Agenda

- Overview of Medicaid Waiver Programs
- Waiver processes
- Iowa Medicaid provider responsibilities
Audience

- CM/SW
- HCBS Waiver Providers
- CDAC providers
Individual CDAC
I-CDAC Agenda

- What is CDAC
- CDAC Agreement
- Claim for Targeted Medical Care
- CDAC Procedures
- Audits and Reviews
- Question and Answer
What is CDAC?

• CDAC = Consumer Directed Attendant Care
• A CDAC provider assists a CDAC member (consumer) with self-care tasks that they would normally do themselves, but are not currently able.
• These services allow the member to continue living in their own home.
Services Covered Under CDAC Program

• Unskilled Services
  – Getting dressed & undressed
  – Bathing & grooming
  – General housekeeping
  – Scheduling appointments & communications

• Skilled Services
  – Monitoring medication
  – Catheter & colostomy care
  – Recording vital signs
Services Not Covered Under CDAC Program

• Heavy maintenance or minor repairs to walls, floors, railings, etc.
• Non-essential support: polishing silver, folding napkins, etc.
• **Heavy** cleaning: moving heavy furniture, floor care or painting and trash removal
• Animal Care
• Supervision of the member, verbal prompts or reminders
• Any services that are **not** specifically described in the CDAC Agreement
The CDAC Agreement
The CDAC Agreement

- The agreement is required when a provider is first matched with a member and **before** CDAC services can begin
  - Or
- At the member’s annual plan review
  - Or
- When there are changes in the needs of the member

*The agreement is designed to work with the Daily Service Record (DSR)*
The CDAC Agreement Continued:

• The member may need many of the available services or just a few.
• The agreement is specific to each member/provider combination; no two agreements are alike.
• Providers and members use the agreement to identify the specific services that the member NEEDS and the Provider agrees to perform.
CDAC Services

<table>
<thead>
<tr>
<th>Documentation Service Code</th>
<th>Non-Skilled Service Components To be completed by the consumer or consumer’s legal representative.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>Dressing</td>
</tr>
<tr>
<td>N2</td>
<td>Bathing, grooming, personal hygiene – includes shaving, hair care, make-up, and oral hygiene</td>
</tr>
<tr>
<td>N3</td>
<td>Meal preparation and feeding – includes cooking, eating, and feeding assistance (but not the cost of meals themselves)</td>
</tr>
<tr>
<td>N4</td>
<td>Toileting – includes bowel, bladder and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter)</td>
</tr>
</tbody>
</table>

- Each service category has been assigned a code.
- These codes are the same as the ones used to complete the Daily Service Record.
Overview of the Agreement

• This will outline the *specific* services the provider will agree to do for the member.
• It will outline the amount of time/units allotted per month for each agreed upon service.
• Once agreed upon the member’s Case Manager will review and determine if the services are appropriate.
• The provider, member, and Case Manager (CM) will determine a rate per hour to be paid to the provider.
I agree to abide by all the requirements in this CDAC agreement including the following:

- That my criminal and abuse records will be checked for reported or confirmed criminal history or abuse.
- To hold the Department of Human Services harmless against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of the performance of this CDAC agreement by any and all persons.
- To keep both fiscal and designated clinical/medical documentation records of all CDAC services provided which are charged to the medical assistance program and to maintain these CDAC records for at least five years from the date of claims submission. Documentation shall include the following information for each unit of CDAC service provided and billed:
  
  1. Full name of the consumer receiving the CDAC service as it appears on their medical assistance card.
  2. Consumer’s date of birth.
  3. Medical assistance identification number.
  4. Full name of the person providing the service. If the provider functions under a professional license or is certified to perform certain tasks, list the title after the provider’s name. If the provider does not have a title, enter “CDAC Worker.”
  5. Agency name (if applicable).
  6. Specific date of the CDAC service provided including the day, month, and year.
  7. Total units billed for the date of service.
  8. Waiver type and service procedure code as identified in this agreement.
  9. Duration of the CDAC service provided including the start and end time.
  10. The number of units as computed from the start and end time.
  11. Specific service activity provided as described in this agreement.
  12. Location in which the service was provided.
  13. Description of the CDAC service provided as described in this agreement and as authorized in the service worker/case manager comprehensive service plan.
  14. Description of the provider’s interventions and supports provided and the consumer’s response to those interventions and supports.
  15. Identification of any health, safety, and welfare concerns.
  16. Consumer’s signature, provider’s signature, and the date.

I hereby confirm that all information provided by me on this form is true and correct to the best of my knowledge.
CDAC Daily Service Record
# The CDAC Daily Service Record (DSR)

**Consumer Directed Attendant Care (CDAC) Daily Service Record**

<table>
<thead>
<tr>
<th>1. Provider Name (first, middle initial, last)</th>
<th>2. Agency Name (if an agency)</th>
<th>3. Date of Service (Month, Day &amp; Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Consumer name (first, middle initial, last)</td>
<td>5. Consumer's Medicaid ID number</td>
<td>6. Location(s) where service was given</td>
</tr>
</tbody>
</table>

### 7. Time I was with the Consumer

<table>
<thead>
<tr>
<th>Start Time</th>
<th>End Time</th>
</tr>
</thead>
</table>

### 8. Service code(s) 9. Actual hours of CDAC services

<table>
<thead>
<tr>
<th>8. Code</th>
<th>9. Actual hours of CDAC services</th>
</tr>
</thead>
</table>

### 10. Description of the Services I performed for the Consumer

<table>
<thead>
<tr>
<th>Did I notice anything to be concerned about?</th>
</tr>
</thead>
</table>

### 11. How did it go?

### 12. Total Hours

<table>
<thead>
<tr>
<th>Start Time</th>
<th>End Time</th>
</tr>
</thead>
</table>

### Service Codes: Choose from the list below. Enter the code in the ‘Service Code’ box above to show the service you provided.

- **Non-Skilled Services:**
  - N1 - Dressing
  - N2 - Bathing, grooming, personal hygiene
  - N3 - Meal preparation & feeding
  - N4 - Tolieting
  - N5 - Transferring, ambulation, mobility
  - N6 - Essential Housekeeping
  - N7 - Minor Wound Care
  - N8 - Financial and scheduling assistance
  - N9 - Assistance in the workplace
  - N10 - Communication
  - N11 - Essential transportation
  - N12 - Medication assistance

- **Skilled Services:**
  - S1 - Tube feedings
  - S2 - Intravenous therapy assistance
  - S3 - Parenteral injections
  - S4 - Catheterizations
  - S5 - Respiratory care
  - S6 - Care of decubitus and other areas
  - S7 - Rehabilitation services
  - S8 - Colostomy care
  - S9 - Care of medical conditions
  - S10 - Post-surgical nurse delegated activities
  - S11 - Monitoring reactions to medication
  - S12 - Prepare/monitor therapeutic diets
  - S13 - Recording and reporting of changes in vital signs to the nurse or therapist

**13. Consumer's Signature**

**14. Provider's Signature**

**15. Date**
CDAC Daily Service Record (DSR)

• Service Record must be completed and signed daily by the provider.
• Form is available in a template version at www.ime.state.ia.us
• This record **MUST** be completed in English.
• Must be kept on file for five years from the last date of payment.
• Should not be submitted with the claim form – only ever submit records if they have been specifically requested.
The DSR’s are important because the Iowa Administrative Code 79.3(2)d(35) requires providers to keep accurate logs of services provided each day.

The DSR’s should be reflective of the provider agreement.
Claim for Targeted Medical Care
Claim for Targeted Medical Care

**Member Information**

1. Medicaid ID Number  
2. Member’s Name

**Provider Information**

3. NPI Provider Number  
4. Provider’s Name
5. Provider Address
6. Zip Code  
7. Taxonomy Code

**Other Information**

8. Other Health Insurance □ Yes □ No  
9. Other Health Insurance Denied □ Yes □ No
10. Other Health Insurance Payment  
11. Client Participation Amount

**Services**

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</tr>
</tbody>
</table>

19. Total Claim Charges

**Authorized Signature(s)**

I certify that the statements on the back apply to this bill and are made as a part of it.

Provider Signature  
Date

For consumer-directed attendant care claims only.

Member/Guardian Signature  
Date

---

470-2406 (Rev. 12/11)  
White: Iowa Medicaid Enterprise  
Yellow: Provider
Claim for Targeted Medical Care

- Revised form effective March 1st, 2012
- The claim must accurately reflect the total units performed in a month
- Must be signed by both the provider and member
- It is important that the dates of service do not span more than one calendar month.
CDAC Procedures
CDAC Adjustments

CDAC Adjustment

I understand that by using this coversheet I am asking for a previously paid claim to be changed/corrected. I am attaching this coversheet to a corrected claim.

________________________________________  ________________
Signature                                           Date

________________________________________
NPI

470-5023 (3/11)
Adjustments continued

• Paid claims that require a correction are submitted for an adjustment
  – Cover sheet available at www.ime.state.ia.us/Providers/Forms.html
  – Form 470-5023

• Reasons for an adjustment
  – Missing cents place – Example: $536 will pay $5.36
  – Rate Increase
  – Additional Units
Incident Reporting

All providers who have personal contact with Medicaid members under the Home-and-Community-Based Habilitation Services are required to fill out a Incident Report when a Major incident has occurred.
Major Incident

• Required to be reported within 24 hours of the discovery of the incident.

• Examples of a Major Incident:
  – Results in the death of the member
  – Results in a injury to or by the member that requires a physician’s treatment or
  – Requires the intervention of law enforcement
  – Involves the member’s location as being unknown by their provider.
Minor Incident

• Does not need to be reported to the IME, but should be documented following the standard documentation procedures- The Daily Service Record.

• Examples of Minor Incident;
  – Results in the application of basic first aid
  – Results in bruising

• Situations requiring physician’s treatment or admission to a hospital which are due to symptoms of an illness, disease process, or seizure activities ARE NOT considered a major incident and should not be reported as such
How to Report a Major Incident

• As announced in Informational Letter 1119 Incident Reports must be submitted electronically.

• We offer two options:
  – Contact the Provider Services Call Center 1-800-338-7909 or Des Moines area 515-256-4609
  – Using the IMPA tool
Atypical Code Conversion

• Centers for Medicare and Medicaid Services (CMS) has directed Iowa Medicaid to convert atypical codes (e.g. W1267) into approved standardized codes (e.g. T1019)

• Case Managers will be sending providers a updated Notice of Decision with their approved code, rates, and units.

• Please refer to Informational letters 1007 and 1113. More details available at: www.ime.state.ia.us/Providers/AtypicalCode.html
Documentation
Requirements
Documentation Requirement

References

• Provider Agreement Section 4.1- “The provider shall maintain books, records and documents which sufficiently and properly document and calculate all charges billed to the Department throughout the term of this Agreement for a period of at least five (5) years following the date of final payment or completion of any required audit”
  – Daily Service Record(DSR) is an example
  – Document thoroughly with details of services
Documentation Requirements (Continued)

• CDAC Agreement Page 4 number 3- “The CDAC Provider must be able to document and maintain the fiscal and clinical/medical records he/she provides per Iowa Administrative code 441 79.3. List evidence of basic math, reading, and writing skills (e.g., high school diploma, GED, etc.)
QUESTIONS AND ANSWERS

• At this time we will take some additional questions.
• If you have further Questions or Concerns please feel free to contact the Provider Services Call Center at: 800-338-7909 (toll free) or 515-256-4609 (Des Moines)
HCBS Waiver Services
HCBS Waiver Services Overview

- Allows the State to furnish services that allow members to live in the community and avoid institutionalization.
- Supplements the services that are available to participants through the Medicaid State plan.
HCBS Programs

• Ill & Handicapped
• AIDS/HIV
• Brain Injury
• Children’s Mental Health
• Elderly
• Intellectual Disability
• Physical Disability
• Habilitation
Eligibility

• Member must be Medicaid eligible & meet income guidelines
• Member must meet the level of care requirements
• Waiting lists on some waivers
• Service plan must be developed by an interdisciplinary team and approved by DHS
Ill & Handicapped Waiver

• Under age 65
• Disabled, SSI
• Level of Care
  – Nursing Facility
  – Skilled Nursing Facility
  – ICF/MR
• Service Coordination
  – DHS Service Worker

2,473 members approved to receive services as of May 2012
Ill & Handicapped Allowable Services

- Homemaker
- Home Health
- Adult Day Care
- Respite Care
- CDAC
- Home & Vehicle Modification
- Personal Emergency Response System
- Home-delivered Meals
AIDS/HIV Waiver

- No age restrictions
- AIDS/HIV diagnosis by a physician
- Level of Care
  - NF or Hospital
- Service Coordination
  - DHS Service Worker

34 members approved to receive services as of May 2012
AIDS/HIV Allowable Services

• Respite Care
• Home-delivered meals
• CDAC
• Counseling
• Home Health Aide
• Nursing Care
• Adult Day Care
• Financial Management
Brain Injury Waiver

• Age 1 month-64 years
• Brain Injury diagnosis as defined in Iowa Administrative Code (IAC) 83
• Level of Care
  – Nursing Facility
  – Skilled Nursing Facility
  – ICF/MR
• Service Coordination
  – Medicaid Case Manager

1175 members approved to receive services as of May 2012
Brain Injury Allowable Services

- Respite
- Supported Employment
- Interim Medical Monitoring & Treatment
- Case Management
- Home & Vehicle Modification
- Personal Emergency Response

More information available at:

Children’s Mental Health Waiver

• Under age 18
• Serious emotional disturbance diagnosis
• Level of Care
  – Hospital
• Service Coordination
  – Medicaid Case Manager

700 members approved to receive services as of May 2012
CMH Allowable Services

- Environmental Modifications
- Adaptive Devices
- Therapeutic Resources
- Family & Community Support Services

More information available at:

Elderly Waiver

• Age 65 and older

• Level of Care
  – Nursing Facility
  – Skilled Nursing Facility

• Service Coordination
  – Case Management Provider

8,756 members approved to receive services as of May 2012
Elderly Allowable Services:

- Adult day care
- Emergency response system
- Homemaker
- Chore
- Home-delivered meals
- Home and vehicle modification
- CDAC
- Financial management
- Respite care
Intellectual Disability (ID) Waiver

• No age limit
• Primary diagnosis of mental retardation as determined by a psychologist or psychiatrist
• Level of Care
  – ICF/MR
• Service Coordination
  – Initial- DHS Service Worker
  – Ongoing- Medicaid case manager

11,472 members approved to receive services as of May 2012
ID Allowable Services

- Respite
- Personal emergency response system
- CDAC
- Prevocational services
- Supported community living
- Home and vehicle modification
- Adult day care
- Transportation
Physical Disability (PD) Waiver

• Age 18 through 64
• Have a physical disability as determined by Disability Determination Services
• Level of Care
  – Nursing Facility
  – Skilled Nursing Facility
• Service Coordination
  – DHS Service Worker

850 members approved to receive services as of May 2012
PD Allowable Services

- Home & Vehicle Modification
- Personal Emergency Response
- Financial Management
- Self-directed Personal Care
HCBS Habilitation

- Added as a State Plan Amendment in 2007
- No age limit
- Income must be below 150% of Federal Poverty Level
- Must be eligible for Medicaid
- Needs based & must meet 1 of 2 risk factors:
  - Psychiatric treatment more intensive than outpatient care >1 per lifetime
  - More than 1 episode of continuous professional supported care other than hospitalization
HCBS Habilitation (continued)

• Must meet 2 of 5 *additional* criteria:
  – Unemployed, employed in sheltered setting or limited skills + poor work history
  – Needs financial assistance for maintenance & is unable to procure
  – Severe inability to maintain social support system
  – Needs help w/ basic living skills
  – Exhibits inappropriate social behavior requiring intervention

• 4,135 members approved to receive services as of May 2012
Habilitation Allowable Services

- Case Management
- Home-Based Habilitation
- Prevocational Services
- Supported Employment
- More information available at:
  www.ime.state.ia.us/HCBS/HabilitationServices/Info.html
HCBS Waiver Information:

Visit:
www.ime.state.ia.us/HCBS/HCBSIndex.html

Email:
HCBSwaivers@dhs.state.ia.us

HCBS Specialist by region or county at:
www.ime.state.ia.us/HCBS/HCBSContacts.html
Mental Health and Disability Services Redesign
Mental Health & Disability Services (MHDS) Redesign

• Mental Health and Redesign Act enacted 7/1/12
• Service plan & rate approval processes are affected by the legislation
• Results in little (if any) impact on provider & member participation in Medicaid waiver programs
• Announced in Informational Letter 1141
County Buyout/Redesign Resources

- Key updates and announcements are available at: www.dhs.state.ia.us/Partners/MHDSRedesign.html
- CPC questions should be directed to Robin Wilson at rwilson@dhs.state.ia.us or Julie Jetter at jjetter@dhs.state.ia.us
- Informational Letter 1150
Service Approval Process
Individualized Services Information System (ISIS)

- ISIS assists in the processing & tracking of waiver program requests
- Records are tracked in ISIS until the member stops accessing the services
- Services must be approved before billing Iowa Medicaid
Rate Freeze

• Executive Order # 19 mandated a 10% cut in state government spending
• IL 869 outlined rule changes enacted to reduce HCBS Waiver rates by 2.5%
• IL 1046 announced the rate restoration with an effective date of 7/1/11
• Rates were restored but Executive Order 19 is still in place
• Executive Order 19 is available for review at: http://publications.iowa.gov/8554/1/Executive_Order_No19.pdf
Waiver Prior Authorization (WPA)

• Effective since 10/1/10
• Services Requiring WPA
  – Consumer Directed Attendant Care
  – Home & Vehicle Modification
  – Prevocational Services
  – Environmental Modifications
  – Adaptive Devices
• All waiver services will require Medical Services reviews in the future
WPA (continued)

• Implemented to assist with service plan development

• Median units were determined
  – Anything entered into ISIS above the median unit requires a review
  – Median units are available at: www.ime.state.ia.us/docs/UnitReview.xls

• Additional, clarifying documentation may be requested by the WPA reviewer

• There is a potential for unit decrease based on the information reviewed
WPA (continued)

• When a review determines units should be decreased the decrease is effective:
  – The decrease will be in effect the following month if the decision was made the 1\textsuperscript{st} through the 15\textsuperscript{th} of the month
  – Between the 16\textsuperscript{th} and the end of the month the decrease will be in effect the month after next.

*The decrease of units must be reflected in new CDAC agreement signed by the member and provider*
WPA-Things to Remember

• The most economical service that meets the member’s medical necessity should be provided
• Prevocational services-must include specific & measureable progress with a viable discharge plan
• CDAC agreements- Must reflect essential services & include a complete description of the payable activity
• Non-allowable activities must be excluded from the CDAC agreement
• Documentation must be legible and include a signature & date
• Home and Vehicle Modifications- An itemized bid is needed & separates the cost for each item from the cost of the labor.

• Durable Medical Equipment- supplies cannot include delivery, freight, postage, or other operating expenses

• Medical Equipment- Is the price quote MSRP or dealer cost? Catalog pages or print outs from the internet cannot be accepted in place of a price quote.

• Skilled CDAC services require supervision of a licensed nurse or licensed therapist working under the direction of a physician
Notice of Decision (NOD)

- Sent to the member indicating approval or denial of services
- Denial should state the reason for the decision
- Will list hours/units approved
- Contains timeframe for approved services
Provider Responsibilities
Background Checks

• All Habilitation, Remedial, and Home and Community Based Services (HCBS) waiver providers must complete
  – Child abuse
  – Dependent adult abuse
  – Criminal

background screenings before employment of a prospective staff member per Iowa Code 249A.29 and 135C.33
Background Checks (Continued)

- If the prospective staff has any of the following on their record:
  - Criminal
  - Child abuse
  - Dependent adult abuse

A Department of Human Services (DHS) evaluation must be completed per Iowa Code 135C.33(2) and Iowa Administrative Code 441-ch.119

- The prospective staff member may not provide any services pending the outcome of the initial background and any evaluation by DHS for findings on their record
Office of Inspector General (OIG)

• All providers and contracting entities are required to check the program exclusion status of a potential employee prior to employment.

• Search the Department of Health and Human Services Office of Inspector General (HHS-OIG) website at www.exclusions.oig.hhs.gov

• Any provider that is excluded or employs an excluded individual and submits claims for reimbursement or causes claims to be submitted may be subject to civil money penalties and other damages per section 1128A(a)(1)(D) of the Social Security Act.
HHS-OIG Continued

• Providers should search the HHS-OIG website monthly to
  – Capture exclusions
  – Reinstatements

• Claims paid by Medicaid to an excluded individual could be subject to repayment
  • Informational Letter #1001
Mandatory Child Abuse Reporter

- **Any** employee providing
  - Remedial services
  - Habilitation services
  - HCBS waiver services

To a child must be a mandatory child abuse reporter per Iowa Code section 232.69(3)(b)

- Staff must complete 2 hours of training within 6 months of initial employment

- Must obtain a statement of abuse reporting requirements from employer within 1 month of employment

- Employee must complete at least 2 hours of training every 5 years
Mandatory Dependent Adult Abuse Reporter

- Any employee providing services to a dependent adult must be a mandatory dependent adult abuse reporter per Iowa Code 235B.3(2)
- Staff must complete 2 hours of training within 6 months of initial employment
- Must obtain a statement of abuse reporting requirements from employer within 1 month of employment
- Employee must complete at least 2 hours of training every 5 years
Mandatory Reporter Training

• A list of approved curriculum for child and dependent adult abuse is found at: www.idph.state.ia.us/bh/abuse_ed_review_curricula.asp

• Abuse & Neglect hotline 1-800-362-2178

❖ Failure to follow any of these requirements could result in:
  - Recoupment
  - Sanctions
  - Termination of your contract to provide services

Per Iowa Administrative Code 441-79.2
Incident Reporting
IAC 441-77.25 (5)

- The organization documents the following information:
  - The name of the individual served who was involved in the incident.
  - The date and time the incident occurred.
  - A description of the incident.
  - The names of all organization staff and others who were present or responded at the time of the incident.
  - The action the organization staff took to handle the situation.
  - The resolution of or follow-up to the incident.
Major Incident Definition

- Incident resulting in the death of the member
- Requires emergency mental health treatment of member
- Requires the intervention of law enforcement
- Requires a report of child abuse
- Requires a report of dependent adult abuse
- Constitute a prescription medication error or a pattern of medication errors that lead to any outcomes stated above
- Involves a member’s location being unknown by provider staff who are assigned protective oversight
IMPA- Incident Reporting

• Should be reported once you are aware a major incident occurred.
• The provider who has knowledge of the major incident will complete the report.
• IME uses the data to determine trends
  – Populations
  – Individuals
  – Deaths
• Reporting major incidents is required by CMS
Incident Reporting and IMPA

Click here for the User Registration Guide

- **Provider Enrollment Renewal Guide**
- **Provider Informational Letters** [Go here and sign up!]
- **Provider incident reporting** - As a provider, you can have the ability to report, track and monitor incidents in "real time".
- **Remittance Advice** - View weekly remittance advice online at your convenience.
- **Presumptive Eligibility** - Presumptively approve an infant or child for Medicaid benefits.
  - [Application (English version)]
  - [Application (Spanish version)]
- **List Serv Subscriptions** - Subscribe to different topics on the IMPA List Serv.
  - Subscribe to the selected topics

Helpful Hints

Looking for a Medicaid participating provider? Find one

Be sure to find all of the latest Provider Information.

Medicaid in the news

**Under Use Of Safer Kidney Cancer Surgery For Medicare, Medicaid Patients** (5 days ago)
An increasingly common and safer type of surgery is not as likely to be used for o...

**Link Between Hospital Readmission Rates And Socioeconomics** (7 days ago)
Differences in regional hospital readmission rates more closely tied to the av...

**Introduction Of Bipartisan Bill To Eliminate Medicare Payment Formula** (5/11/2012)
The American College of Physicians (ACP) has asg Schwartz (D-Pa.) and Rep. Joe He...

**Recommendations By AMA Committee On Doctor Shortage** (5/8)
To calculate physicians' fees under Medicare - w some state and private payers...
Billing
Claim for Targeted Medical Care

• Providers should submit their claim forms once per month
  – On the first day of the month after services were given.
  – Documentation should NOT be submitted with the claim form.

• Claims must be completed carefully and accurately – mistakes may result in denial, payment delays or audit concerns.
Claim for Targeted Medical Care

(If handwritten, use blue or black ink only. Accuracy is important.)
This form may be downloaded at http://www.ime.state.ia.us/Providers/claims.html

<table>
<thead>
<tr>
<th>Member Information</th>
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<tbody>
<tr>
<td>1. Medicaid ID Number</td>
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<tr>
<th>Provider Information</th>
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<td>3. NPI Provider Number</td>
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<td>7. Taxonomy Code</td>
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<tr>
<td>9. Other Health Insurance Denied</td>
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<td>10. Other Health Insurance Payment</td>
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<th>Services</th>
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9. Total Claim Charges

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<tr>
<td>I certify that the statements on the back apply to this bill and are made a part of it.</td>
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<tr>
<td>Provider Signature Date</td>
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Revised 12/11

Printable template available at:
www.ime.state.ia.us/Providers/claims.html

Order paper forms by calling IME Provider Services
Client Participation (CP)

• In some cases members must contribute to the cost of waiver services.
• Client Participation (CP) is member responsibility
• The CP amount must be submitted on the claim in Box 11.
Timely Filing Guidelines

• Claims must be filed within 365 days of the date of service (DOS).

• A claim that is timely adjudicated (paid, denied, or suspended), will have an additional 365 days from the adjudication date to resubmit, not to exceed 2 years from the DOS.

• Last Clarified on Informational Letter 637
Common Denial Reasons

• Missing or invalid NPI

• Missing consumer signature (when needed)

• Claim is a photocopy
Electronic Billing

• Providers must enroll with EDISS through their Total On-Boarding program

• PC-ACE Pro32- Free software available through DHS
  – PC-Ace Pro32 Help documents available at
    www.ime.state.ia.us/Providers/Forms.html#PAPHD
Electronic Billing (continued)

- Agency & Assisted Living CDAC Services may bill certain codes electronically
  - W1265
  - W1266
  - W2517

- A time sheet signed by the member is required for review purposes
Oversight & Reviews
Service Reviews

• Services paid by the department are subject to reviews by:
  – Program Integrity
  – Department of Inspections & Appeals
  – Office of Inspector General
  – Medicaid Fraud Control Unit
  – Division of Fiscal Management
  – Program Managers
  – Center for Medicare and Medicaid Services (CMS)
Service Reviews (continued)

Typical Deficiencies during a review:

– No and/ or missing documentation
– Not credible documentation
– Missing/ Incomplete date or time frames
– Missing/ illegible signature
– Not meeting Iowa Administrative code(IAC) definition
– Billing errors
Medical Record Loss

• Form 470-4560 Attestation of Medical Record Loss or Destruction

• Available at: [www.ime.state.ia.us/Providers/Forms.html](http://www.ime.state.ia.us/Providers/Forms.html)

• Only used for documents that were partially or completely destroyed.

• Must be supported by a disaster declaration by the Governor of Iowa

• One form must be filled out & maintained for each member
IME Resources & Updates
What is HIPAA 5010?

- a new standard that regulates the electronic transmission of specific health care transactions

Iowa Medicaid specific HIPAA 5010 resources available at: www.edissweb.com/med/news/hipaa5010.html
Website Redesign

• New & improvedIME website coming **Summer 2013**  [www.ime.state.ia.us](http://www.ime.state.ia.us)

• More user-friendly

• The website will be changing as new features are added as the transition progresses
Provider Manuals

• Updated manuals available beginning July 2012

• Combined HCBS manual – NEW!

• Updated Case Management manual

www.dhs.state.ia.us/policyanalysis/PolicyManualPageMedProvider.htm#All%20Provider%20Chapters
IMPA
(Iowa Medicaid Portal Access)

- Remittance advice
- Document uploading
- Incident reporting
- Informational letters
- Provider re-enrollment
Enrollment Renewal

• Required of all Iowa Medicaid Providers
• Renewal **must** be completed by December 31, 2012
• Complete Ownership and Control Disclosure
• IMPA Tool
• Announced in Informational Letter 1128
• Enrollment renewal takes place every 5 years
Re-enrollment and IMPA

Welcome to the Iowa Medicaid Portal Application!

Click here for the User Registration Guide

Featured Functionality
- Provider Enrollment Renewal Guide
- Provider Informational Letters -Go here and sign up!
- Provider incident reporting - As a provider, you can...

Helpful Hints
Looking for a medicaid participating provider? Be sure to find all of the latest Provider Information here.

Medicaid in the news
Under-Use Of Safer Kidney Cancer Treatments For Poorer, Sicker Medicare, Medicaid Beneficiaries (days ago)
An increasingly common and safer treatment for kidney cancer is not as likely to be used...

Link Between Hospital Readmissions And Availability Of Care, Socioeconomics
Differences in regional hospital readmissions for heart failure are more closely tied to the availability...

Atypical Code Conversion

• Non-standard or “W” billing codes must be converted to the national, standardized codes

• Revised implementation dates:
  – Fee schedule based codes: October 1, 2012
  – Cost report based codes: July 1, 2013

• Refer to Informational Releases 1007 & 1113

• A crosswalk for each code is available at:
  www.ime.state.ia.us/Providers/AtypicalCode.html
ICD-10

- ICD-10 is a diagnostic coding system implemented by the World Health Organization replacing ICD-9
- Allows for more accurate coding of diagnoses
- *Proposed* implementation set for October 2014
- Look for Informational Releases detailing changes
- Visit [www.cms.gov/ICD10](http://www.cms.gov/ICD10) for the latest news and resources to help you prepare for the transition to both 5010 as well as ICD-10.
Provider Services  Call Center

- Can confirm member information supplied by caller

<table>
<thead>
<tr>
<th>ID numbers</th>
<th>Social Security numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth</td>
<td>Date of death</td>
</tr>
<tr>
<td>Spelling of names</td>
<td>Medicare ID</td>
</tr>
<tr>
<td>Approved services in MMIS (for that provider only)</td>
<td></td>
</tr>
</tbody>
</table>

- Call center has a 5 minute/5 questions limitation per call
Provider Services Outreach Staff

- Outreach Staff provides the following services:
  - On-site training
  - Escalated claims issues
  - Please send an email to imeproviderservices@dhs.state.ia.us
You Have Now Completed HCBS Waiver and Habilitation Training 2012

Thank you

Questions?