterilization are covered only under certain conditions. Hospital admissions and certain surgical procedures, including surgery for obesity, are subject to prior approval by the IME Medical Services Unit.

42. Podiatrists

Legal reference: 441 IAC 78.5(249A)

Covered services primarily include surgery of the foot and certain orthotic appliances for the foot. Services that are not covered include treatment for flat feet or routine foot care.

43. Program of All Inclusive Care for Elderly (PACE)

Legal reference: 441 IAC 88.81(249A)

PACE is a Medicaid State Plan managed care program that must provide all Medicare and Iowa Medicaid covered services and other non-traditional services that will improve and maintain the member's overall health status. The intent of the PACE program is to provide needed services that will allow members to stay in homes and communities. If a member requires nursing facility care, that care is also covered.

44. Psychiatric Medical Institutions

Legal reference: 441 IAC Chapter 85

Inpatient psychiatric services are provided in three types of psychiatric facilities in addition to general hospitals with psychiatric units: acute care psychiatric hospitals, psychiatric medical institutions for children, and nursing facilities for the mentally ill.

Except for services in the state mental health institutes, Medicaid covers only persons under the age of 21 and persons aged 65 and older in acute care psychiatric hospitals. Medicaid covers only persons under the age of 21 in psychiatric medical institutions for children, and only persons aged 65 and older in nursing facilities for the mentally ill.

These rules establish conditions of participation for providers, record-keeping requirements, reimbursement methodologies, and member eligibility requirements.

45. Psychologists
Legal reference: 441 IAC 78.24(249A)

Covered services include psychological examinations, evaluation, and individual and group psychotherapy in the psychologist's office, a hospital, or a nursing or residential care facility.

46. Public Health Agency
Legal reference: 441 IAC 78.48(249A)

Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease.

47. Rehabilitation Agencies
Legal reference: 441 IAC 78.19(249A)

Services of a rehabilitation agency are covered if the agency has been certified eligible to participate in the Medicare and Medicaid programs. Services of physical therapists, occupational therapists, and speech-language pathologists can be covered.

48. Rural Health Clinics
Legal reference: 441 IAC 78.21(249A)

Services of rural health clinics are covered if the clinic has been certified eligible to participate in the Medicare and Medicaid programs. Covered services include those of a physician, nurse, physician assistant, and other ambulatory services.

49. Screening Centers
Legal reference: 441 IAC 78.18(249A)

Screening services are quick, simple procedures to sort out apparently well persons who have a disease or abnormality and to identify those in need of more definitive study. These services are available for members under age 21.

50. Speech-Language Pathology

Legal reference: 441 IAC 78.54(249A)

Speech pathology services are covered in accordance with Medicare criteria when provided by a speech pathologist employed by a hospital, home health agency, rural health clinic, nursing home, rehabilitation agency or physician, or by an independently practicing speech-language pathologist.

C. GENERAL REQUIREMENTS FOR SERVICES

1. Service Delivery

The policies in this section apply to all providers of Medicaid services.

The services covered by Medicaid shall:

- Be consistent with the diagnosis and treatment of the member's condition.
- Be in accordance with standards of good medical practice.
- Be required to meet the medical need of the member and be for reasons other than the convenience of the member or the member's practitioner or caregiver.
- Be the least costly type of service that would reasonably meet the medical need of the member.
- Be eligible for federal financial participation, unless specifically covered by state law or rule.
- Be within the scope of the provider's licensure.
- Be provided with the full knowledge and consent of the member or someone acting in the member's behalf, unless otherwise required by law or court order, or in emergencies.
- Be supplied by a provider who is eligible to participate in the Medicaid program.

Medicare definitions and policies shall apply to services provided by Medicaid, unless terms or policies are specifically defined differently in this manual.

In an effort to ensure quality care and to contain costs under the Medicaid program, certain restrictions have been placed on Medicaid payments to providers of service. The following list of medical and health care services that are not covered is presented as a general reference. See Chapter III, Iowa Code or Iowa Administrative Code for restrictions and limitations applicable to each provider group.

Payment will not be made for medical care and services that:

- Are medically unnecessary or unreasonable.
- Fail to meet existing standards of professional practice, are currently professionally unacceptable, or are investigational or experimental in nature.
- Are rendered during a period when the member was ineligible for Medicaid.
- Require prior approval but for which approval was not obtained or was denied.
- Are the responsibility of third parties, such as Medicare or private health insurance. Bill the other insurance before billing Medicaid. (See Third-Party Liability.)
- Are fraudulently claimed.
- Represent abuse or overuse.
- Are for cosmetic purposes and are provided only because of the member's personal preference.
- Have already been rejected or disallowed by Medicare, when the rejection was based upon findings for any of the reasons set forth above.
- Are provided to a person while the person is an inmate of a non-medical public institution. A non-medical public institution includes, but is not limited to, jails, prisons, and juvenile detention centers.

If a non-covered service is provided, providers must inform the member before providing the service that the member will be responsible for the bill.

Providers are expected to supply all the same services to Medicaid members as offered to other clients.

As a condition of receiving Medicaid payments, providers must comply with Title VI of the Civil Rights Act of 1964, as amended, and federal regulations 45 CFR Part 80. No person in the United States shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, or national origin, under any program or activity receiving federal financial assistance from the U.S. Department of Health and Human Services.

As a condition of receiving Medicaid payments, providers must comply with the Section 504 of the Rehabilitation Act of 1973, as amended, and federal regulations 45 CFR Part 84 as amended to December 19, 1990. Discrimination on the basis of handicap is prohibited in all programs or activities that receive or benefit from federal financial assistance provided by the U.S. Department of Health and Human Services.

As a condition of receiving Medicaid payments, providers must comply with the Age Discrimination Act of 1975, as amended, and federal regulations 45 CFR Part 91. Discrimination on the basis of age is prohibited in all programs or activities that receive or benefit from federal financial assistance provided by the U.S. Department of Health and Human Services.

2. Determination of Coverage

Services are covered only for Medicaid members. See Chapter II, Section A, for a discussion of the ways members can demonstrate eligibility and methods for providers to verify eligibility.

Presentation of a *Medical Assistance Eligibility Card* does not guarantee that a person continues to be eligible for Medicaid. Verify the person's eligibility and check for any restrictions on payment at each visit (or monthly for persons in a facility or hospital).

Possession of Medicaid eligibility does not guarantee that all services will be paid.

- Bills not used to meet a spenddown for Medically Needy eligibility will be paid.
- Certain services must be authorized or must have prior approval before they are covered. For example:
  - Nursing facilities and ICF/ID should check with the local Department office to verify that payment for medical institutional care will be made for a person who is Medicaid eligible.
  - Home- and community-based waiver services require specific authorization.
- There may be restrictions on which providers can be paid for services to a specific member.
  - Members with a patient manager require the manager's authorization for most services.
  - Managed care plans may limit the provision of certain services.
  - Members may be "locked in" to service by certain providers because of overuse of service.

3. Determining Member Status

Use the Iowa Eligibility Verification System (ELVS) or the IME web portal to get the information concerning member eligibility and restrictions on payment. See Chapter II, Eligibility Verification, for instructions. For pharmacies, this information is available in the point-of-sale system.

The verification system will indicate whether the member:

- Has full or limited Medicaid benefits.
- Has a patient manager.
- Is enrolled in:
  - A managed care organization.
  - PACE.
- Has health insurance (third-party liability).

If the member has limited Medicaid benefits, the verification system will say what benefits the member has. Only those benefits will be paid.

If the member is enrolled in the managed care plan, the plan is named on the verification system with the telephone number for more information.

If the member has health insurance, the policy number and the type of coverage are given. Most times the insurance company name is given. However, for the less common companies, a code is given in place of the name. Contact the IME Provider Services Unit for the name and address of the health insurance company.

4. Prior Authorization

Following is a list of medical services and equipment requiring prior authorization, pre-procedure review, or preadmission review. Refer to Chapter III of the provider manual for information regarding specific criteria that must be met for approval.

- Services, procedures, and medications prescribed by a physician (M.D. or D.O.):
  - Certain drugs as indicated on the Iowa Medicaid Preferred Drug List (PDL) available at www.iowamedicaidpdl.com.
  - Certain frequently performed surgical procedures. (See the *Physician Services Provider Manual*.)
  - Cochlear implants.
  - Bariatric surgery for treatment of obesity.
  - Prescription or nonprescription nutritional supplements.
- Hospital services (see the *Acute Hospital Services Provider Manual* Chapter III, Certification of Inpatient Care, for details):
  - All physical rehabilitation admissions and continued stays
  - All swing-bed and lower-level-of-care admissions and continued stays
  - Certain diagnoses and procedures
  - Certain inpatient and outpatient surgical procedures
  - Medical or surgical procedures, as set forth above

- Dental services:
  - Endodontic retreatments
  - Fixed and removal prostheses
  - Implants
  - Crowns
  - Orthodontic services
  - Periodontal services
  - Occlusal guard Bruxism and other occlusal factors
- Ambulatory surgical centers:
  - Certain surgical procedures require pre-procedure review by the IFMC.
  - Medical or surgical procedures require prior authorization, as set forth above.
- Home health agency EPSDT private-duty nursing and personal care services.
- Durable medical equipment and supplies:
  - Automated medication dispensers
  - Diabetic equipment and supply items produced by a manufacturer that does not have a current rebate agreement with the Department when a rebate agreement is in effect for the item
  - Enteral products, feeding pumps, and supplies
  - External insulin infusion pumps
  - Oral nutritional products
  - Patient lift, non-standard
  - Power wheelchair attendant control
  - Rehab shower commode chair
  - Reimbursement over an established fee schedule amount
  - Safety beds
  - Speech generating devices (augmentative communication systems)
  - Ventilator, back-up
  - Vest airway clearance systems

- Hearing aids:
  - A hearing aid costing more than $650
  - Binaural hearing aids costing more than $1,300
  - Replacement of a hearing aid less than four years old for members 21 years of age and older
- Optometric services and eyeglasses:
  - A second lens correction within a 24-month period for members eight years of age and older.
  - Press-on prisms (Fresnel) may be approved when vision cannot adequately be corrected with other prisms.
  - Subnormal visual aids, including hand magnifiers, loupes, telescopic spectacles, and reverse Galilean telescope systems where near visual acuity is better than 20/100 at 16 inches, 2m print.
  - Photo-chromatic tint for members who have a documented medical condition that causes photosensitivity. Visual therapy warranted by case history or diagnosis, (i.e., convergence insufficiency and amblyopia).
- HCBS waiver (See the HCBS Waiver Provider Manual):
  - Home and vehicle modification
  - Assistive devices
  - Environmental modification
  - Consumer-Directed Attendance Care (CDAC) over 164 units per month
  - Prevocational services

Submit a request for prior authorization to confirm whether a rare or unusual item or service is covered. When medical services or equipment are provided and later determined that prior approval was necessary, submit a retroactive approval request. Approval is not guaranteed.

a. Requests for Prior Authorization

Services require prior approval, the request form and instructions for its use are included in Chapter III of the provider manual.

The request for prior authorization should address the criteria applicable to the particular service, medication, or equipment for which the request is submitted, according to the standards in Chapter III. Copies of pertinent information rather than incorporate them on the prior authorization form.

- **Medical prior authorization.** Make requests for prior approval on form 470-0829, *Request for Prior Authorization*. Click here to access the form online.

  Send requests to:

  IME Medical Prior Authorization
  PO Box 36478
  Des Moines, IA 50315

  Requests may also be faxed to (515) 256-4624.

  Pharmacies requesting prior authorization for medical equipment or medical supply items shall make requests using this process.

- **Drug prior authorization.** Requests can be submitted by faxing to (800) 574-2515. The form can be downloaded at www.iowamedicaidpdl.com.

- **HCBS waiver prior authorization.** Make requests for prior authorization using the following forms based on type of authorization:

  - 470-5047, Certificate of Medical Necessity for Waiver Assistive Devices
  - 470-5048, Certificate of Medical Necessity for Consumer-Directed Attendant Care
  - 470-5049, Certificate of Medical Necessity for Environmental Modification
  - 470-5050, Certificate of Medical Necessity for Home and Vehicle Modification
  - 470-5051, Certificate of Medical Necessity for Prevocational Services

  Requests may be faxed to (515) 725-1388.

b. Review of Request

The IME reviews requests for prior authorization according to the policies in this chapter, Iowa Code, Iowa Administrative Code (IAC), and the conditions for payment as established in Chapter III. Where ambiguity exists as to whether a particular item or service is covered, requests for prior authorization are reviewed according to the following criteria, in order of priority:

- The conditions for payment outlined in the provider manual, Iowa Code and IAC with reference to coverage and duration.
- The determinations made by the Medicare program, unless specifically stated differently in state law or rule.
- The recommendation to the Department from the appropriate advisory committee.
- Whether there are other less expensive procedures that are covered and which would be as effective.
- The advice of an appropriate professional consultant.

c. Denial of Request

If the IME denies a request for authorization, submit a request for reconsideration with additional justification.

In the event of the denial of a drug prior authorization request, the IME will fax a copy of the denial to the prescriber and the pharmacist. A letter of denial is mailed to the member.

The Department issues a notice to members upon a denial of a request for prior authorization. The notice of decision to the member, form 470-0390, is mailed within five working days of the date the prior authorization form is returned to the provider. Decisions regarding HCBS waiver decisions are entered into the state's Individualized Services Information System (ISIS). A notice of decision is created by the service worker, case manager or integrated health home.

The aggrieved party (the member) may file an appeal within 90 days of the date of the notice of decision. (See Appeals for appeal procedures.)

5. Records

The provider's contract with the Iowa Medicaid program requires maintenance of clinical and fiscal records necessary to fully disclose the extent of services, care, and supplies furnished to Medicaid members. Records may be typewritten, handwritten, or electronic format. Clinical and fiscal records shall be retained for a minimum of five years from the date service was rendered.

Fiscal records shall support and document services provided for which a charge is made to the Medicaid program. A fiscal record does not constitute a clinical record.

Clinical records shall support charges made to the Medicaid program by documenting:

- Medical necessity of the services.
- The services provided are consistent with the diagnosis of the member's condition.
- The services are consistent with professionally recognized standards of care.

Documentation shall be complete and legible.

The clinical record shall document each patient encounter, and include the following when appropriate:

- Complaint and symptoms, history, examination findings, diagnostic test results, assessment, clinical impression or diagnosis, plan for care, date, and identity of observer.
- Specific procedures or treatments performed.
- Medications or other supplies.
- Member's progress, response to treatment, changes in treatment, and revision of diagnosis.
- Information necessary to support each item of service provided on Medicaid claim form.

Both types of records must support claims submitted to the Iowa Medicaid Enterprise. Records must be currently maintained. A claim form or billing statement does not constitute a clinical or fiscal record. Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment.

The legal reference for Medicaid policy on maintenance of clinical and fiscal records is 441 IAC 79.3(249A).

Upon proper identification, authorized representatives of the Department shall have the right to review clinical and fiscal records using generally accepted auditing procedures to determine whether:

- The Department has accurately paid claims for goods or services.
- Services have been furnished to Medicaid members.
- Clinical and fiscal records substantiate claims submitted for payment during the audit period.

Federal regulations allow for access to any member's medical records by authorized Department of Health and Human Services personnel and DHS personnel.

Medical records (exclusive of billings) may be released to other people according to applicable HIPAA guidelines.

Whenever a member or the representative of a member, including the member's attorney, requests duplicates of claims billed to or paid by Medicaid:

- Release copies of the billing or medical records to the member or representative; then
- Notify the IME Revenue Collection Unit if there was an accident or trauma claim and provide information that is available concerning the incident. Provide this information by mail or by calling the Revenue Collection Unit at (866) 810-1206, or locally in Des Moines at (515) 256-4619.

When subpoenaed for medical bills, release the bills. At the same time, send a copy of the subpoena and any additional information to:

IME Revenue Collection Unit
PO Box 36446
Des Moines, IA 50315

D. REIMBURSEMENT FOR SERVICES

As a condition of participation in the Medicaid program, providers must agree to accept the payment made by the Medicaid program as payment in full and make no additional charges to the member or others.

No Medicaid payment can be made directly to a member or to anyone other than the provider of service. A Medicaid claim may be submitted when a member becomes eligible after service is provided and has already paid for the service. To do this, refund the payment to the member before submitting the Medicaid claim.

Questions about reimbursement rates should be directed to the IME Provider Services Unit or review the current fee schedule.

1. Claims

Obtain CMS-1500, UB-04, pharmacy, and dental claim forms from any wholesale vendor. Order the *Claim for Targeted Medical Care* from the IME Provider Services Unit.

The Iowa Medicaid Enterprise supports the electronic submission of claims. Through electronic submission, providers are able to submit claims more accurately. Medicaid payments are received more quickly than submitted paper claims.

If not currently submitting claims electronically but would like to do so, IME offers a free software program called PC-ACE Pro32. An IBM-compatible personal computer running Windows-95 or newer, as well as a local modem and analog phone line access, are needed to use PC-ACE Pro32. For information about electronic claims, please call (800) 967-7902.

To begin electronic billing, contact the EDISS coordinator at (800) 967-7902 or visit the IME website. Follow the links for electronic data interchange to find the required EDI forms as well as the PC-ACE Pro32 software for downloading. The EDI staff can assist in installing PC-ACE Pro32.

a. Procedure Coding

The Health Care Financing Administration Common Procedure Coding System (HCPCS) includes specially designed codes and modifiers for reporting medical services and procedures that are copyrighted by the American Medical Association.

Iowa Medicaid has adopted a coding scheme based on the Current Procedure Terminology, current edition, by the American Medical Association. The CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures.

b. Claim Submission

Most claims can be submitted any time. Certain restrictions apply to nursing facilities, hospitals, and HCBS waivers. Payment will be made for covered services when the IME receives the initial claim within one year from the date of service.

Claims submitted beyond the one-year limit may be paid when they are delayed due to delays in receiving third-party payments or retroactive certification for eligibility. State on the claim form the reason the claim is late, or attach it.

To correct an error on an original claim, clearly mark them as a resubmission of a previous claim.

2. Third-Party Liability

The Medicaid Program is the payer of **last resort** for medical services covered by the program. Federal and state rules require that providers make a reasonable effort to pursue third-party resources.

Call ELVS or access the web portal to determine if other third-party resources are available to pay for the services being provided.

In addition, question the member to determine if any other resources are available for payment. If a discrepancy exists between the member's statement and the verification system, please notify the IME Revenue Collection Unit, either:

- Verbally at (866) 810-1206 or (515) 256-4619 (Des Moines)
- In writing to:

  Iowa Medicaid Enterprise
  Revenue Collection Unit
  PO Box 36450
  Des Moines, IA 50315

- By email to: REVCOL@dhs.state.ia.us

When a third-party liability (other insurance) for medical expenses exist, this resource shall be used before the Medicaid program makes any payments, unless the Department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third-party in the form of pay and chase.

"Pay and chase" means the provider bills Medicaid, even though the member has health insurance and Medicaid bills the insurance company. Medicaid allows "pay and chase" for certain situations, including when services are provided to:

- Pregnant women. The Medicaid system is programmed to recognize pregnant women when the diagnosis is entered on the claim.
- Children whose medical is provided from an absent parent, as identified by statements of the parent concerning who provides the insurance.
- Children under the age of 21 for preventative pediatric services, which include all drugs; home health services with procedure codes S9122, S9123, S9124; and the following V codes:

V01.0-V01.9	V20.0-V20.2	V77.0
V02.0-V02.9	V70.0	V77.7
V03.0-V06.9	V72.0-V72.3	V78.2-V78.3
V07.0-V07.9	V73.0-V75.9	V79.2-V79.3

List on the claim form any payments made by the other insurance, whether made to the provider or to the member. If the other source denies payment, indicate this on the Medicaid claim form. Refer to provider-specific manuals for additional information.

- After insurance makes a payment, submit a claim to Medicaid for consideration, unless payment in full is received.
- On the claim, show the amount that was paid by the other insurance. Providers are not required to show the contractual write-off as payment from a third-party payer. Indicate only the actual payment you received from the third-party payer.
- Medicaid will make payment only according to the Medicaid allowance. The third-party payment plus any Medicaid payment cannot exceed the Medicaid allowance.
- If the third-party payment equals or exceeds the Medicaid allowance, Medicaid will pay the claim at $0.00. Medicaid now considers the claim paid, and the provider cannot bill the Medicaid member.

3. Eligibility Under Both Medicare and Medicaid

Medicare is a federally administered program of health insurance for people who are 65 years of age or older or are permanently disabled. When enrolling in Medicare the member has the option to have traditional Medicare (Parts A and B) and add Part D as a "stand-alone" drug plan or a Medicare Advantage plan (Medicare Part C) that offers an alternative way of receiving Medicare benefits through local or regional private plans and often includes prescription coverage.

- **Medicare Part A (Hospital Insurance)** helps cover:
  - Inpatient care in hospitals
  - Skilled nursing facility care
  - Hospice care
  - Home health care
- **Medicare Part B (Medical Insurance)** helps cover:
  - Services from doctors and other health care providers
  - Outpatient care
  - Home health care
  - Durable medical equipment
  - Some preventive services

- **Medicare Part C (Medicare Advantage)**:
  - Includes all benefits and services covered under Part A and Part B
  - Run by Medicare-approved private insurance companies
  - Usually includes Medicare prescription drug coverage (Part D) as part of the plan
  - May include extra benefits and services for an extra cost
- **Medicare Part D (Medicare Prescription Drug Coverage)**:
  - Helps cover the cost of prescription drugs
  - Run by Medicare-approved private insurance companies
  - May help lower prescription drug costs and help protect against higher costs in the future

When Medicare benefits are available for services also provided under the Medicaid program, the only charges payable by the Medicaid program are the Medicare deductibles and coinsurance amounts, beginning with services rendered on or after the first day of the member's eligibility for Medicaid.

Medicare providers must in all instances accept assignment if Medicaid is to make payment for deductibles or coinsurance. There is no provision in Medicaid to reimburse a Medicaid member directly for any payments the member may make to a provider.

It is not necessary to secure the member's signature on the Medicare claim form, because there is on file in the Department's local office a one-time statement from all Medicare beneficiaries agreeing to a permanent assignment of all claims.

a. Services Provided to Traditional Medicare Beneficiaries

To obtain Medicaid reimbursement for services provided to traditional Medicare beneficiaries, observe the following special conditions:

- Always bill the Part A or Part B Medicare intermediary first for any Medicare-covered services. Use the Medicare billing form.

  Following payment of Medicare-covered services, the Medicare intermediary transfers the claim to the Iowa Medicaid Enterprise for payment of deductibles, coinsurance, and any Medicaid-covered services beyond the scope of Medicare.

- If the member has been denied benefits through Medicare on the basis that the benefits were not medically necessary, the member is not eligible to receive these benefits under the Medicaid program for the same reason.
- Medicaid payment for Medicare deductibles and coinsurance amounts is limited to the maximum allowable charge under the Medicare program for that particular service.
- When parts of the services are covered by traditional Medicare and others are covered only by Medicaid, submit **separate** billings to the Medicare intermediary and to the Iowa Medicaid Enterprise.

The Medicaid program pays in its usual manner for services that Medicaid covers but Medicare does not. Submit claims for these services separately to the Iowa Medicaid Enterprise on the regular Medicaid billing form.

b. Traditional Medicare with Other Insurance

If a member has traditional Medicare coverage and other insurance, bill the other sources before submitting a bill to Medicaid. If the provider receives a payment, but the other resource has not paid the full charge, the central Medicare contractor will send the claim to the IME.

If the payment received is less than the allowable Medicaid payment, Medicaid will pay the difference, up to the Medicare allowed amount.

c. Medicare Advantage Plans and Crossover Invoices

To obtain Medicaid reimbursement for services provided to Medicare Advantage beneficiaries, observe the following special conditions.

All providers enrolled with the IME are ***required*** to use the *Medicare Crossover Invoice* and <u>attach a copy</u> of the Medicare Explanation of Benefits (EOMB) when it is necessary to send a paper crossover to the IME. This requirement is pursuant to an amendment passed to 441 IAC 80.2(2)“h.”

The forms may be used only after Medicare or the Medicare Advantage plan has paid and established a coinsurance or deductible. These forms are not for submission of a claim where Medicare has denied the charges. Continue to attach the denied EOMB from Medicare or the Medicare Advantage plan to the CMS-1500 and UB-04 claim forms when submitting for denied or non-covered charges.

There are two different forms depending on which provider and claim types used to submit to Medicare:

- The *Professional Medicare Crossover Invoice*, form 470-4708, should be submitted along with the EOMB for services that were originally billed to Medicare or the Medicare Advantage plan on a CMS-1500 claim form that did not electronically crossover from Medicare. Click here to view instructions for completing this form.
- The *Institutional Medicare Crossover Invoice*, form 470-4707, should be submitted along with the EOMB for services that were originally billed to Medicare or the Medicare Advantage plan on a UB-04 claim form that did not electronically crossover from Medicare. Click here to view instructions for completing this form.

For traditional Medicare claims, please allow four weeks processing time from the date Medicare issues payment (and remarks that the claim has been forwarded to IME) before submitting a crossover claim on paper to the IME.

The mailing address for the crossover claims remains the same as all other claims:

Medicaid Claims
PO Box 150001
Des Moines, IA 50315

4. Copayment

A copayment is a charge that the member must pay to the provider of service when the service is covered under Medicaid.

As a condition of participating in the Medicaid program, a provider may **not** deny care or services to a member because of the member's inability to pay a copayment. An assertion that the person is unable to pay establishes inability to pay. However, this does not remove the member's liability for these charges, and it does not preclude a provider from attempting to collect the copayment.

a. Drugs

The member must pay a copayment for new and refill prescription drugs as follows:

- **$1.00** for generic drugs and preferred brand-name drugs.
- **$2.00** for non-preferred brand-name drugs for which the cost to the state is $25.01 to $50.00.
- **$3.00** for non-preferred brand-name drugs for which the cost to the state is $50.01 or more.

b. Other Services

The member must pay a **$1.00** copayment for the total services rendered on a given date for the following types of services:

- Chiropractor services
- Physical therapists
- Podiatrist services

The member must pay a copayment of **$2.00** for the total services rendered on a given date for the following types of service:

- Ambulance services
- Audiologist services
- Hearing aid dealer services
- Medical equipment and appliances
- Optician services
- Optometrist services
- Orthopedic shoes
- Prosthetic devices and sickroom supplies
- Psychologist services
- Rehabilitation agency services

The member must make a copayment of **$3.00** for the total covered service rendered on a given date for:

- Dental treatment
- Hearing aids
- Services rendered in a physician (MD/DO) office visit

Dually eligible Medicare and Medicaid members must make a copayment of **$1.00** for Medicare Part B (crossover) claims submitted to Medicaid for services in which Medicaid collects a copayment.

c. Exemptions

Copayment is **not** applicable to the following services:

- Services provided to members under age 21. The member's age is indicated on the member's *Medical Assistance Eligibility Card*.
- Family planning services (oral contraceptives, contraceptive devices).
- Services provided to members in nursing facilities, ICF/ID, or psychiatric institutions. **EXCEPTIONS:** Copayment is required for:
  - Residents in a noncertified facility or noncertified bed,
  - Nursing facility residents who have transferred resources, or
  - Medically Needy members who reside in a nursing facility.

  Medicaid cannot make payment for nursing care for these residents; therefore they are not exempt from copayments.
- Any service provided to pregnant women. Members have been advised that if they wish to be exempt from copayment, they are responsible to inform the providers or their income maintenance worker if they are pregnant.
- Services provided by an HMO.
- Emergency services. Emergency services are those services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate attention could reasonably be expected to result in:
  - Placing the member's health in serious jeopardy,
  - Serious impairment to bodily functions, or
  - Serious dysfunction to any bodily organ or part.

  Diagnosis codes are used indicate the emergency service exemption from copayment. Click here to view RC-0113 for the list of emergency diagnosis codes that meet the copayment exemption.

5. Problems with Submitted Claims

After submission of a Medicaid claim, providers will receive a *Remittance Advice* indicating whether the claim was paid, denied, or suspended. A sample of the *Remittance Advice* is included in Chapter III of the provider manual.

Providers should review each *Remittance Advice* promptly to determine whether there were any problems with claims. If so, note the "transaction control number" for that claim and contact the IME Provider Services Unit.

a. Provider Inquiry, Form 470-3744

To inquire as to why a claim was denied or why a claim payment was not as expected, complete a *Provider Inquiry*, form 470-3744. Providers may also use this form to submit questions regarding policy interpretation.

Obtain this form by printing or copying the sample in the manual or contacting the IME Provider Services Unit. Click here to view a sample of this form online.

Attach copies of the claim, the *Remittance Advice*, and any supporting documentation to be considered, such as additional medical records.

Send provider inquiry forms to:

IME Provider Services Unit
PO Box 36450
Des Moines, IA 50315

b. Adjustment Request, Form 470-0040

To make an adjustment to a claim following receipt of the *Remittance Advice*, complete *Adjustment Request*, form 470-0040. Obtain this form by printing or copying the sample in the manual or contacting the IME Provider Services Unit. Click here to access the form online.

Use the *Adjustment Request* form to notify the IME to take an action against a paid claim, such as when a procedure code, revenue code or to correct a billed amount.

NOTE: Requests for adjustments on paid claims will not be processed if more than one year has elapsed between the date of payment of the claim in question and the date the IME receives the request for adjustment.

Send adjustment forms to:

IME Provider Services Unit
PO Box 36450
Des Moines, IA 50315

c. Recoupment Request, Form 470-4987

Use the *Recoupment Request*, form 470-4987, to notify the IME to take an action against a paid claim when money needs to be credited back. Click here to view a sample of the *Recoupment Request* online.

6. Appeals

Providers have the right to appeal a denied claim for services only after all administrative procedures with the IME are exhausted. At that point, the IME issues an official notice that the service is not covered by Medicaid and notifies provider of the right to an appeal.

Administrative procedures include, but are not limited to:

- Resubmitting the claim due to errors in completing the original claim.
- Providing all requested documentation.

To appeal a denied claim, submit a written request for a hearing within 30 days from the date of the official notice denying the claim.

To appeal in writing, do one of the following:

- Complete an appeal electronically at http://dhs.iowa.gov/appeals/appeal-a-dhs-decision, or
- Write a letter telling the IME why a decision is wrong, or
- Fill out an *Appeal and Request for Hearing* form. This form can be obtained from the local DHS office. Specify in the request the nature of the complaint. If possible, include a copy of the official notice of the denial of the claim.

Take or mail the request to:

Appeals Section
Iowa Department of Human Services
1305 E Walnut Street
Des Moines, IA 50319-0114

The Department's rules on appeal hearings are found at 441 IAC Chapter 7.

7. Reviews and Audits

Providers may be audited at any time at the discretion of the Department. The legal reference for Medicaid provider reviews and audits is 441 IAC 79.4(249A).

The Department will select the appropriate method of conducting a review and will protect the confidential nature of the records being reviewed. Providers may be required to furnish records to the Department. Providers may select the method of delivering any requested records to the Department.

Review procedures may include, but are not limited to, the following:

- Comparing clinical and fiscal records with each claim.
- Interviewing members of services and provider employees.
- Examining third-party payment records.
- Comparing Medicaid charges with private client charges to determine that the charge to Medicaid is not more than the customary and prevailing fee. Records of privately paying clients will be requested by subpoena.

The Department's procedures for auditing Medicaid providers may include the use of random sampling and extrapolation. When the Department's audit findings have been generated through sampling and extrapolation, and the provider disagrees with the findings, the burden of proof of compliance rests with the provider.

8. Overpayments

All overpayments identified by the provider must be returned to the IME within 60 days of identification. When an overpayment is found by the Department, the Department may proceed with one or more of the following:

- Request repayment in writing.
- Impose sanctions provided for in 441 IAC 79.2(249A), which may include:
  - A term of probation for participation in the Iowa Medicaid program.
  - Termination from participation in the Iowa Medicaid program.
  - Suspension from participation in the Iowa Medicaid program.
  - Suspension or withholding of payments in whole or part.
  - Prior authorization of services.
  - Review of all claims before payment.
  - Referral to the state licensing board for investigation.
- Investigate and refer to an agency empowered to prosecute under applicable federal or state laws.

Providers must make repayment or reach agreement with the Iowa Medicaid Enterprise regarding repayment. Overpayments and interest charged may be withheld from future payments.

9. Penalties

Refer to Iowa Code 249(a).47 regarding improperly filed claims, imposition of monetary recovery and sanctions, and other violations.