

MED - Medical Support Claims Pre-pay Identification of Suspended Hospital Inpatient, Outpatient, Physician, and Dental Claims

Purpose: To identify claims requiring pre-pay review for determination of medical necessity, meeting Medicaid guidelines, appropriate billing, and/or manual pricing.

The Department of Human Services (DHS) has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – obtains and distributes the DHS\IMEUniversal Suspense Report.

Performance Standards:

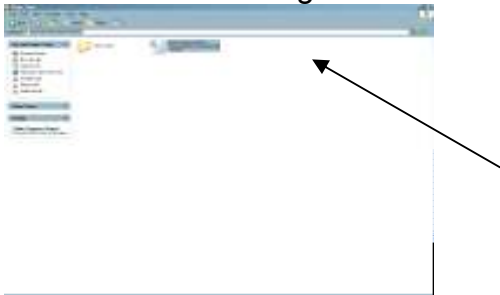
Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: A claim hits edits in Medicaid Management Information System (MMIS) and suspends for review.

Step 2: RC will obtain the suspense report in OnBase following the procedure listed below.

- a. Click on [\\dhsime\imeuniversal\Medical Services\Claims Team\](#).
- b. Click and drag the document to your desktop



- c. To open up the report, double click on the spreadsheet.

Step 3: To share the report:

- a. Open the spreadsheet
- b. Click on review tab
- c. Click on share worksheet
- d. Click Ok.

Claim Location	Claim Type	TCN	StateID	NPI	ProvNum	FromDOS	ToDOS	LocDays	ClaimAge
02	INPATIENT					10/14/2011	10/15/2011	0	18
02	HCFA 1500					9/8/2010	9/8/2010	0	19
02	HCFA 1500					3/23/2012	3/23/2012	0	10
02	HCFA 1500					4/17/2012	4/20/2012	0	18
02	HCFA 1500					4/13/2012	4/13/2012	0	18
04	INPATIENT					8/22/2011	8/26/2011	4	6
04	HCFA 1500					2/3/2012	2/4/2012	12	34
04	LONG TERM CARE					5/3/2012	5/14/2012	0	1
04	LONG TERM CARE					5/1/2012	5/31/2012	0	1
04	LONG TERM CARE					3/6/2012	3/31/2012	0	1
04	LONG TERM CARE					4/1/2012	4/30/2012	0	1
04	LONG TERM CARE					5/1/2012	5/31/2012	0	1
04	LONG TERM CARE					3/8/2012	3/31/2012	0	1
04	LONG TERM CARE					4/1/2012	4/5/2012	0	1
04	LONG TERM CARE					4/6/2012	4/30/2012	0	1
04	LONG TERM CARE					5/1/2012	5/31/2012	0	1
04	LONG TERM CARE					2/1/2012	2/29/2012	0	1
05	DENTAL					2/8/2012	2/8/2012	3	12
05	INPATIENT CROSSOVER					4/21/2011	5/2/2011	55	69
05	INPATIENT CROSSOVER					12/27/2011	1/7/2012	55	66
09	HCFA 1500					12/27/2011	12/27/2011	45	53
09	HCFA 1500					10/2/2011	10/2/2011	33	42
09	HCFA 1500					10/29/2011	10/29/2011	30	40
22	HCFA 1500					3/3/2012	3/3/2012	14	14
22	HCFA 1500					5/1/2012	5/1/2012	12	13

Step 4: The original paper claim received is scanned into OnBase document retrieval by the mailroom staff.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS

OnBase

IME Universal share drive

Attachments:

N/A

MED - Medical Support Claims Pre-pay Receipt of Suspended Hospital Inpatient/Outpatient/Physician/Dental Claims

Purpose: Receive suspended claims for review. DHS has established standards governing which payment will be made and formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – receives list of suspended claims.

Manager – provides direction, training, and oversight in claims adjudication.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC will receive an excel document with a list of assigned suspended claims daily.

Step 2: The RC will access MMIS File 2 and enter the Transaction Control Number (TCN) for the suspended claim obtained from the DHS\IMEUniversal Suspense Report or enter the appropriate location in the ENTER THE SUSPENDED CLAIM LOCATION field.

Step 3: The RC determines why the claim suspended by locating the medical edits at the bottom of suspended claim screen. Each edit refers to a specific diagnosis and/or procedure code suspending for review.

Step 4: The RC will determine if there is documentation attached to the claim based on the TCN.

Step 5: The RC will retrieve the paper claim and documentation through Document Retrieval in OnBase.

Rev. 6/14

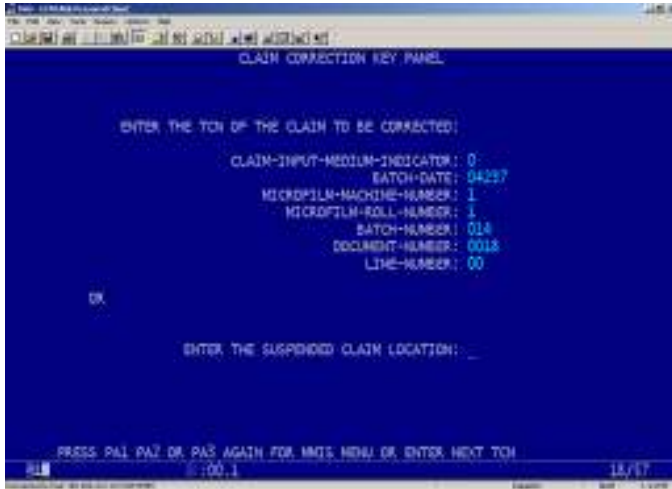
Step 6: The RC will determine if the documents received are sufficient to perform the review. Documentation may include, but is not limited to, history and physicals, lab results, operative reports, pathology reports, physician progress notes, ultrasound reports, sterilization consents, hysterectomy statements, referral and/or consult notes, invoices, and certifications of medical necessity (CMN).

MMIS File 2



Step 7: The RC will access MMIS File 2 and enter the TCN from the DHS\IME\IMEUniversal Suspense Report for the claim to be worked or enter the appropriate location number in the ENTER THE SUSPENDED CLAIM LOCATION field.

MMIS File 2 with TCN



Step 8: Enter TCN

MMIS Suspended Claim

Step 1: The RC will click on the 3 in the ST field of the exception code towards the bottom of the screen.

Step 2: Press the F2 key.

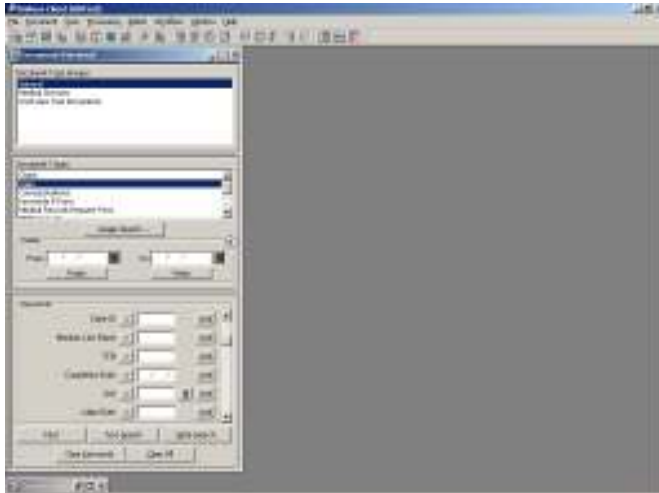
- a. This will display the exception code message explaining the edit that is posting for review.



OnBase Client.Ink

Step 3: RA or RC will double click on the OnBase Client icon on desktop and log on. This will auto populate the Document Retrieval screen.

OnBase Document Retrieval



Step 4: On the Document Retrieval screen, click on the General Document Type Group.

Step 5: On the Document Retrieval screen RA and/or RC will click on the Claim, Core Internal Credit/Adjustment, Core Credit Adjustment, or ACN Document Type. This will auto populate the keywords box for the desired document type.

Step 6: The RA or RC will scroll through the keywords to find the desired field and enter the appropriate keywords.

Step 7: RA or RC will click the Find button to bring up the desired document. This will bring up the desired document.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS

OnBase

IME Universal share drive

Attachments:

Rev. 6/14

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Hospital Inpatient, Outpatient, Physician, and Dental Claims

Purpose: The RC will review the claim to determine if Medicaid guidelines are met, medical necessity is shown, the fee schedule can be applied, or if manual pricing is required. DHS has established standards governing which payment will be made and formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC reviews claims to determine if Medicaid guidelines and medical necessity are met and/or if manual pricing is required.

Step 2: The RC applies appropriate administrative rules and coverage guidelines.

Step 3: The RC will determine that the appropriate diagnoses and/or procedure codes were used.

Step 4: The RC verifies that the number of units billed is appropriate for services billed.

Step 5: If the RC is reviewing a claim or claims history and discovers the claim should not have paid or paid incorrectly, the RC will complete an internal credit/adjustment e-form with the to perform a history search:

Forms/Reports:

Iowa Department of Human Services
 Iowa Medicaid Enterprise

REQUEST FOR PRIOR AUTHORIZATION
 (PLEASE TYPE - ACCURACY IS IMPORTANT)

1. Patient Name (Last)		(First)	(Initial)	2. Patient Medicaid Identification No.	3. Date of Birth Month Day Year			4. Provider Taxonomy No.	
5. Dispensing Provider Name				6. Dates Covered by Request					
				From			To		
7. Provider Phone No	8. Provider Fax	9. Provider NPI		Mo.	Day	Year	Mo.	Da y	Year
10. Service Location Street Address				12. PRIOR AUTHORIZATION NO. (To be assigned by IME) Enter this number in the appropriate box when submitting the the services authorized.					
11. Service Location City, State, Zip									

13. Reasons For Request (Provide specific information and use additional sheet if necessary)

SERVICES TO BE AUTHORIZED

14. Line No.	15. Procedure, Supply, Drug To Be Provided or NDC if applicable	16. Code, HCPCS, CPT or CDT	17. Units of Service	18. Authorized Units (leave blank)	19. Amount Requested	20. Authorized Amount (leave blank)	21. Status (leave blank)
01							
02							
03							
04							
05							
06							
07							
08							
09							

<p>22. IMPORTANT NOTE: In evaluating requests for prior authorization the need for treatment will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service by calling the ELVS line at 1-800-338-7752 (locally at 515-323-9639) or by accessing the Web Portal. Contact Provider Services at 800-338-7909 or (locally) 725-1004 for assistance in accessing the Web Portal.</p>	<p>23. Requesting provider</p> <hr/> <p>Signature of Authorized Representative Date</p>
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RFP Reference:

6.2

Interfaces:

MMIS
 OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Sterilization Claims

Purpose: The RC will review sterilization claim to determine if claim meets Medicaid guidelines. DHS has established standards governing which payment will be made and formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC determines the claim to be reviewed is for a sterilization by clicking on the first digit or letter of the procedure code on the suspended claim in MMIS, pressing the F4 key, and noting that the code is a sterilization procedure.

Step 2: The RC determines if the sterilization form 470-0835 or 470-0835S is included with the claim and fully completed.

Step 4: The RC applies appropriate administrative rules and coverage guidelines.

Step 5: If the consent form is not completed the RC will deny the claim with the appropriate denial code, call the provider, or send a Request for Additional Information. The only exception to this requirement is the Interpreter's Statement that is completed when an interpreter is used.

Step 6: The RC will pay the claim if the sterilization consent form is completed accurately and the following administrative rules and guidelines are met:

- a. The member must be at least 21 years of age at of the counseling.
- b. A waiting period of at least 30 days and no more than 180 days is required between the date the counseling was completed and the date the sterilization procedure is performed.

Forms/Reports:

Sterilization Consent Form

CONSENT FOR STERILIZATION

NOTICE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ . When I first asked for the doctor or clinic information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FIP or Medicaid that I am now getting or for which I may become eligible. I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children. I was told about temporary methods of birth control that are available and could be provided to me that would allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a _____.

The discomforts, risks, and benefits with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs. I am at least 21 years of age and was born on _____.

_____ day _____ year _____ month
 I _____ hereby consent of my own free will to be sterilized by _____, by a method called _____ doctor _____.

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to:
 • Representatives of the Department of Health and Human Services or
 • Employees of programs or projects funded by that Department, but only for the purpose of determining if federal laws were observed. I have received a copy of this form.

Signature	Month	Day	Year
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The following race and ethnicity information is requested, but is not required: Race and ethnicity designation (please check):
 White (not of Hispanic origin) Asian or Pacific Islander
 Black (not of Hispanic origin) American Indian or Alaska Native
 Hispanic

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the person to be sterilized: I have translated the information and advice presented orally to the person to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

Interpreter	Date
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STATEMENT OF PERSON OBTAINING CONSENT

Before _____, signed the consent form, I explained to him/her the nature of the sterilization operation, _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it. I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent. I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds. To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent	Date
Facility	
Address	

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ name of person to be sterilized on _____ date of sterilization operation I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent. I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds. To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the person's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

- (1) At least 30 days have passed between the date of the person's signature on this consent form and the date the sterilization was performed.
- (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the person's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
 - Premature delivery, person's expected date of delivery _____
 - Emergency abdominal surgery: (describe circumstances): _____

Physician	Date
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RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Hysterectomy Claims

Purpose: The RC will review hysterectomy claim to determine if it meets Medicaid guidelines. DHS has established standards governing which payment will be made and formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC determines the claim to be reviewed is for a hysterectomy by clicking on the first digit or letter of the procedure code on the suspended claim in MMIS, pressing the F4 key, and noting that the code is a hysterectomy procedure.

Step 2: The RC determines if the required documentation is included with the claim.

Step 3: The RC applies appropriate administrative rules and coverage guidelines.

Hysterectomies are payable when one or more of the following guidelines are met:

- a. The member or representative has signed an acknowledgement of sterilization statement that says she has been informed that the hysterectomy will make her permanently incapable of reproducing. This must be signed and dated by the member unless the procedure is performed in an emergent situation.
- b. The physician has made a statement in writing that the member was sterile before the hysterectomy was performed and the cause of the sterility. This statement must be signed and dated by the physician. This includes history and physicals, operative reports, or claim forms.
- c. The physician has made a statement stating the hysterectomy was performed as the result of a life-threatening emergency situation. The physician must include a description of the nature of the emergency and will be reviewed on an individual basis.
- d. The member is 60 years of age or over and is considered sterile. This does not require an acknowledgement of sterilization statement.

Forms/Reports:

Example of Hysterectomy Acknowledgement of Sterilization Statement

"Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.

(Date) (Signature of Member or Person Acting on Her Behalf)"

Example of Physician's Statement of Sterility

"Before the surgery, this member was sterile and the cause of that sterility was

*_____
(Physician's Signature) (Date)"*

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Abortion Claims

Purpose: The RC will review abortion claim to determine if it meets Federal and/or State guidelines. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Review Assistant (RA) – provides clerical support at IME facility.

Manager – provides direction, training, and oversight in claims adjudication.

Medicaid Director-consult with Medical Services staff and the Governor's office regarding all abortion requests

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC determines the claim to be reviewed is for an abortion by clicking on the first digit or letter of the procedure code on the suspended claim in MMIS, pressing the F4 key, and noting that the code is an abortion related procedure. State or Federal qualifying abortions must fall into one of the following categories:

- a. The attending provider certifies in writing that continuing the pregnancy would endanger the life of the pregnant woman.
- b. The attending provider certifies in writing on the basis of the provider's professional judgment that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
- c. The pregnancy is the result of rape, that incident was reported to law enforcement agency or public or private health agency, which may include a family physician, within 45 days of the date of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency must so certify in writing.
- d. The pregnancy is the result of incest, that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident, and that report contains the name, address and signature of the person making the report.

Step 2: The RC and manager determine if the required documentation is included with the claim. The following are required to be submitted with the claim:

- a. History and physical, operative report, pathology report, laboratory results, ultrasound reports, physician progress notes, consultation notes, and any other documents that support the diagnosis.
- b. A copy of the form, Certification Regarding Abortion (470-0836), must be attached to any Medicaid claim associated with the abortion and filled out appropriately.
- c. In the case of pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required

Step 3: If all the required documentation is not submitted with the claim, the RC will deny the claim with the appropriate denial message or call the provider and request the required documentation.

Step 4: If all required documentation is submitted with the claim the RC, with manager approval, submits the claim to the MMD through workflow in OnBase.

Step 5: The RC will attach the MMD Router to the documentation requiring the MMD review.

Step 6: The RC will enter the TCN number on the form and provide a case summary on this form for MMD requesting confirmation that all required documentation was submitted with the claim.

Step 7: The RC and MMD will discuss face-to-face if necessary.

Step 8: The MMD will review case and notify RC and manager if all necessary documentation was included with the claim.

Step 9: If all necessary documentation was submitted with the claim the manager will coordinate with the Medicaid Director a review of the claim with the Governor's office.

Step 10.: The claim will be adjudicated in accordance to the decision obtained from the Governor's office.

Step 11: The RC will provide the manager with hardcopies of all federally/state-funded abortions at the end of each calendar quarter.

Forms/Reports:

Abortion Certificate located at <http://www.ime.state.ia.us/docs/470-0836.pdf>.

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Ambulance Claims

Purpose: The RC will review ambulance claim to determine if medically necessary and if Medicaid guidelines are met. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: The RC determines if the claim to be reviewed is for ambulance services by clicking on the first digit or letter of the procedure code on the suspended claim in MMIS, pressing the F4 key, and noting that the code is an ambulance code.

Step 2: The RC will determine if documentation is necessary to review the claim or if the claim is payable without supporting documentation.

Step 3: The RC will review the submitted run report or the claim for medical necessity of ambulance transportation. Ambulance service must be medically necessary and not merely for the convenience of the member. Medically necessary may include:

- a. Emergency situations and when any other means of transport would be contraindicated i.e. will further endanger the individual's condition significantly.
- b. The member is in an emergency situation such as injury resulting from an accident, or illness with acute symptoms.
- c. The member requires restraints by a professionally trained ambulance attendant.
- d. A newly developed state of altered consciousness, such as unconsciousness or unresponsiveness.
- e. The member's condition requires oxygen during transport. The administration of oxygen itself does not satisfy the requirement that a member needs oxygen.
- f. Emergency measures or treatments are indicated.
- g. Immobilization of the member is necessary in order to prevent complications because of a fracture that has not been set.
- h. A suspicion of neurological injury and head or spine immobilization is necessary.

Non-emergent ambulance transport maybe covered when:

- a. Bed confinement is necessary before and after the ambulance trip and a one way or round trip is for medically necessary reasons.
- b. The member could only be moved by stretcher and could only be transported by ambulance use of a wheelchair ambulance or cab ambulance must be contraindicated by the member's condition OR if his or her medical condition, regardless of bed confinement.
- c. The cost of the round trip ambulance transport was less than it would have cost to bring the service to the member.

Step 4: The RC will review three main types of ambulance transports:

- a. Residence/scene/nursing home to hospital these may be ground or air transports
- b. Hospital to hospital may also be ground or air transports
- c. Hospital to Residence/nursing home are only ground transports

Step 5: If the transport is by air ambulance, the RC will approve the claim to be paid when:

- a. The member's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance; and either
- b. The point of pick-up is inaccessible by land vehicle.
- c. Transportation by land ambulance is contraindicated, such as cases where great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities and speedy admission is essential.

Step 6: The RC will review for the following ambulance service charges:

- a. A base rate

- b. Mileage-only for the number of miles the member was on board.
- c. Oxygen
- d. An extra attendant

Step 7: The RC will approve payment when:

- a. The member is transported to the nearest hospital with appropriate facilities.
- b. The member is transported from one hospital to another only if there is a valid documented medical reason for transporting the member to the second hospital.
- c. The member is transported from home or hospital to a nursing facility.
- d. On discharge from the hospital, the ambulance service is to the nursing facility where the member is a resident.
- e. The member is transported to the outpatient department of a hospital or to a physician's office for use of specialized services.

Step 8: When an ambulance claim is not payable, the RC will deny the claim and an MMIS system generated Notice of Decision (NOD) will be sent to the member.

Forms/Reports:

MMIS NOD

IOWA DEPARTMENT OF HUMAN SERVICES
HOOVER STATE OFFICE BUILDING
DES MOINES IA 50138-0114
MEDICAID CLAIM DENIAL NOTICE

THIS IS NOT A BILL

DATE

MEMBER NAME
MEMBER ADDRESS

Dear MEMBER NAME:

The Medicaid claims listed below for MEMBER NAME, MEMBER SID were denied for payment under the Iowa Medicaid Program:

Provider No: XXXXXXXX Provider Name: PROVIDER NAME
TCN: X-XXXX-XXX-XXX-XX
Date of Service: XX/XX/XXX Service Provided: AMBULANCE

Reason For Denial: XXX
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Reason For Denial: 147
THE PROCEDURE CODE BILLED IS NOT VALID FOR THE PROVIDER BILLING THE SERVICE.

Since these services were not payable by the Medicaid program, if the provider informed you before providing the service, you may be asked to pay for them. 441 IAC 79.9(4)

Your rights of appeal are explained on the back of this notice.
470-0385(Rev 6/02)

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Concurrent Care Claims Location 40

Purpose: The RC will review concurrent care claim to determine if medically necessary and if Medicaid guidelines are met. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC determines if the claim to be reviewed is for concurrent care by clicking on the first digit or letter of the procedure code on the suspended claim in MMIS, pressing the F4 key, and also noting the edit posting is a concurrent care edit.

Step 2: The RC will bring up the related claims screen.

Step 3: The RC will find the related claim TCN with the appropriate referenced edit.

Step 4: The RC will pull up the related TCN in claims history.

Step 5: The RC will compare the line number of the suspended claim and the line number of the related claim and review according to the guidelines below.

Step 6: The RC will repeat this process for all related claims.

Step 7: The RC will review the identified claims for the below services utilizing the guidelines below for concurrent services:

Subsequent Inpatient Physician Visits, Critical Care Physician Visits, Emergency Department Physician Visits, and Physician Consultations

Force pay the following procedure codes for inpatient physician visits for the same date of service if the providers are of different specialties or subspecialties:

- a. The edits seen are 103 and/or 002
- b. 99231, 99232, 99233 Subsequent hospital care
- c. 99291 and 99292 Critical care evaluation and management
- d. 99294/99472 Subsequent inpatient pediatric critical care

- e. 99296/99469 Subsequent inpatient neonatal critical care
- f. 99298/99478 and 99299/99479 Subsequent intensive care, per day
- g. T1015 Clinic visit and/or encounter RHC and FQC always considered a family practice visit
- h. 99281, 99292, 99293/99471, 99284, 99285 Emergency department visit.
- i. The preceding initial inpatient codes 99221 through 99223, 99293/99471, 99295/99468 discharge codes 99238 and 99239 and consultation codes 99251 through 9925 may be forced when bumping against one of the above codes for edits 103 or 002.
- j. All the above inpatient codes for place of service 21 or 23 may be forced if they bump against the following outpatient/office visits and outpatient consultations for place of service 11, 22, 71, or 72.
- k. The RC will deny if both physicians have the same specialties.

Inpatient Hospital Admissions and Discharges

The following physician inpatient services are payable to only one physician per hospital admission:

- a. The edit is 091.
- b. The place of service is 21.
- c. 99221, 99222 and 99223 Initial hospital care.
- d. 99293/99471 Initial inpatient pediatric critical care.
- e. 99295/99468 Initial inpatient neonatal critical care.

The following inpatient hospital discharge services are payable to only one physician per hospital admission:

- a. The edit is 091.
- b. The place of service is 21.
- c. 99238 Hospital discharge day management, 30 minutes or less.
- d. 99239 Hospital discharge day management, 30 minutes or more.

Before denying an admission or discharge, The RC will determine if the patient had been transferred to another facility or had not been admitted, discharged and then readmitted within a 24-hour period.

Pay both codes if billed for two separate admissions by the same or different providers. Deny one and force one admission code if two admission or discharges were billed during the same hospitalization. If one code has already been paid, deny the other.

Inpatient and Outpatient Physician Consultation Services

- a. Physician inpatient and outpatient consultation service is limited to one consultation per member per individual provider per 12 months whether completed inpatient or outpatient.
- b. Iowa Medicaid will only reimburse one consultant in each specialty field during a given hospital admission.
- c. Additional consultations are payable for the same physician if it is for an unrelated medical condition during a prior hospitalization.

Office or Outpatient Services

- a. The RC will pay outpatient codes if billed by two separate physicians with different specialties or diagnoses on the same date of service.
- b. The RC will deny outpatient codes if billed by the same physician or by different on the same date of service when the physician specialties and/or diagnoses are the same.
- c. Exception: Occasionally a physician will see a member twice on the same date of service. Prior to denying, the RC will check the diagnoses and any codes listed on the claim for test procedures.

Inpatient Adult Critical Care

- a. Critical care is usually, but not always given in a critical care area.
- b. Services for a member who is not critically ill but in a critical care unit are reported using the subsequent hospital care codes see 99231 through 99233 as appropriate.
- c. Force the following inpatient critical care codes for the same date of service if the providers are of different specialties or subspecialties.
- d. 99291: Critical care evaluation and management of a critically ill member requiring constant attendance of the physician for evaluation and management of the critically ill member, the first hour.
- e. 99292: Critical care, evaluation and management of critically ill or injured member requiring constant attendance of the physician for evaluation and management of the critically ill member, each additional 15 to 30 minutes beyond the first hour. The computer has a five hour limit eight units.
- f. The following services are included in reporting critical care when performed during the critical period by the physician providing critical care. These services are considered part of critical care and must be included with the critical care codes.
- g. Deny the following codes if billed in addition to the above Critical Care codes.

36000	71020	93042	94657	71015
36410	82800-82810	93561-93562	94760	43752
36415	91105	94656	94761	91102
36600	92953	94660	94762	94002-94004
71010	93010	94662	99090	36540
31500 (intubation is payable in this situation)				

Attendance at Delivery and Newborn Care

The following codes are payable when requested by the delivering physician and the diagnosis supports the need. Usually a pediatrician will bill this; however, a provider other than a pediatrician may bill if there is a reasonable explanation such as 'pediatrician not available'. It can only be used once per date.

- a. 99436 Attendance at delivery and initial stabilization of newborn.
- b. 99436 may be reported in addition to 99431.
- c. 99436 may not be reported with 99440/99465 or used in conjunction with 99360.
- d. 99436 may be reported with other evaluation and management (E&M) inpatient codes.
- e. 99436 may be reported with an inpatient consultation code 99251 through 99255 if performed separately and at a different time.

Deny the following code if more than one provider bills this code.

- a. 99431 History and examination of the normal newborn infant, initiation of diagnosis and treatment programs and preparation of hospital records use this code for birthing room deliveries too.

The following codes are used to report services to normal or high risk newborns in different settings:

- a. 99431 History and Physical (H&P) of the normal newborn infant. Initiation of diagnosis and treatment programs and preparation of hospital records.
- b. 99432 normal newborn care in other than hospital or birthing setting, including physical exam of the baby and conferences with parents.
- c. 99433 subsequent hospital care for the evaluation and management of a normal newborn per day.
- d. 99435 History and exam of a newborn.

Inpatient Neonatal and Pediatric Critical Care

The neonatal intensive care unit (NICU) codes are used for services provided by a physician directing the care of a critically ill neonate of a low or very low birth weight infant in NICU only. The pediatric critical care codes are used for physicians directing the care of an infant or child 29 days through 24 months.

- a. 99293/99471 Initial inpatient pediatric critical care, 31 days up through 24 months for the evaluation and management of the critically ill infant or young child
- b. 99294/99472 Subsequent inpatient pediatric critical care, 31 days up through 24 months for the evaluation and management of the critically ill infant or young child
- c. 99295/99468 Initial inpatient neonatal critical care, per day for the evaluation and management of the critically ill neonate and/or infant
- d. 99296/99469 Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill and unstable neonate 28 days or less.
- e. 99298/99478 Subsequent intensive care, per day, for evaluation and management of the recovering very low birth weight infant present body weight less than 1500 grams.
- f. 99299/99479 Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant present body weight of 1500-2500 grams.
- g. Force the above procedure codes for inpatient neonatal and pediatric intensive care physician visits for the same date of service if:
 - i. The providers are of different specialties or subspecialties.
 - ii. The providers are pediatric physicians or pediatric physician assistants.
- h. Deny the following procedure codes if used along with or in addition to the above Neonatal and Pediatric critical care codes.
 - i. 31500 36000 36140 36400 36405 36406 36420 36430 36440 36510 36555 36600 36620 36660 43752 51000 51701 51702 62270 90760-90761 94375 94660 64656 64657 94760-94762.
- i. CPT code 99440/99465 Newborn resuscitation can be billed along with 99295/99468 and 99296/99469 if it is being reported separately as a distinct procedure performed in the delivery room.
- j. The following procedure codes are not billable in addition to NICU care given on the same date of service:
 - i. 94646 - 94657 ventilator management

- ii. 99431 - history and physical
- iii. 99291 - 99292 critical care
- iv. 99231 - 99233 subsequent inpatient hospital care
- v. 94660 - continuous positive airway pressure (CPAP) management

EXCEPTIONS

- a. 99295/99468 Initial day neonatal critical care can be used in addition to codes 99360 physician standby services, 99436 attendance at delivery or 99440/99465 newborn resuscitation when the physician is present for delivery 99360 or 99436 and newborn resuscitation is required. Other procedures performed as a necessary part of the resuscitation ex: 31500, intubation is also reported separately as part of the pre-admission delivery room care.
- b. To report critical care services provided in the emergency room 23 POS for neonates and pediatric members up thru 24 months of age as well as children 24 months and older and adults, use the hourly critical care codes 99291 and 99292.

Physician Standby Services

This code is used to report physician standby assistance that is requested by another physician and involves attendance without face-to-face member contact. It is not used for standby services of less than 30 minutes. The physician cannot be providing care to another member during this period.

- a. 99360 Physician standby services each 30 minutes up to two hours
- b. Physician standby can be reported in addition to the following codes :
 - i. 99431 Hx and exam of newborn
 - ii. 99440/99465 - Newborn resuscitation
 - iii. 99295/99468 Initial NICU

Prolonged Physician Services

- a. Codes 99354 through 99357, prolonged physician services require face-to-face member contact beyond the usual service. It is not expected that prolonged service be billed if the diagnosis does not substantiate the medical need and should not be billed on a daily basis for extended care. This service is reported in addition to other physician services, including evaluation and management services at any level.
- b. 99354 Prolonged physician service in the office or other outpatient setting; first hour
- c. 99355 Prolonged physician services in the office or outpatient setting; each additional 30 minutes.
- d. 99356 Prolonged physician service in the inpatient setting; first hour
- e. 99357 Prolonged physician services in the inpatient setting; each additional 30 minutes.
- f. The prolonged services codes may be used to report the final 15 to 30 minutes.
- g. Prolonged service codes can be used with the following two codes:
- h. 99360 Physician standby
- i. 99440/99465 Newborn resuscitation
- j. Prolonged service codes cannot be used with the following codes:
 - i. 99291 - 99292 adult critical care
 - ii. 99293/99471 - 99294/99472 pediatric critical care

- iii. 99295/99468 - 99299/99479 NICU care
 - iv. 54656-94657 ventilator management
 - v. 94660 PAP management
 - vi. Prolonged services in the office or outpatient setting 99354 and 99355 can be used in conjunction with the following codes:
 - vii. 99201 through 99215 office/outpatient visits
 - viii. 99241 through 99245 office/outpatient consultations
 - ix. Prolonged services in the inpatient setting 99356 and 99357 can be used in conjunction with the following codes:
 - x. 99221 through 99233 subsequent inpatient hospital care
 - xi. 99251 through 99255 inpatient consultations
 - xii. 99433 through subsequent hospital care for the evaluation and management of a normal newborn
- k. When a provider provides prolonged service in excess of two hours in the office setting or three hours in the hospital setting, the provider must send the claims to provider relations for special handling with a 22 modifier and provide documentation of the additional time spent.

Global Obstetrical Care

Medicaid payment for obstetrical (OB) care is made on a global basis. This includes payment for all of the following:

- a. Delivery,
- b. Routine antepartum care
- c. Postpartum care

Postpartum and Ante-partum Care

Ante-partum Care Only

- a. If global obstetrical care is provided, all visits must be included in the global package.

Visits for unrelated services must be clearly identified with a diagnosis not related to maternity care. The following situations may be billed separately:

- a. Hospitalizations for complications or for false labor if delivery does not occur during the stay.
- b. Observation or emergency room visits with an appropriate diagnoses or medical necessity
- c. Medical problems complicating the management of labor or delivery.

Postpartum and ante-partum care may only be billed in the following instances:

- a. Delivery will not be billed by this physician/clinic.
- b. Pregnancy is terminated
- c. The member was not eligible for Medicaid on the date of delivery

Surgeries

- a. 49230 Diagnostic Laparoscopy bumping against 58558 Surgical Hysteroscopy or 58563 Hysteroscopy with ablation-payable with either code
- b. 58660 Laparoscopy with lysis of adhesions bumping against 58671 Laparoscopy with occlusion of oviducts-pay both 58660 and 58671

- c. 58661 Lap with partial or total oophorectomy, bumping against 58662 Lap with fulguration or excision of lesions of ovary, pelvic viscera, peritoneal surface-pay both 58661 and 58662
- d. 58662 see above bumping against 58670 lap with fulguration of oviducts-pay both 58662 and 58670

Durable Medical Equipment

- a. Rental of respiratory suction machine versus purchase of supplies
- b. E0600RR home respiratory suction pump bumping against any of the following three codes.
 - i. A7000 Canister, disposable for the suction pump
 - ii. A7001 Canister, non disposable
 - iii. A7002NU Tubing used with suction pump
- c. Modifier RR stands for rental and modifier NU stands for new.
- d. When a home respiratory pump is rented, all new supplies needed to use the machine or to run the machine are included in the rental price.
- e. Pay E0600RR
- f. Deny A7000 and /or A7001 and/or A7002NU when billed in the same month as E0600 RR whether they have an NU or RR modifier after the code.
- g. A5512 (Multiple density insert, direct formed) or A5513 (Multiple density insert, custom molded)
 - i. 6 units are allowed in 365 days. If more than 6 units in this timeframe then deny using denial code 914.

Levonorgestrel Releasing Intrauterine Contraceptive (IUD)

- a. Payable once every five years.

Hylan G-F 20 16 mg for Intra-Articula Injection (Synvisc)

- b. This is often found in locator 40 and has usually been completed and priced. When this code comes up for review, check for a 433 edit at the bottom of the screen. If edit 433 is forced, go ahead and force or pay the edit for J7320.

Visual Acuity and Preventative Medicine

When 99173 visual acuity bumps against one of the following codes:

- a. 99391
- b. 99392 or
- c. 99394 (preventative medicine).

The RC will deny 99173 and pay 99391, 99392, 99393,99394, 99395, 99396, 99397.

Ophthalmic Procedures

When 92135 scanning i.e. laser with interpretation and report bumping against either of the following two codes:

- a. 92225 ophthalmoscopy, extended or
- b. 92226 subsequent

The RC will pay 92135 (pays the highest dollar amt) and deny 92225 or 92226.

Ophthalmic Scans

76516 Ophthalmic biometry by ultrasound echography cannot be billed with the following two codes:

- a. 76512 B-scan
- b. 76513 anterior segment ultrasound, immersion B-scan or high-resolution biomicroscopy.

The RC will pay 76516 and deny 76512 or 76513. When CPT 76512 bumping against CPT 76519 the RC will pay both codes.

Echocardiography

99307 echocardiography and 99308 echocardiography, limited

The RC will pay 99307 and deny 99308 for fragmenting

Physician Outpatient Consultation and Hyperbaric Oxygen Treatments

- a. 99183 physician attendance and supervision of hyperbaric oxygen therapy bumping against any one of the following codes:
- b. 99241 through 99245 office or outpatient consultation, the RC will pay both codes

Hearing Aids

- a. Replacement parts are payable, there is no limit on replacement parts.
- b. The RC will pay the hearing aid claim when the cost of one is less than \$650 or the cost of two is less is more than \$1,300.
- c. A prior authorization is required if the cost of one is outside of these guidelines.
- d. If the claim is higher than the identified amounts and a PA was not completed the RC will deny the claim.

Comprehensive Medication Services

- a. H2010 comprehensive medication services bumping against another H2010 code or bumping against 90862 Medicare claim for comprehensive med services
- b. The RC will pay the claim when there are 6 days between each comprehensive medication service.

Personal Care Service

- a. T1020 Personal care service, per diem (per day) or one unit bumping against another
- b. T1020 code either on the same claim in suspense or claims history:
- c. The RC will count the number of total units for each procedure code. If there are 23 or less than 23 units in any one month, pay the edit. If there are more than 23 units during any one-month the RC will deny. No units are allowed on weekends.

Total Protein

84155 Protein, Total, except refractory blood test bumping against 84156 Protein, Total; Urine, the RC will pay both codes

General Health Panel

80050 General Health Panel includes the following and are payable by the RC:

- a. 80053 Comprehensive metabolic profile includes: 82040, 82447, 82310, 82374, 82435, 82565, 82947, 84075, 84132, 84155, 84295, 84460, 84450, 84520, (do not use 80053 in addition to 80048, 80076)
- b. 85025 Complete (CBC) automated to include Hg, Hct, RBC, WBC and platelet count and automated differential WBC count or
- c. 85027 Complete CBC, automated Hg, Hct, RBC, WBC, platelet and 85004 Blood count; automated differential WBC counts.
- d. 85027 and
- e. 85007 WBC count, microscopic, manual or
- f. 85009 WBC manual differential, buffy coat
- g. 84443 Thyroid stimulating hormone.

Dialysis Services

- a. 90918 - 90921 Dialysis services reported per month and payable by the RC. These codes are reported according to the patient's age.
- b. 90922 - 90925 Dialysis service reported when the member spends part of the month as an inpatient or when the outpatient related services are initiated after the first of the month. The appropriate age related code would be reported from these codes and payable by the RC:
 - i. 90935 Dialysis performed inpatient with a single physician evaluation.
 - ii. 90937 Dialysis performed inpatient requiring repeated evaluations.
- c. 90945 and 90947 Non dialysis services performed in an outpatient setting payable by the RC.
- d. The RC will deny 90918-90921 if any outpatient dialysis codes are bumping against these codes in the same month or more than one is reported for the same month.
- e. The RC will pay the following codes if the member receives dialysis inpatient part of the month and outpatient part of the same month:
 - i. Dialysis codes 90922-90925 should be reported on a daily basis for inpatient along with 90935 or 90937 reported daily for outpatient services in the same month.
 - ii. 90922 through 90925 are bumping against 90935 or 90937 as long as they are reported on a daily basis.
- f. The RC will pay 90945 and 90947 if reported outpatient daily
- g. The RC will deny 90945 and 90947 if reported inpatient

Medical Necessity of Extended Inpatient Stays as Related to Diagnoses

- a. Edit 004 is the edit that posts to these claims. This alerts RC to the fact that task will be to review for extended inpatient stays.
- b. The RC will pay the following codes:
 - i. 99221 through 99223 All inpatient evaluation and management codes
 - ii. 99291 through 99299/99479 All inpatient critical care codes
 - iii. 99251 through 99255 All inpatient consultation codes
- c. The RC will check the diagnoses and dates of service or the related claims. If the diagnoses all warrant the need for an extended hospital stay, pay the edit.
- d. The RC may request records for review. After reviewing the record, if RC still feels not payable, then send to PR. The RC will pay or deny the claim per the PR's decision.

Dental Concurrent Care Claims

- a. The RC will review the pay to provider and treating provider on the suspended claim and related claim in claims history.
- b. The RC will deny the claim when the same office bills on the same day for the same service.
- c. The RC will pay the claim if it is a different provider after reviewing the provider's specialty and referring to the Dental Provider Manual to determine if another unit of service can be performed on the same date.
- d. The RC will deny the claim if it is for the exact same procedure for the same tooth number.

Forms/Reports:

N/A

RFP Reference:

N/A

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Concurrent Care Claims Location 33

Purpose: The RC will review concurrent care claim to determine if medically necessary and if Medicaid guidelines are met. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Concurrent care is when the member's diagnosis supports medical necessity for multiple physicians to treat a member concurrently

Step 1: The RC determines if the claim to be reviewed is for concurrent care by clicking on the first digit or letter of the procedure code on the suspended claim in MMIS, pressing the F4 key, and also noting the edit posting is a concurrent care edit.

Step 2: The RC will review each claim for medical necessity and determined to be payable or not payable based on the following:

- a. The diagnosis shown on each physicians claim
- b. The specialty of each physician billing.
- c. The number of days billed by each physician.
- d. The length of hospitalization
- e. Services billed by each physician
- f. The level of care by each physician

Step 3: The RC will find the related claim TCN with the appropriate referenced edit.

Step 4: The RC will repeat this process for all related claims.

Step 5: The RC will review the identified claims for the below services utilizing the guidelines below for concurrent services:

Dental Concurrent Care Claims

- a. Review the suspended claim and related claim in claims history.
- b. The RC will review the pay to provider and treating provider. If it is the same office billing for the same services, the RC will deny the claim.
- c. If it is a different provider, the RC will review the provider's specialty refer to the Dental Provider Manual to determine if another unit of service can be performed on the same date and pay the claim if it meets guidelines.
- d. The RC will deny the claim if it is for the exact same procedure for the same tooth number.

CMS 1500 Concurrent claims

These claims suspend when there are two claims bumping against each other with the same date of service, member SID and procedures codes.

- a. The RC will pull up suspended claim and the related claim.
- b. The RC will check the office visit procedure code and provider on each claim.
- c. If the code is an office visit and the two providers are of different specialties the RC will pay the claim.
- d. If the two providers are of the same specialty but have different sub-specialties and the diagnosis are different the RC will pay the claim.
- e. When reviewing labs, the RC will pull up both claims and pay the independent lab claim first when a concurrent situation exists and pay claims in the following order:
 - i. First Lab (10), second Pathology (22), Third Physician (02/03). If the physician was paid and the lab should be paid, the RC will credit the physician claim and pay the lab.
- f. Emergency Room (ER) visits: Two ER visits can be paid on the same day with the same type of provider if services are in different locations.

- g. If diagnosis on both claims are the same or do not support medical necessity, the RC will check documentation if available to see if member might be a possible lock-in candidate.
- h. The RC will pay two ER visits when the diagnoses are unrelated and support medical necessity with the same doctor.
- i. Ambulatory surgery center provider type 36 claim usually bumps up against a physician. The RC will pay the when the a physician claim is provider type 02,03,04,05.
- j. The RC will pay a surgery claim when a surgical code billed is by a physician no modifier that bumps another claim for the same code, same date of service and has an 80 or AS modifier, both claims are payable, if the CPT code accepts the modifier.
- k. The RC will pay a surgical claims that bump and both claims have the 62 modifier, are payable.
- l. The RC will pay the claim when is bumps against an ambulatory surgery center.
- m. : Newborn babies with respiratory problems frequently have many chest x-rays.
- n. The RC will pay newborn X-Rays claims with a valid diagnosis, when the age of the child is under 6 months and it is medically necessary. . .
- o. The RC will pay general X-ray claims based on medical necessity on a case-by-case basis. To be payable they require a valid diagnosis and sometime supporting documentation to be reviewed.
- p. The RC will pay X-rays claims with a 76 or 77 modifier without further review.

Inpatient Claims

These are inpatient hospital claims that suspend when there are two claims bumping against each other with at least one or more dates of service overlapping and having the same member ID. These usually bump another Inpatient claim, but they can bump an outpatient, inpatient crossover or LTC Claim.

- a. When inpatient bumps outpatient, the RC will pay the claim and take back outpatient claim unless the outpatient claim has the diagnosis V57.1, V57.3, V557.21, V58.0, V58.1 or V56.X. pay inpatient claim
- b. When an inpatient claim bumps an inpatient claim the RC will:
 - i. Check facility and dates of service on each claim.
 - ii. If dates overlap by one day, this could be because member was transferred to another facility. Check documents.
 - iii. If the difference is more days overlap drill down into claim to see who is billing for what services.
 - iv. If same facility is billing on both claims, drill down to check services billed.
- c. When Medicare has picked up some services on the paid claim the RC may pay the claim when:
 - i. The same facility is billing on both claims and both are billing for room and board, and other similar services check carefully the date span of claim, room and board that was billed as covered and non-covered day and check for Medicare exhaust. If both are billing for same services, deny suspended claim. If the member has Medicare exhaust with the effective date as a date before or same date of the claim date then the claim is payable.
 - ii. If different facilities are billing on both claims, check dates carefully. Drill down to see what each facility is billing for. If both are billing for room and

board, each must have correct covered and non-covered days listed as such. If this is correct then claim may be payable. If too much overlap, deny claim.

- d. When two hospitals try to bill for the delivery of a baby and inpatient stay, in different parts of the state and no documents are available with either claim the RC will deny the suspended claim until supporting documents are submitted.

Inpatient Crossover

- a. When inpatient crossover bumping inpatient the RC must check dates of service carefully for overlapping of days.
 - i. If claims are from two different facilities and days do not overlap, the RC will pay the claim.
- b. When overlap with different facilities occurs by more than one day:
 - i. The RC will drill down into claim to see what services are being billed. OnBase can be checked for possible documents to make correct determination as to who should get paid.
- c. When inpatient crossover and inpatient bumping claims are from the same facility with overlapping days the RC must check dates carefully drill down into both claims to see what they are billing for to help make a determination.
- d. When the provider is split billing, such as, the revenue code(s) are not the same on the inpatient and crossover, the RC will force the 103 edit.
- e. When the provider is billing the same revenue code(s) on both the inpatient claim and crossover claim, the RC will deny the 103 edit.
- f. When inpatient crossover bumping LTC occurs:
 - i. The same facility is billing on both claims the days need to bill correctly to not overlap services.
 - ii. When they overlap, the LTC days need to be adjusted accordingly with correct number of covered days and non-covered days. One day overlap is acceptable.
 - iii. If a different facility is billing against a LTC claim, check date span carefully and then make sure LTC claim is billed with the correct covered, non-covered, hospital or leave days to match suspended claim. If not, then adjust LTC claim.
- g. The RC will pay both claims when the effective date of the Medicare exhaust is the same as the date of service or before.

Outpatient

These claims usually bump against an outpatient crossover claim.

- a. When an outpatient claim bumps an inpatient claim:
 - i. The RC will deny the claim when bumping an inpatient claim unless the outpatient claim has one of the following diagnoses listed, V57.1, V57.3, V57.21, V58.0, V58.1, or V56.X.
 - ii. If the Outpatient claim has already paid and does not contain one of the above diagnosis codes, The RC needs to credit the outpatient claim and then pay the inpatient claim.
- b. When an outpatient claim bumps an outpatient crossover and involves Home Health the RC will pay the claim if no other claims billed for longer dates of service are found.

- c. When an outpatient bumps another outpatient claim often they involve the same facility i.e. Broadlawn or the U of I and IowaCares members. The RC will check member eligibility and date of service to determine which claim is payable. When the wrong claim has already been paid, the RC will need to credit the incorrectly paid claim and the suspended claim paid

Long Term Care

This claim usually bumps up against a waiver claim, another Long Term Care (LTC) facility or a hospital.

- a. When a LTC claim bumps a waiver claim the RC will pay the long-term care claim.
- b. When a LTC claim bumps an inpatient claim the RC will determine if each claim has billed for the correct number of days in each category covered days, non-covered days, hospital days and leave days. When not billed correctly on the LTC claim then the RC will make an adjustment to reflect correct number in each category. Inpatient claim is then paid.
- c. When a LTC claim bumps an inpatient crossover the inpatient crossover claim will pay and an adjustment is made for the LTC claim to reflect the correct number of days in each category of the LTC claim. However, if the inpatient crossover claim is billed with type of bill 22X, the LTC claim is also payable

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Claims Requiring a Prior Authorization

Purpose: The RC will review claim to determine if a prior authorization was obtained. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: The RC determines if the claim to be reviewed is for a service that requires a PA by clicking on the three in the ST field of the edit that is posting and the exception code states that this service requires a PA.

Step 2: The RC will determine which procedure code on the claim requires prior authorization by noting which line the exception code refers to.

Step 3: The RC will look in MMIS file 12 by member's SID number to determine if a PA was obtained.

Step 4: The RC will deny the claim if there is no PA.

Step 5: If there is a PA, the RC will verify that the procedure code, provider, and date of service match. If these do not match, the RC will deny the claim.

Step 6: If the procedure code, date of service, and provider match, the RC will determine if there are enough approved units left on the PA to cover the requested units on the claim.

Step 7: The RC will pay or deny the claim accordingly.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

MED - Medical Support Claims Pre-pay Review of Exception to Policy Claims

Purpose: The RC will review claims suspended for manual pricing relating to an ETP (Exception to Policy). DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: The RC will open documentation or ETP letter in OnBase

Step 2: The RC will read the entire ETP letter, noting the dates of approval.

Step 3: If letter is a “Payment Exception” for a percentage of the charges the RC will:

- a. Manually price each line accordingly on a CMS 1500.
- b. Manually price the first line of an Outpatient claim according to the percentage allowed of the total claim’s submitted charge and then manually price all subsequent lines at \$0.00.
- c. Manually price the allowed amount on the first page of an Inpatient claim at the percentage allowed of the total claim’s submitted charge.

Step 4: The RC will force the applicable edits that post.

Step 5: If the 414 edit posts, the RC will look for an ETP letter. If not found the RC will deny.

Step 6: If the ETP letter is not clear in the description of how to price or what is to be paid, the RC will email the appropriate policy and/or Medical Services staff member for clarification.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Inpatient Claims

Purpose: The RC will review inpatient claim to determine if medically necessary and if Medicaid guidelines are met. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC determines if the claim to be reviewed is an inpatient claim and if it is the diagnosis or the procedure that is suspending for review.

Step 2: The RC will check MMIS file 12 for a PA before sending for physician review.

Step 3: Review of other procedures and diagnoses refer to provider manuals can be found at: <http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/MedProvider.htm>

Step 4: The RC will refer any questions regarding how to review other procedures and diagnoses to the manager.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Outpatient Claims

Purpose: The RC will review outpatient claim to determine if medically necessary and if Medicaid guidelines are met. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) - reviews suspended claim.

Path of Business Procedure:

Step 1: The RC determines if the claim to be reviewed is for outpatient services and if the diagnosis or the procedure is to be reviewed.

Step 2: The RC determines the reason for reviewing the claim by the edit that posts.

Step 3: Refer any other questions regarding reviewing outpatient claims to the manager.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS

OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Other Suspended Physician Claims

Purpose: The RC will review all other physician claims to determine if medically necessary and if Medicaid guidelines are met. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Path of Business Procedure:

Step 1: The RC determines if the claim being reviewed is for physician services not specified in other operational procedures.

Step 2: The RC determines by reviewing the edits that post if the diagnosis or procedure needs reviewed.

Step 3: The RC will send the case to PR if unable to determine medical necessity.

Step 4: If after PR it is determined that the claim is payable, the RC needs to review the number of units and verify that the code pays correctly.

Step 5: The RC may refer to other operational procedures, Medicare updates, and Provider Manuals regarding coverage guidelines for the billed service at

<http://dhs.iowa.gov/ime/providers/rulesandpolicies>

Step 6: The RC will refer questions to the manager.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS

OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Dental Claims

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Purpose: The RC will review dental claims that do not require a prior authorization to determine if medically necessary and if Medicaid guidelines are met. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC determines if the claim to be reviewed is a dental claim.

Step 2: The RC determines what procedure is suspending for review.

Step 3: The RC determines if the following criteria is met:

- a. Code D9610 requires documentation of the name of the specific drug and why it was medically necessary. This is now set to auto-pay without review.
- b. Routine drugs are not reimbursed separately from the surgical procedure.
- c. If the member has a medical condition that makes a routine drug medically necessary, the drug can be billed separately.
- d. Code D7241 requires documentation showing the surgical complications.
- e. Charges billed for infection control and sterile tray setup is considered part of the office fee. Deny with denial code 927.
- f. Watch for fragmenting of services.
- g. As of May 10, 2002, endodontic services for adults 21 years of age and over are covered only for root canal treatments on permanent anterior teeth numbers 6 through 11 and 22 through 27. Crowns necessary to maintain the integrity of a permanent anterior tooth after a root canal treatment are covered for adults. Crowns require a prior authorization.

Step 4: The RC may refer to the informational releases and the dental provider manual regarding guidelines for coverage of other services, and services that are no longer covered by Medicaid.

Step 5: If a claim does not meet the above criteria it may require physician or consultant review.

Step 6: The RC will refer questions to manager for further determination.

Step 7: If a PA was obtained, services were medically necessary, the submitted charges are fragmenting of other charges submitted or previously paid, or if manual pricing is needed the RC will review claim. Refer to the Dental Provider Manual for a list of services that require a PA.

Step 8: The RC will to review the documentation for necessity or send to consultant for review for necessity and pricing.

Step 9: The RC will need to check OnBase for a claim to determine what service was rendered and if it is payable or submit to the dental consultant if necessary.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended Adjustment Claims

Purpose: The RC will review adjusted claim to determine if medically necessary and if Medicaid guidelines are met. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended adjustment claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC determines claim to be reviewed is an adjustment by noting a 33 being in the seventh and eight digits of the TCN.

Step 2: The RC determines why the adjustment is suspending for review.

Step 3: The RC researches the adjustment, determines why the adjustment is being completed, and reviews the claim following the appropriate operational procedure.

Step 4: The RC will access Credit/Adjustment form through document retrieval in OnBase.

- a. The form must explain in detail the reason for the credit or adjustment.
- b. It is not necessary to submit a copy of the claim or a screen shot from MMIS.

Step 5: The RC will refer to provider manuals for clarification on coverage guidelines. This can be found at: <http://dhs.iowa.gov/ime/providers/rulesandpolicies>

Step 6: The RC will refer any further questions to the manager.

Step 7: The RC will force or deny the edits as appropriate.

Step 8: The RC will work the 844 adjustment edit only after all other edits have been worked.

Credit Adjustment

NEW: Core Internal Credit/Adjustment Request

-Credit/Adjustment Request

Request Type: Adjustment Credit

Claim Type: History Live

Requesting Unit:

TCH:

Provider Number:

NPI Number:

Provider Last Name:

Provider First Name:

Address:

City:

State:

Zip:

State ID:

Adjustment/Credit Reason:

CCH:

User ID:

Comments:

Adjusted TCH:

DCN: Contact Log #:

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS

OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-Pay Physician Reviewer

Purpose: Claims without a fee schedule requiring manual pricing or claims in which medical necessity is questioned will be referred for physician review for further determination. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be

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

Identification of Roles:

Review Coordinator (RC) – refers claim to physician reviewer.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RC will refer a claim for physician review when:

- a. medical necessity is questioned
- b. a fee schedule is not in place
- c. claim has a 22 or 62 modifier

Step 2: The RC will provide MMD or CAMD with additional information and route through the OnBase workflow.

- a. If necessary, the RC may need to print off additional information scanned in OnBase and route hardcopy to MMD or CAMD.

Step 3: The RC will attach the MD Router form to the additional information and route it through OnBase workflow.

Step 4: The RC will enter the TCN number on the form and provide a case summary on this form for physician review.

Step 5: The RC and MMD and/or CAMD will discuss face-to-face if necessary.

Step 6: The MMD and/or CAMD will review case and provide RC with rationale of decision made.

Step 7: The MMD and/or CAMD will return the reviewed claims to the RC via route submitted and process as appropriate.

Forms/Reports:

Medical Services - Request for Medical Director Review
Route all requests for Medical Director Review to Medical Services

- | | | |
|--|--|---|
| <input type="checkbox"/> DHS Policy Staff | <input type="checkbox"/> Member Services | <input type="checkbox"/> Retro Review |
| <input type="checkbox"/> EPSDT | <input type="checkbox"/> Pharmacy Services | <input type="checkbox"/> SURS |
| <input type="checkbox"/> Exception to Policy | <input type="checkbox"/> Pre-Pay | <input type="checkbox"/> Targeted Case Mgmt |

- Lock-in Prior Authorization Waiver
 Long Term Care Medical Support

Other
(specify) _____

Person requesting review: _____ Ext: _____

Date:	Date of Service:
Review Type:	Attending Physician:
Member Name:	Telephone #:
Member ID:	Hospital ID:
Admission Date:	Hospital Name:
Discharge Date:	Hospital City:

Case Summary: (explain reason for Medical Director review - include known facts, concerns, etc.)

Medical Director rationale for decision: _____

Concern Identified No Concern Identified Approve Deny

Immediate Action Recommended: _____

Indicate amount of time spent reviewing this case: _____

External consultants utilized: Yes (identify below) No

External consultant(s): _____

Medical Director Signature: _____ Date: _____

MDRouter/#05

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

Rev. 6/14

N/A

MED - Medical Support Claims Pre-pay Requesting Additional Information

Purpose: Some claims do not have all the necessary information to complete the review. Additional information will be requested as needed either by denying the claim with the appropriate denial message or through a letter to the provider. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – determines claim requires additional information to complete the review.

Review Assistant (RA) – produces letters.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The RA and/or RC will review the submitted documentation to insure that the request is complete.

Step 2: The RA and/or RC will complete a request for additional information if needed. Only information that is necessary to approve the service may be requested.

- a. If one of the following denial codes would be used to deny the claim, instead of denying the claim, RC can pend the claim to a holding location.

Code	EOB Description	Remark Code
901	The member was not, at least, age 21 when counseling was provided.	N129
902	The sterilization consent form is not legible or is completed incorrectly.	N228
903	Prior authorization number is incorrect.	M62
904	A 30-day waiting period for sterilization was not met; 180 day maximum exceeded or 72 hr waiting period for emergency sterilization was not met.	No Remark Required
905	The percentage of the procedure that was completed must be included in the operative report.	N233
906	The physician, member, counselor, and/or interpreter signature/date are missing or invalid on the consent form.	N228
907	Add-on codes must always be billed in conjunction with the appropriate primary code.	N122
908	The procedure/surgery was performed outside of an OR for treatment of complications of another surgery and is not separately reimbursable.	N390

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Medical Services Unit

909	Office visit notes/medical record/therapy notes are required to review this service. Please resubmit with documentation.	N225
910	Required fields are blank on the sterilization consent form.	N228
911	A valid tooth number or surface is required for this procedure.	N75
912	The abortion certificate was not attached/must be the revised 07/11 version.	N398
913	A physician signed procedure/surgical report is required.	M29
914	The medical necessity was not shown for the service and/or units billed.	N163
915	An NCCI edit exists for the code combination billed.	M51
916	The diagnosis does not support the service billed.	M76
917	A diagnosis or documentation indicating the outcome of the delivery is required to review the claim.	M76
918	Unlisted procedures CPT/HCPS codes must be clearly identified in Box 19 on claim form.	MA66
919	Hysterectomy acknowledgement or sterilization consent is missing.	N228
920	The service/procedure billed is not a Medicaid benefit.	N425
921	Statutorily excluded service(s).	N30
922	Ambulance service needs to be billed to Mental Health Contractor, Magellan.	N109
923	Based on medical review, the assistant at surgery is not medically necessary.	N250
924	The charge is part of the DRG of the first hospital.	N47
925	No reason was provided for an ambulance transfer to a different hospital.	N115
926	The documentation submitted is not legible.	N205
927	The charge represents fragmented/incidental billing with other charges submitted.	N19
928	Documentation indicating fetal status at the time of/or prior to the procedure is required to review this claim.	N464
929	The service/procedure billed does not meet Medicare LCD/NCD guidelines.	N115
930	Supporting ultrasound documentation is required in order to evaluate this claim.	M60
931	The incorrect modifier has been used for assistant at surgery/assistant surgeon.	N250
932	Visual field acuity test, taped and untaped is missing.	N178
933	Units of service exceed medically unlikely edit/max units.	N362
934	Service exceeds frequency limitations.	N362
935	The date span of this claim overlaps the date span of the previous paid claim.	N300
936	There is no documentation showing member trialed equipment and documented results.	N223
937	The claim requires the length of the extension set.	N354
938	There is a limit of one consultation per patient per individual provider per 12 months for related conditions.	M90
939	Two separate physicians have billed for "initial hospital care". Only one physician is allowed to bill this code per hospitalization.	M86
940	The billing instructions on the DHS exception letter were not followed.	N54
941	A modifier is required when billing this service.	N519
942	Concurrent care was rendered. It did not meet Medicaid criteria for payment.	M86
943	Prior authorization for the item/service billed was not approved.	M62

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Medical Services Unit

944	The medical need for the ambulance was not provided.	N115
945	The miles were reduced; the trip was not to the nearest appropriate facility.	No Remark
946	Air ambulance need was not shown.	N115
947	Documentation is not complete.	N225
948	Warranty status is required; please include make/model/purchase date.	N150
949	Frequency/duration/number of hours per visit for the service is required.	135
950	Use of the 22 modifier is not warranted based on review of the documentation provided.	N519
951	Experimental services/procedures are not covered.	N425
952	Documentation describing increased services is required for additional payment to be considered.	N29
953	Manufacturer's invoice is required.	M23
954	There appears to be a more specific HCPCS/CPT/CDT procedure code/revenue code that describes the item or service billed.	M20
955	Obstetrical care must be billed as a global fee.	N390
956	Paragraph 1 or 2 must be crossed out on the consent form or the incorrect paragraph is crossed out.	N28
957	A signature stamp is not valid on the consent form.	N399
958	Documentation indicating date of surgery, date CPM use began, and/or date of discharge is required to review this claim.	M125
959	The services provided and units billed do not match.	N430
960	Dates of services are outside the approved prior authorization date span.	N351
961	Required medical history and physical are missing.	N221
962	Documentation showing degree & duration of symptoms & prior attempts at conventional treatment is required to review this claim.	N29
963	Progress notes are missing.	N393
964	This item is not payable in a nursing facility/skilled nursing facility.	N95
965	Resubmit claim with photographs supporting medical necessity (if available).	N178
966	The reference provider number is missing or invalid.	N286
967	The place of service field must reflect the location where service was provided.	M77
968	The plan of treatment is missing or is invalid for services billed.	M135
969	Iowa Medicaid does not provide additional reimbursement for the 63 modifier.	N519
970	Date span conflicts with units billed or date span required when billing this service.	N300
971	An incorrect diagnosis code was used.	M76
972	Incomplete/invalid documentation/orders/notes/summary/report/chart.	N225
973	Repair or replacement of DME is not covered.	N171
974	The physician order is missing.	N455
975	Service billed must be clearly identified on invoice.	N354
976	Equipment must be patient owned.	M124
977	Incorrect consent form is attached.	N228
978	Additional information is required.	N29
979	Incorrect modifier for item or service billed.	N519
980	The NDC is not a rebatable NDC.	M119
981	Units on prior authorization were exceeded.	N362

982	Items billed are included in rental fee.	No Remark
983	Documentation was not valid for date(s) of service/member billed.	M59
984	An ambulance run report must be submitted with the CMS 5010 claim form.	N29
985	Date of last x-ray invalid. Check x-ray date for validity under Iowa Medicaid policy.	N326
986	Diagnostic testing or laboratory reports are required to review this claim.	N395
987	Documentation must include dose/strength of medication and height/weight and BSA of member.	M123
988	Physician statement must be signed by the physician who performed the procedure. A staff signature is not acceptable.	MA81
989	Required abortion documentation is missing.	M225
990	This service is an exact duplicate of a previously paid claim.	No Remark
991	This service has been incorrectly billed multiple times on one claim form for the same date of service.	No Remark
992	There is a discrepancy between the date of birth on the documentation and date of birth listed in our records.	N327
993	The facility name is missing.	N261
994	The operative report does not support the use of the 62 modifier or MPFS indicates that Co-Surgeons are not payable for this procedure.	N519
995	The claim must be billed as technical component only- with modifier TC.	N195
996	The service billed does not match the order.	N206
997	Manufacturer's price invoice submitted is not for the item billed.	N354
998	The bill type submitted is invalid or incorrect for the billing. Consult the Medicaid billing instructions for correct type of bill.	MA30
999	A physician order signed and dated within the last year of service request is required.	N455

Step 3: After the claim is pended to the appropriate location, the RC will either send an email to the RA with a screen shot of the claim that requires additional information and a note clarifying the additional information that is needed or the RC will generate the letter.

Step 4: The RC or RA will generate a template letter to the provider requesting the specific documentation needed to complete the review. The template letter is an e-form.

a. If the requested information is not received within the timeframe outlined above, the RC will deny the claim..

b. If the requested information is received, it will be scanned into workflow.

Step 5: The RA will receive the requested additional information in the MS Correspondence queue and assign keywords.

Step 6: The RA will then forward the additional information to the appropriate RC through OnBase to the appropriate RC noted in the letter.

Step 7: The RC will attach the additional information to the original claim documentation in OnBase.

Step 8: The RC will then review the claim following the steps outlined in the appropriate Medical Support Claims Pre-Pay Operational Procedure.

a. If the requested documentation is not received, the RC can deny the claim with the appropriate denial message the day after the date on the letter or after the claim has been in the pended location for 14 days.

Forms/Reports:

Request for Information

Date:

Provider Number:

RE: Your claim for _____, Member ID Number _____, Date of Service _____, TCN number _____

Dear _____:

The above referenced claim has been reviewed by the Department of Human Services, Medical Services. It has been determined that the following additional information is required to complete the review of this claim.

- | | |
|--|--|
| <input type="checkbox"/> Ambulance Run Report | <input type="checkbox"/> Plan of Care |
| <input type="checkbox"/> Abortion Certificate | <input type="checkbox"/> Ultrasound Report |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Invoice |
| <input type="checkbox"/> Consult Notes | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> History and Physical | |
| <input type="checkbox"/> Sterilization Consent Form | |
| <input type="checkbox"/> Physician Office Notes | |
| <input type="checkbox"/> Hysterectomy Acknowledgement of Sterilization Statement | |
| <input type="checkbox"/> Other: | |

Fax or mail this letter along with the additional information by _____ to:

Department of Human Services
Iowa Medicaid Enterprise-Medical Services
Fax Number: 515-725-1355

OR Department of Human Service
Iowa Medicaid Enterprise-Medical Services
100 Army Post Road
Des Moines, IA 50315

Failure to respond to this request by the above date will result in a denial. To avoid any delays in the processing of your claim, please attach this letter to the requested information.

Sincerely,

Iowa Medicaid Enterprise
Medical Services

RFP Reference:

6.2

Interfaces:

MMIS
OnBase
Convergence Point Portal

Attachments:

N/A

MED - Medical Support Claims Pre-pay Review of Suspended CCI Claims- Location 47

Purpose: The RC will review CCI (Correct Coding Initiative) claim to determine if the CCI editing should be bypassed. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews suspended claim.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Claims go through regular MMIS editing. Once the claims have cleared all MMIS editing, a file of all suspended claims are sent to the CCI vendor. The CCI vendor runs the claims through their edits and returns a file to IME. The edits are based on open, public sources provided by CMS and the AMA (American Medical Association). IME then accepts or rejects the editing. If IME accepts the editing, a new edit is shown on the claim in MMIS. Not all claims with a CCI edit suspend to location 47.

Step 1: The RC reviews the suspended claim and first looks to see if a CCI edit is posting.

Step 2: The RC will then identify which CCI edit(s) are posting.

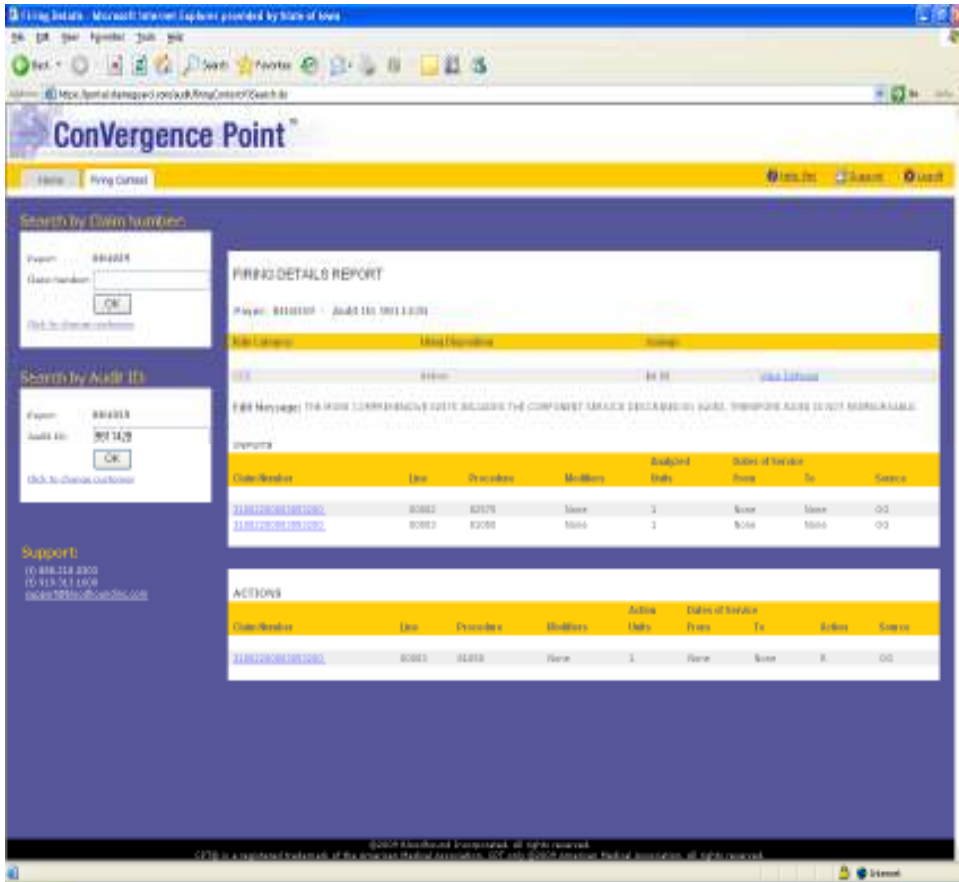
Step 3: The RC will identify if there is anything entered in the ACN field of the claim. Often times there will be “ETPMED005” in the ACN field of the claim. ETPMED005 is used internally to suspend the claim to location 47.

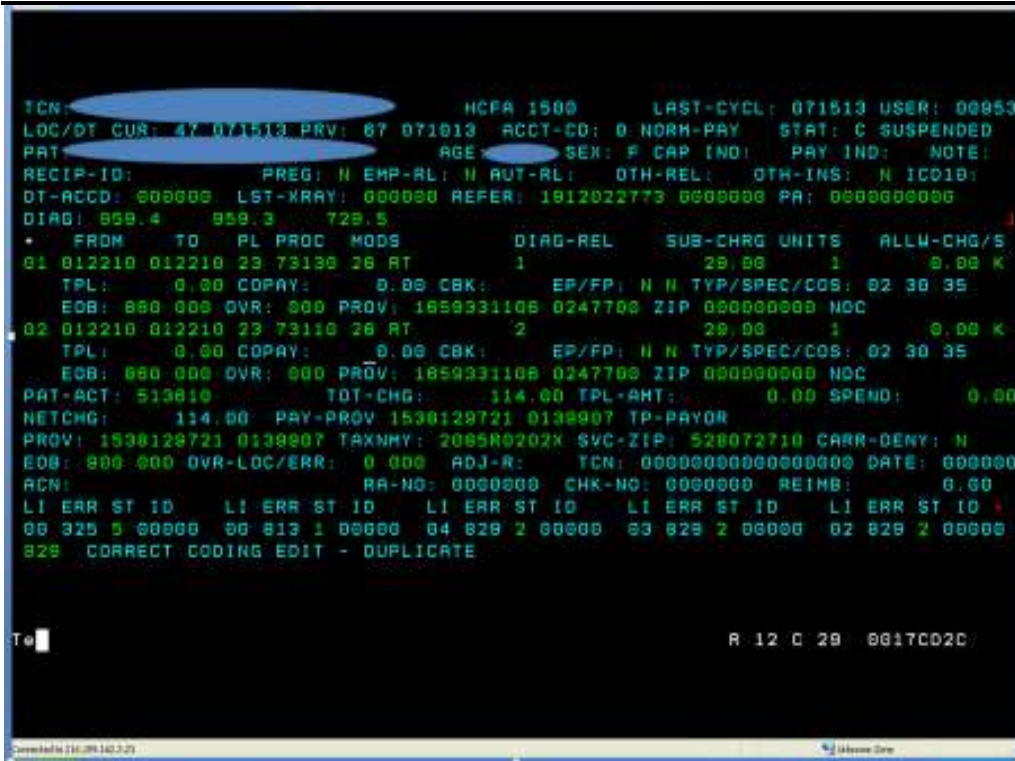
Step 4: If there is nothing in the ACN field, the RC will pull up the TCN in the Convergence Point Portal to determine why the claim line(s) denied for CCI editing. Convergence Point Portal will have a detailed defense report as to why the editing occurred.

Step 5: If the claim line(s) denied correctly then the RC will allow the CCI editing to proceed with the denial. If the claim line(s) should be paid based on DHS policies and procedures, the RC will force the CCI editing to bypass the CCI denial(s).

Step 6: If there is ETPMED005 in the ACN field of the claim, pull up the TCN in OnBase. The RC will scan the documentation for the special batch form to review why the claim was special batched.

Step 7: If the claim line(s) denied correctly then the RC will allow the CCI editing to proceed with the denial. If the claim line(s) should be paid based on DHS policies and procedures, then the RC will force the CCI editing to bypass the CCI denial(s).





RFP Reference:
6.2

Interfaces:
MMIS
OnBase

Attachments:
N/A

MED - Medical Support Claims Pre-pay Manual Pricing Multiple Surgery Claims

Purpose: Claims are reviewed for a variety of reasons. Reimbursement for services and/or items is based on a fee schedule. Some are not as easily quantifiable or are unusual. These will require review and manual pricing. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews fee schedule and determines correct payment of claim

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

The 104 edit posts when a provider bills for multiple procedures on a member for the same date of service and indicates manual pricing may be required. Medicaid follows Medicare's methodology for pricing this type of claim. All surgical procedure codes 10000 through 99999 are reviewed for application of multiple surgical pricing rules. In general, the procedure with the highest fee schedule amount pays at 100 percent and all remaining procedures paying at 50 percent.

Step 1: After claim has been reviewed, RC determines claim requires manual pricing.

Step 2: To determine how to manually price multiple surgery claims, RC will check for related claims.

Step 3: The RC will check current claim and all related claims for proper CPT coding:

- a. Use reference materials (CPT book, Coders Desk Reference, Provider manuals, CMS websites, Provider manuals) paying attention to descriptions of procedure codes.
- b. Watch for unbundling and/or fragmenting or double billing use denial code 927
- c. When billing for multiple units of a procedure done on the same day of service, the number of units must be paid on the same claim. The first code should have no modifier and the subsequent codes should have the appropriate NCCI modifier indicating how it is separate from the first code
- d. The only codes that should be billed on the same line with the appropriate number of units are time based codes, add-on codes and HCPCS codes. If the IME max units, MU's or MUE's are exceeded, then the GD modifier should be appended and documentation supporting medical necessity must be attached.

Step 4: The RC will determine the fee schedule for each line.

Step 5: The RC will price the highest paying procedure at 100 percent of the fee schedule

Step 6: The RC will price remaining procedures at 50 percent of the fee schedule as applicable.

- a. Refer to the Medicare fee schedule to ensure that the code may be reduced. See attached information.
- b. Add on codes are never reduced add on codes usually have each additional listed in their description and a plus next to the code in the CPT manual.

Step 7: When pricing multiple units the RC will consider the following:

- a. If units requested exceed max units allowed, medical necessity needs to be shown for the number of units billed and GD modifier must be appended. If the diagnosis codes and/or modifiers appended clearly identify the medical necessity of the units billed, additional documentation is not needed.
- b. Pricing of multiple units on the highest paying procedure: If the Medicare fee schedule allows for multiple surgical reduction of this code: Pay the first unit at 100 percent and reduce all remaining units to 50 percent each i.e. three units pays at 200 percent = 100 percent + 50 percent + 50 percent
- c. If the Medicare fee schedule does NOT allow for price reduction of this code: Pay all units at 100 percent of fee schedule. i.e. three units pay at 300 percent = 100 percent +

100 percent + 100 percent. Bilateral exception also applies here. If billing multiple units and RT/LT modifiers, price according to bilateral surgery rules. 150 percent instead of 200 percent.

Step 8: When pricing f multiple units on all other procedures:

- a. If the Medicare fee schedule allows for multiple surgical reduction of this code: Pay all units at 50 percent i.e. three units pay at 150 percent = 50 percent + 50 percent + 50 percent. Exception would be for bilateral codes. If the Medicare fee schedule has a bilateral indicator of "1" on a code, and the code was billed for two units with the RT/LT modifiers appended, use bilateral pricing rules. 150 percent of the fee schedule.
- b. If the Medicare fee schedule does NOT allow for price reduction of this code: Pay all units at 100 percent i.e. three units pay at 300 percent =100 percent + 100 percent + 100 percent. Bilateral exception also applies here. If billing multiple units and RT/LT modifiers appended, use bilateral pricing rules. 150 percent instead of 200 percent.

Step 9: The RC will force or deny as applicable the 104 edit for each line

Step 10: For approvals the RC will:

- a. Enter the calculated price into the allow-chg/s field in MMIS
- b. Place an M after price to indicate the line was manually priced.
- c. Force the 104 edit
- d. A 319 edit may appear after the 104 edits have been processed.
- e. Ensure that RC did not manually price the procedure for more than the amount submitted and correct if necessary.
- f. Force the 319 edit.

Step 11: The RC will adjust pricing on related claims as necessary

Step 12: The RC will note the following claims with Assistant (AS) modifier:

- a. The same provider ID can be paid as both the primary and surgery assistant AS modifier, not 80 for the same procedure code.
- b. At times the system will incorrectly post a 101 edit duplicate billing when the primary surgeon has billed for payment as both the primary surgeon and assistant at surgery.
- c. When Medicare fee schedule does not allow for an assistant and MMIS does allow, the RC will obtain an op report and send to PR to determine if an assistant is appropriate for the procedure code.

Medical Support Claims Pre-pay Manual Pricing Durable Medical Equipment and Supply Claims

Purpose: Claims are reviewed for a variety of reasons and reimbursement for services or items are based on a fee schedule. Some are not as easily quantifiable or are unusual. These will require review and manual pricing. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews fee schedule and determines correct payment of claim.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: The RC will review durable medical equipment (DME) and supplies claims that suspend to location 23 for pricing and medical necessity.

Step 2: The RC will review these claims considering the following:

- a. All durable medical equipment without a specific fee is paid at the manufacturer's suggested retail invoice price minus 15 percent. Therefore, an invoice is required to review these claims.
- b. Edits suspending to DME or supply claims requiring pricing include:
- c. 334 edit- Procedure code requires manual pricing
- d. 409 edit- Procedure code and/or modifier requires manual pricing
- e. 438 edit- Procedure code requires manual pricing for date of service
- f. 066 edit- Maximum limit for diapers has been exceeded
- g. 029 edit- Maximum limit for underpads has been exceeded
- h. 433 edit- CPT 78999 is billed with TC or 26 modifier

Step 3: The RC will deny the following Non-covered DME items:

- a. Physical fitness equipment i.e., exercise bike or weights
- b. First aid or precautionary equipment i.e. preset portable oxygen units
- c. Self-help devices i.e., safety grab bars, raised toilet seats, shower benches, transfer boards, bath chairs and bath accessories
- d. Training equipment i.e., speech-training machines, Braille-training texts
- e. Equipment which basically serves comfort or convenience functions, or is primarily for the convenience of a person caring for the member i.e., elevators, stairway elevators, ramps, or posture chairs
- f. Equipment used for environmental control or to enhance environmental setting. i.e., room heaters, air conditioners, humidifiers, dehumidifiers, or electric air cleaners.
- g. Equipment used to back-up existing equipment
- h. Deluxe models of equipment when a standard model will meet the member's needs
- i. Ear plugs and/or molds other than hearing aid molds
- j. Convenience items i.e., breast pumps, eating utensils, urine cups, cervical pillows, K-Y jelly, or sterile basins
- k. Two forms of the same equipment, such as, one being portable and one being stationary (i.e., suction machine)
- l. Scales of any kind
- m. Portable oxygen carrier
- n. Toothettes
- o. Nasal aspirator
- p. Potty trainer chairs
- q. Cryo cuff
- r. Non-medically necessary services

Step 4: After claim has been reviewed, and RC determines claim is payable requires manual pricing, the RC will determine how to manually price the claim by following the guidelines listed below according to what type of DME and/or supply was billed:

Rental of DME items:

- a. Rental items are indicated with the RR modifier
- b. Consideration is given to rental or purchase based upon the price of the item and the length of time it would be required. The physician's order needs to identify length of time.
- c. Items identified with a long-term need should be purchased, not rented.
- d. A trial period may be appropriate to establish that a specific item meets the member's needs. i.e. posture walkers being tried out to ensure they work for the member prior to purchasing them
- e. Ventilators, apnea monitors, BiPap machines, CPM devices, enteral feeding pumps, billirubin lights, IV therapy, wound vac systems and oxygen system must be maintained on a rental basis for the duration of use.
- f. Rental items are paid until the total rental paid equals 150 percent of the total purchase price. At this point the member is considered to own the item and rental payments may no longer be billed.
- g. MMIS is set to keep track of rental payments. During the rental period, equipment modification or repair is not separately payable for most items. All supplies and accessories are included in the rental allowance and cannot be billed separately. Adjudication of dump codes and other codes that pay by report except L-codes listed in the Medicare fee schedule:
- h. Check to ensure that the item being billed is covered by Iowa Medicaid by reviewing the Medical Equipment and Supplies Provider Manual, 2007 training for medical equipment and supplies.
- i. Medical necessity must be shown for the item being billed.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS

OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Claims Adjudication

Purpose: The RC will determine outcome of claim and adjudicate appropriately. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – adjudicates suspended claim.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: After reviewing the claim and referring to MMD if necessary, the RC will adjudicate the claim.

Step 2: The RC will access File 2, in MMIS to work the claim.

Step 3: The RC will enter an F to force or pay a claim or a D to deny a claim.

Step 4: The RC will enter the appropriate denial message or denial reason code when a claim is being denied.

Step 5: The RC will refer to the manual denial codes list for the appropriate denial message.

- a. If an ambulance claim does not meet medical necessity, the review coordinator will deny the edits and a system generated ambulance NOD will be sent to the member.
- b. A notice of appeal rights is provided with each notice of adverse decision that is sent out.
- c. Notices of appeal rights include timeframes for filing a formal appeal.
- d. DHS requires that medical services not provide a formal reconsideration or first level appeal.
 - i. If new information is submitted by the member or provider following the adverse decision or with the formal request for appeal, medical services review staff will review the information and decision and approve the service if medical necessity criteria are met.
- e. Additional information regarding a service that is a non-covered service will not be considered. If the requested service continues to not be supported by the submitted documentation, medical services review staff will secure additional peer review. Since this is an informal process, it is not necessary to obtain a peer reviewer other than the one who made the initial decision.
- f. It is also not necessary to send a second notice of an adverse decision if the service does not meet medical necessity criteria.

Step 6: For specific operational procedures related to appeals completed by Medical Services on behalf of DHS, the RC should see Med Srv Policy Support Appeals at IME Universal/Operational Procedures/Medical Services.

Step 7: The RC may at any time recoup or adjust or reverse a claim if additional information is received that contraindicates continued approval or if errors are found.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Provider Inquiries

Purpose: The RC will review Exception to Policy. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews inquiry from Provider Services.

Performance Standards:

Send the final determination letter on a claims inquiry to the provider within 10 business days of receipt of complete documentation.

Path of Business Procedure:

Step 1: The RC will receive a Provider Inquiry by accessing the OnBase Provider Inquiry Queue.

Step 2: The RC will locate the appropriate claims information and documentation in MMIS and OnBase to be reviewed.

Step 3: If there is not sufficient documentation for review, the RC will follow Medical Support Claims Pre-Pay Operational Procedure 8301.5 in requesting additional information that is needed to review the inquiry/appeal/ETP or deny the provider inquiry.

Step 4: The RC will utilize the appropriate Operational Procedures, Provider Manuals, the Iowa Administrative Code (IAC), and Medicare Updates in reviewing inquiries/appeals/ETPs that include the necessary documentation.

Step 5: If the service is now payable, RC will complete the response to the inquiry on the appropriate OnBase E-Form and send the notification of claim now payable to provider services and DHS.

- a. If the claim requires special handling, specific processing instructions will be noted on the OnBase E-Form indicating that the claim is a special batch.

Step 6: The RC will fill out special batch form electronically, print it, and attach it to the claim. This information will be paper clipped.

Step 7: The requests will be placed in the Medical Services out box. A courier will pick up the documents and deliver Core.

- a. Each claim will have a separate batch form.

Forms/Reports:

Provider Inquiry Letter

Provider Name
Address
City, State, Zip

Date

RE: Medicaid Claim for [Member Name]/[Member ID] dated [date]. DCN# [dcn number]
Iowa Medicaid Provider Number: [provider number]/ NPI Number: [NPI number]

Dear Medicaid Provider:

Your claim for the above referenced Medicaid Member was forwarded to our Medical Services Unit for review. The results of the review is listed below:

- Your claim has been forwarded for reprocessing. The claim's status will appear on a future Remittance Advice.
- Your Claim has been forward for Credit and Adjustment. The Claim's status will appear on a future Remittance Advice.
- The Claim's denial is correct based on the reason listed below:
- The Claim's payment is correct based on the reason listed below:

Comments:

If you have any questions regarding this claim, please contact Provider Services at: 1-800-338-7909 or locally at 515-256-4623.

Sincerely,
[CSR Name]
Provider Services Unit
Iowa Medicaid Enterprise

Special Batch Request

From:
Unit:
Date:
Member ID:
Escalation by PRV

Why is the special batch bring requested?
--

Provide detailed instruction on how to process the claim. List all edits that need to be forced.

Note: Please attach a claim form, screen print, and any necessary documentation to this form to validate the request being made. If the instruction on this form is not clear, it will be returned to the requestor.

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

Attachment C: Provider Inquiry workflow

MED - Medical Support Claims Pre-pay Abortion Report

Purpose: Manager or RC will review Abortion Report to determine if abortion claims were adjudicated correctly. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews abortion report.

Manager – provides direction, training, completion, and oversight in preparing the report.

Performance Standards:

Provide quarterly reports within 10 business days of the end of the reporting quarter.

Path of Business Procedure:

Step 1: The manager receives hardcopies of all state and/or federally funded abortions paid in the past quarter from the RC.

Step 2: Any claim that is questioned on why it paid or claims that are for the actual abortion procedure are pulled for re-review. This is completed through document retrieval in OnBase.

- a. If it is determined that the claim should not have paid, the claim is credited and noted on the report. Refer to the Medical Support Claims Pre-pay Manually Pricing Claims Operational Procedure 8301.6 for crediting claims. For each payable state or federally funded abortion, there are three related claims: the Physician, Anesthesia, and Hospital claims.

Step 3: If a state or federally funded abortion is paid that requires an abortion certificate, the claim is again reviewed and attached to the report.

Step 4: The paid abortion claims are separated into state or federally funded abortions. The state abortions are reported on the state form and the federally funded abortions are reported on the federal abortion form.

Step 5: When the federal form is completed, the federal funded abortion totals are transferred to the Department of Health and Human Services Centers for Medicare and Medicaid services quarterly report of abortions form.

Step 6: The manager fills out the appropriate forms.

- a. Once all three abortion reports as applicable are completed, a log letter is created and forwarded to DHS with the results of the quarterly abortion report review.

Step 7: The Manager emails the report to appropriate DHS contact.

Step 8: The abortion claims, reports, and emails are saved hardcopy in the manager's file.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Support Claims Pre-pay Policy Research

Purpose: Manager or RC will perform the review of the policy research request. DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews policy research request.

Manager – provides direction, training, and oversight in reviewing the request.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: The manager receives request from DHS policy staff, provider cost audit, provider services, or another unit for research on a specific topic.

Step 2: The manager determines if there is sufficient documentation to continue with the review or if additional information is needed.

Step 3: If additional information is needed, the requestor is informed of the documentation and/or information that is needed to complete the review.

- a. If there is sufficient documentation to review, the manager will perform the research review.
- b. When the manager has completed the research, the manager will determine whether physician review is needed

Step 4: If no PR is needed, or when PR is completed, the manager will determine if pricing information is needed. If no pricing information is needed, or when provider cost audit (PCA) has provided the pricing information, the manager will determine if the research findings require policy review and/or approval

Step 5: If policy review or approval is needed, the research findings and recommendation will be sent to the appropriate policy staff.

Step 6: If policy has additional questions, the manager will research and respond to those questions and provide any additional information needed.

Step 7: Once policy has approved or rejected any recommendations; the requestor and any effected units, will be notified via email.

Step 8: The manager will submit a system action memo (SAM) or request a change management request (CMR) when necessary.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

Attachment D: Policy Research workflow

MED - Medical Support Claims Pre-Pay Potential Fraud Referral Process

Purpose: The medical services manager will refer potential fraud cases to the Program Integrity (PI) unit.

Federal regulations require that the PI unit conduct a preliminary investigation of all potential provider fraud cases, prior to referring them to the Medicaid Fraud Control Unit (MFCU) at the Department of Inspections and Appeals.

The PI unit attends bi-weekly meetings with MFCU, where all referrals are discussed and the MFCU director determines whether to accept each referral or to leave it with the SURS unit for administrative action.

Identification of Roles:

Review Coordinator (RC) – sends potential provider fraud cases to the manager.

Review Assistant (RA) – sends potential provider fraud cases to the manager.

Manager – receives potential provider fraud cases, review case and forwards to the Program Integrity Unit.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: The RC or RA staff will send potential provider fraud cases to their respective manager.

Step 2: The manager will contact the PI Unit supervisor.

Step 3: The manager will provide the PI supervisor the provider name and number, the date range of claims involved, and any other specific information Medical Services may offer that would assist the PI Unit in understanding the nature of the issue, and be able to address as needed.

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Claims Pre-pay Annual Code Updates

Purpose: Manager or RC with the assistance of Physician Review will perform the review of the annual code updates.

DHS has established standards governing which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for

all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth.

Identification of Roles:

Review Coordinator (RC) – reviews codes included in the annual update.

Manager – provides direction, training, and oversight in reviewing the request.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: In mid-August, Medical Services manager receives a file from the Core Unit that includes the ICD-9-CM diagnosis and surgical code updates effective October 1, of that year.

Step 2: The manager will send an email to policy staff to obtain approval to submit a SAM to end date these codes.

Step 3: Once approval is obtained, the manager will submit the SAM.

Step 4: Medical Services reviews these description changes to:

- a. Determine if the changes made will effect whether the diagnosis/surgical code is covered or not
- b. Ensure the long and short descriptions of the codes will fit into the limited MMIS description fields and shorten or abbreviate to maintain the original definition of the description

Forms/Reports:

N/A

RFP Reference:

6.2

Interfaces:

MMIS
OnBase

Attachments:

Attachment A: Annual/Ad hoc Code Updates-New Codes workflow

Attachment B: Annual/Ad hoc Code Updates-Deleted Codes workflow

MED - Medical Support Claims Pre-Pay Internal Quality Control Process

Purpose: To provide continuous quality improvement to the claims pre-pay functions and meet all performance standards.

Internal Quality Control (IQC) is a peer-to-peer review process completed monthly on a percentage of claims reviewed by each reviewer from the previous month.

Identification of Roles:

Review Coordinator (RC) – performs IQC review on assigned claims.

Lead Review Coordinator – distributes and tracks claims IQC reviews and provides follow-up on quality concerns.

Manager – reviews results of IQC reviews and assists with follow-up on any quality concerns.

Performance Standards:

Performance standards not specified for this procedure

Path of Business Procedure:

Step 1: Through e-mail, the lead review coordinator receives a monthly data pull from Data Warehouse by the third business day of the month that includes all claims and edits worked in the previous month by each RC.

Step 2: The lead review coordinator reviews the spreadsheet to ensure each RC was identified on the spreadsheet. The lead review coordinator emails the Data Warehouse if any changes need to be made.

Step 3: The lead review coordinator determines the number of claims to be reviewed for IQC which is 15 percent of the average claims per day reviewed, with a required minimum of 20 claims.

Step 4: The lead review coordinator uses a Random Integer Tool to randomly select the assigned number of claims to be reviewed from the list of claims.

Step 5: The lead review coordinator copies the list onto a spreadsheet used for IQC and distributes by email to an RC who is familiar with the type of reviews to be reviewed.

Step 6: The RC has six questions on the IQC spreadsheet to address for each claim reviewed. The RC documents on the spreadsheet.

Step 7: The RC emails the completed spreadsheet back to the lead review coordinator.

Step 8: The lead review coordinator re-reviews any noted issues and follows-up with the RC who performed the original claims review and resolves any outstanding issues.

Step 9: The lead review coordinator will involve the manager in this process as needed.

Step 10: The lead review coordinator calculates the accuracy percentage and inputs this information along with the number of claims reviewed on the Team IQC tracking log located in the Med Srv Reports Drive>Claims Reporting folder and informs the manager of any outstanding issues.

Step 11: Manager reviews the Team IQC tracking log to ensure the process is completed in a timely manner and works with the Lead Review Coordinator on any quality concerns.

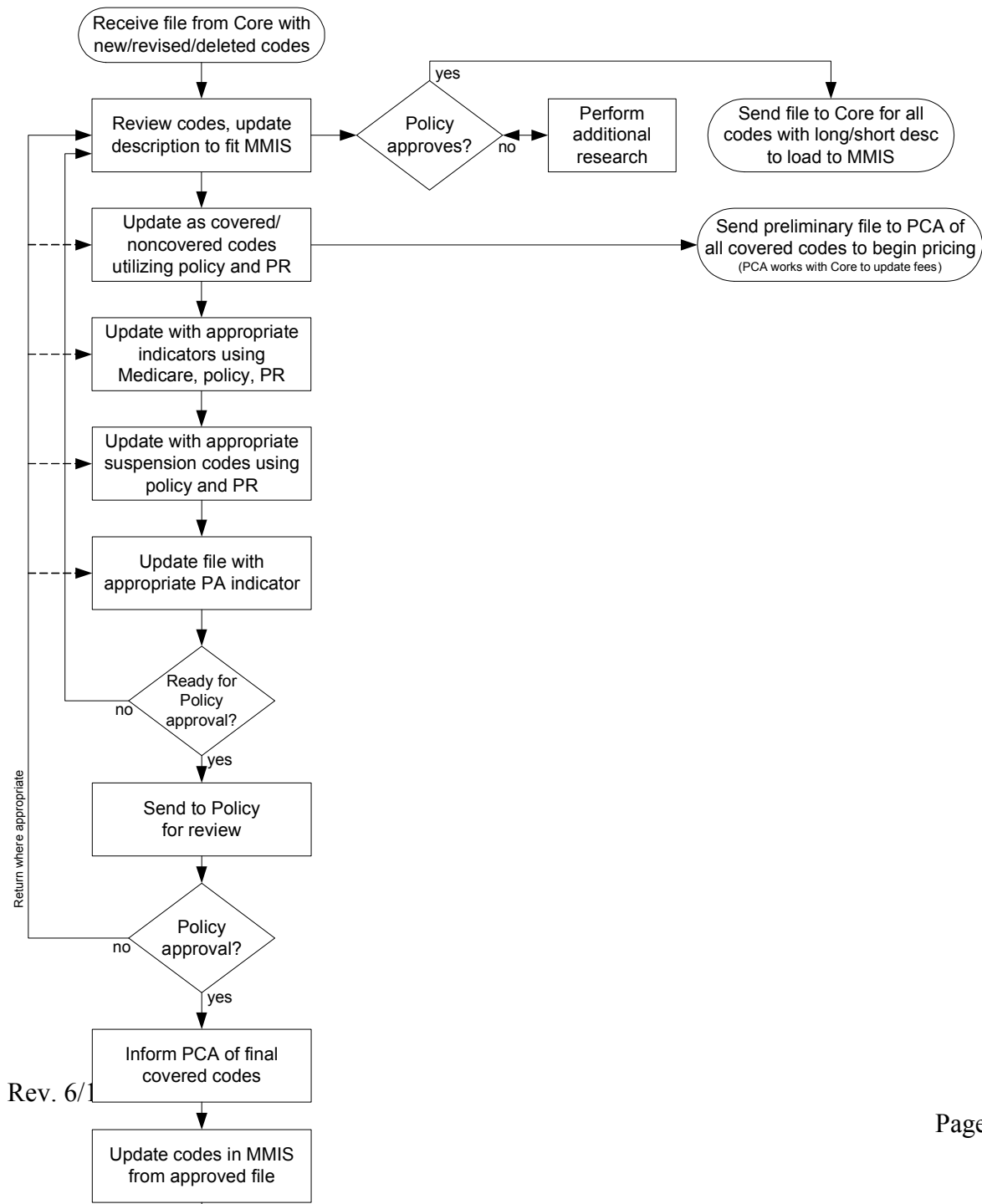
Forms/Reports:

N/A

RFP Reference:
 6.2

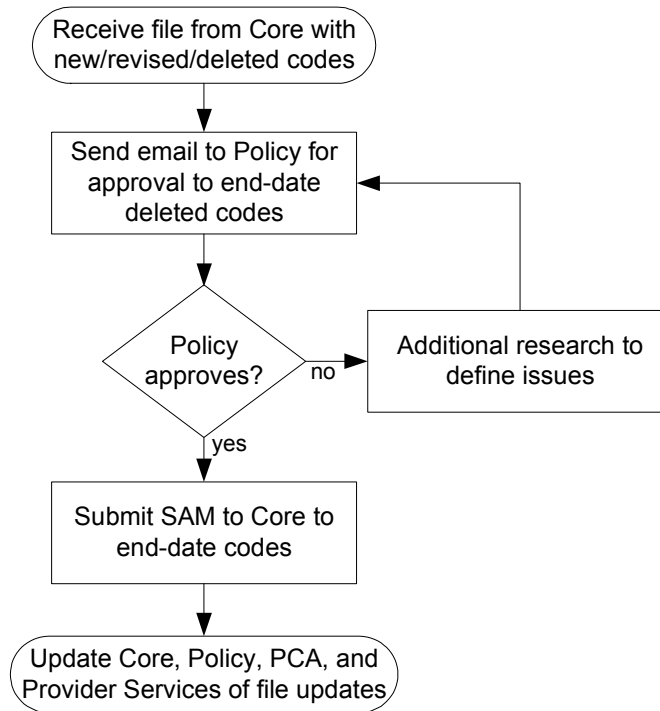
Interfaces:
 MMIS
 OnBase

Attachment A:
 Annual/Ad hoc Code Updates – New Codes



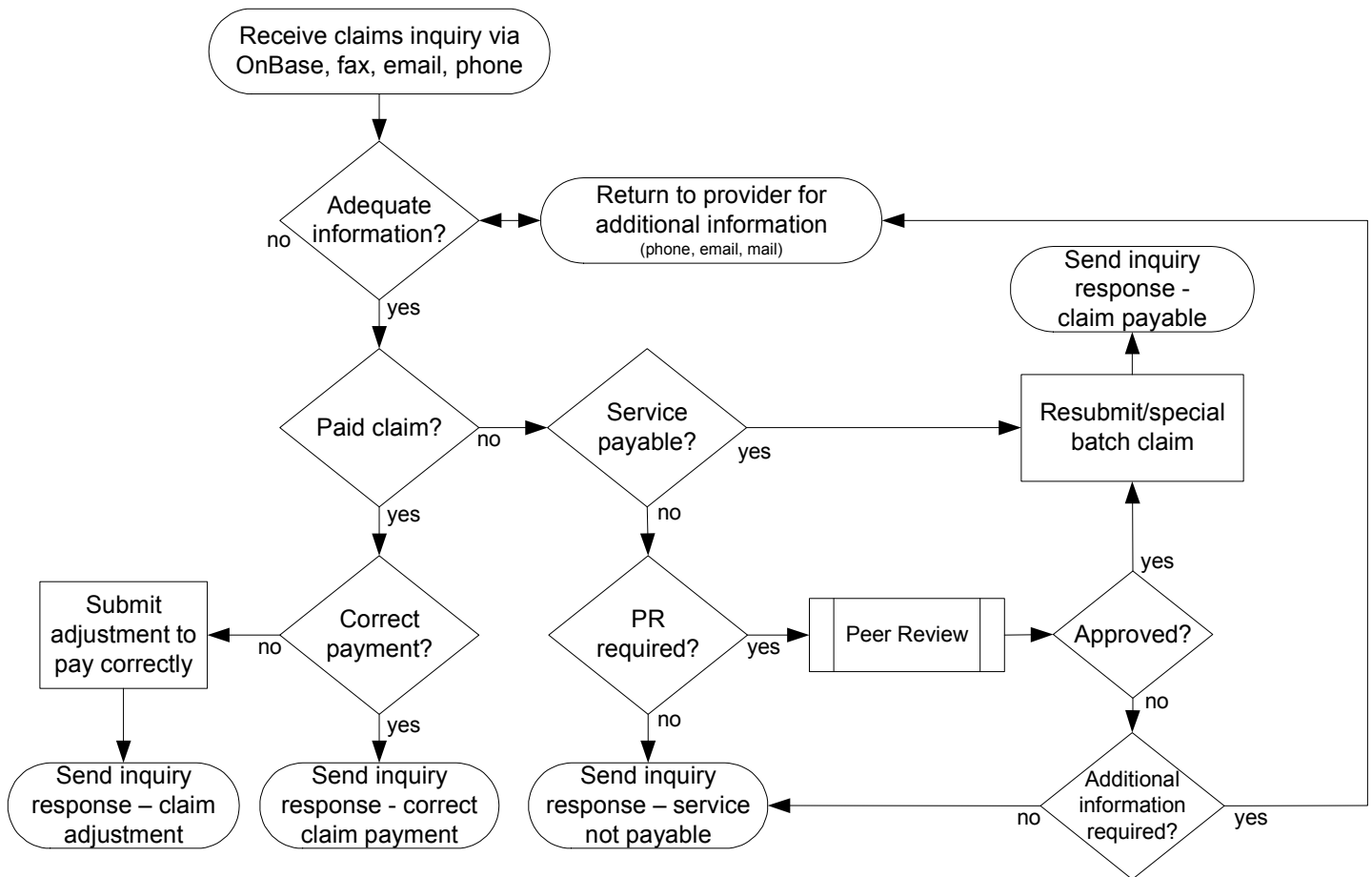
Attachment B:

Annual/Ad Hoc Code Updates – Deleted Codes



Attachment C:

Provider Inquiries



Attachment D:

Policy Research

