



# Iowa Wellness Plan Benefits Coverage List

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
<b>1. Ambulatory Services</b>			
<b>Primary Care Illness/injury Physician Services</b>	✓	Should be performed by patient manager or by referral from patient manger when applicable	
<b>Speciality Physician Visits</b>	✓	By patient manager referral.	
<b>Home Health Services</b>	✓	Not Covered: Private Duty/Nursing Personal Cares	Not Covered: Procedure code S9122 or REV codes 570 or 571
<b>Chiropractic Care therapeutic adjustive manipulative</b>	✓		
<b>Outpatient surgery</b>	✓		
<b>Second Surgical Opinion</b>	✓		
<b>Allergy Testing &amp; Injections</b>	✓		
<b>Chemotherapy- Outpatient</b>	✓		
<b>IV Infusion Services</b>	✓		
<b>Radiation Therapy Outpatient</b>	✓		
<b>Dialysis</b>	✓		
<b>Anesthesia</b>	✓		
<b>Walk-in Centers</b>	✓		

<b>AIDS/HIV parity</b>	✓		
<b>Access to clinical trials</b>	✓	Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.	
<b>Genetic Counseling</b>	✓	Prior authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of tx and not just informational.	
<b>2. Emergency Services</b>			
<b>Emergency Room Services</b>	✓		
<b>Emergency Transportation-Ambulance and Air Ambulance</b>	✓	Reviewed for medical necessity prior to payment.	
<b>Urgent Care Centers/Facilities Emergency Clinics (non-hospital)</b>	✓		
<b>3. Hospitalization</b>			
<b>General Inpatient Hospital Care</b>	✓		
<b>Inpatient Physician Services</b>	✓		
<b>Inpatient Surgical Services</b>	✓		
<b>Congenital Abnormalities Correction</b>	✓		
<b>Anesthesia</b>	✓		
<b>Breast Reduction</b>	✓		
<b>Non-Cosmetic Reconstructive Surgery</b>	✓		

<b>Transplant Organ and Tissue</b>	✓	Covered- certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel. Not Covered- transport of living donor, services/supplies related to mechanical or non-human organs, transplant services and supplies not listed in this section including complications.	
<b>Hospice Care - Inpatient</b>	✓		
<b>Hospice Respite - Inpatient</b>	✓	Limited to 15 days per lifetime for inpatient respite care. 15 days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than 5 days at a time.	Revenue code for Hospice Respite: 655
<b>Chemotherapy - Inpatient</b>	✓		
<b>Radiation Therapy - Inpatient</b>	✓		
<b>Breast Reconstruction</b>	✓		
<b>4. Maternity &amp; Newborn Care</b>			
<b>Maternity/Pregnancy Services - Pre &amp; Postnatal Care - Delivery &amp; Inpatient maternity - Nutritional</b>	✓	Member is required to report pregnancy and eligibility for consideration of benefits under the Medicaid State Plan.	
<b>Tobacco Cessation for Pregnant Women</b>	✓		
<b>Midwife Services</b>	✓		
<b>Newborn child coverage</b>	✓		

5. Mental Health Behavioral Health Substance Abuse			
<b>Mental Health/Behavioral Health Inpatient Treatment</b>	✓	Mental health is a carved out benefit provided on a contracted basis through the Iowa Plan. Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019
<b>Mental Health/Behavioral Health Outpatient Treatment</b>	✓	Mental health is a carved out benefit provided on a contracted basis through the Iowa Plan. Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid State Plan.	
<b>Substance Abuse Inpatient Treatment</b>	✓	Substance abuse treatment is a carved out benefit provided on a contracted basis through the Iowa Plan. Members with disabling substance abuse will be considered medically exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019
<b>Substance Abuse Outpatient Treatment</b>	✓	Substance abuse treatment is a carved out benefit provided on a contracted basis through the Iowa Plan. Members with disabling substance abuse will be considered medically exempt and enrolled in the Medicaid State Plan.	
6. Prescription Drugs			
<b>Prescription Drugs</b>	✓		

<b>7. Rehabilitative and Habilitative Services and Devices</b>			
<b>Physical Therapy, Occupational Therapy, Speech Therapy</b>	✓	Each therapy is limited to 60 visits per year. Occupational only for upper extremities. Not covered- OT supplies, IP OT/PT in the absence of separate medical condition requiring hospitalization.	Each therapy is limited to 60 per year: Therapy services must be billed with the GP, GO, or GN modifier. Refer to Medicare's guidance on billing of therapy services.
<b>Inhalation therapy</b>	✓	Limit of 60 visits in a 12 month period.	N/A
<b>Medical and Surgical supplies</b>	✓		
<b>Durable Medical Equipment</b>	✓	Non-covered items include: elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that are available for purchase without a prescription.	
<b>Orthotics</b>	✓		
<b>Prosthetics</b>	✓		
<b>Cardiac Rehabilitation</b>	✓		
<b>Pulmonary Rehabilitation</b>	✓		
<b>Skilled Nursing Services</b>	✓	Covered in nursing facilities, skilled nursing facilities and hospital swing beds.	This service is limited to 120 days per year.

<b>8. Laboratory Services</b>			
<b>Lab Tests</b>	✓		
<b>X-Rays</b>	✓		
<b>Imaging/Diagnostics MRI CT PET</b>	✓		
<b>Sleep Studies</b>	✓	Treatment for snoring not covered. Claims must be for a diagnosis of sleep apnea.	Services 95800-95811 are covered but not with a diagnosis of 786.09.
<b>Diagnostic Genetic Tests</b>	✓	Requires prior authorization	
<b>Pathology</b>	✓		
<b>9. Preventive Wellness Chronic Disease Management</b>			
<b>Preventive Care</b>	✓	Limited to ACA required preventive services.	
<b>Nutritional Counseling</b>	✓	Max 40 units allowed for 12 month period	Not covered: 97802, 97803, G0270
<b>Nutritional Counseling</b>	✓	Max 20 units allowed for 12 month period	Not covered: 97804 & G0271
<b>Counseling and Education Services</b>	✓	Not covered: Bereavement, family, or marriage counseling. Education other than diabetes.	N/A
<b>Family Planning</b>	✓		

<b>Vision Care Exams (Adult)</b>	✓	Codes only allowed once per year: 92002, 92004, 92012, 92014. This does not limit the medical exams for members. Medical exams should be coded properly for accurate claim adjudication.	Not covered: V2020, V2025, V2100-V2115, V2118, V2121, V2199, V2200-V2221, V2299, V2300-V2315, V2318-V2321, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520-V2523, V2530-V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326, 92340, 92341, 92342, 92370, 92390, 92391, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520-V2523, V2530-V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326, 92340, 92341, 92342, 92370, 92390, 92391
<b>Immunizations</b>	✓	Not covered- immunizations for travel	Not covered: 90476, 90477, 90581, 90585, 90586, 90665, 90690, 90691, 90692, 90693, 90717, 90725, 90727, 90735, 90738
<b>Colorectal Cancer Screening</b>	✓		
<b>Screening Mammography</b>	✓	One per year 77057, 77052, G0202	
<b>Hearing Exam (Adult)</b>	✓	Limit of one hearing exam per year. Codes only allowed once per year: 92551, 92552, 92553, 92555, 92556, 92557, 92558, 92559, 92560, V5008	Not covered: V5010, V5014, V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5120, V5130, V5140, V5150, V5160, V5170, V5180, V5190, V5200, V5210, V5220, V5230, V5240, V5264, V5266, V5267, V5298, V5299
<b>Diabetes - med necessary equip &amp; supplies Education</b>	✓		

Screening Pap tests	✓		
Gynecological exam	✓	One per year	
Prostate cancer screening	✓	One per year for men age 50-64 years	
Foot Care	✓	Must be related to medical condition, routine services are not covered.	
Tobacco Cessation	✓	Immunizations and medical eval for nicotine dependence	
<b>10. Pediatric Services including oral &amp; vision</b>			
EPSDT Ages 19 and 20	✓	Covered for ages 19-20	
<b>Benefits Not Available</b>			
Acupuncture	X	Not covered	
Infertility Diagnosis and Treatment	X	Not covered- infertility treatment resulting from voluntary sterilization, relating to collection/purchase of donor semen or eggs, freezing of the same, surrogate services, infertility diagnosis and tx, and tubal/vasectomy reversals, fertility drugs.	

<b>Bariatric Surgery</b>	<b>X</b>	Not covered.	Not covered: 00797, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, S2083 DRGs: 619, 620, 621
<b>Residential Services</b>	<b>X</b>		
<b>Non-emergency Transportation Services</b>	<b>X</b>		
<b>TMJ</b>	<b>X</b>	Not covered	Not covered for primary diagnosis of: 524.60, 524.61, 524.62, 524.63, 524.64, or 524.69
<b>Hearing Aid</b>	<b>X</b>	Not covered	
<b>Frames and lenses</b>	<b>X</b>	Not covered	