

Core Claims Team - Medically Needy Transmittals

Purpose:

Medically Needy Transmittals are used for old bills that need to be applied to spenddown or for nursing facility claims to apply spenddown to a particular certification period.

Identification of Roles:

Adjustment Examiner – Processes Medically Needy Transmittals

Operations Coordinator - Serves as a back-up for processing Medically Needy Transmittals

Operations Team Lead and Operations Manager – Monitors workload and ensures that work is completed in a timely manner

Performance Standards:

None

Path of Business Procedure:

Step 1: Medically Needy Transmittal is received via mail, email, or fax from income maintenance worker (IM)

Step 2: Determine if the expenses can be applied to the Member's spenddown

Step 3: Expense Processing

- a. If the expenses can't be applied a letter should be sent to the Income Maintenance (IM) Worker from OnBase
 1. Complete the Medically Needy Transmittal in OnBase
- b. If the expenses can be applied enter the Transmittal information into the claims entry file (1) of the Medicaid Management Information System (MMIS)

Step 4: Complete the document in OnBase

- a. Enter keyword information for the document
 1. State ID is the only required keyword

Forms/Reports:

Medically Needy Transmittal

RFP References:

5.2.2.9.4.5, 5.2.2.9.4.14

Interfaces:

IM Workers

OnBase

MMIS

Attachments:

Iowa Department of Human Services
MEDICALLY NEEDED TRANSMITTAL

Case Name		Case Number	
<input type="text"/>		<input type="text"/>	
Recipient ID	Beginning Certification Date	Ending Certification Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Payment Date of the Claim	Payment Amount	Payment Source	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
IM Worker County Number		IM Worker Number	
<input type="text"/>		<input type="text"/>	
IM Worker Name		IM Worker Phone Number	
<input type="text"/>		<input type="text"/>	
Date Claim Received		Date Claim Sent to IME	
<input type="text"/>		<input type="text"/>	

Comments:

Complete this area if submitting a bill for RCF personal care, transportation or facility

Y N RCF Personal Care
 Y N Transportation
 Y N Medical Facility (NF, SNF, ICF-MR)

From Date	To Date	Procedure Code	Charged Amount
<input type="text"/>	<input type="text"/>	W1509	00.01

Provider Name			
<input type="text"/>			
Provider Address			
<input type="text"/>			
City	State	Zip Code	Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>