Iowa Medicaid: Beyond the Basics
Topics

• Provider Agreements
• Fraud, Waste, and Abuse
• Program Integrity
• Third Party Liability
• Prior Authorization
• IME Remittance Advice
• Verifying Eligibility
• Communication
Provider Agreement
Provider Agreement Defined

• An agreement between the State of Iowa, Department of Human Services, and the Provider
  - All providers in your organization are bound to the Agreement

• Outlines the responsibilities and expectations for participating providers

• Renewal is performed every 5 years
Section One: Provider Agrees To…

• Follow their professional standards and the rules and policies of the department

• Comply with applicable Federal, State and local laws, regulations, administrative rules, and executive orders when performing services

• Check the program exclusion status of individuals and entities *prior* to employment or contracts
Section One *continued*

- Ownership and control information must be disclosed
- Person who has 5% or more controlling interest in the provider
  - Include name, date of birth, Social Security Number or other Tax ID number
  - Any disclosing entity where the owner of the disclosing entity has an ownership or control interest
  - Info of any managing employee of disclosing entity
Section One continued

- Ownership and control information must be disclosed upon:
  - Provider submitting the proposal in accordance with the State’s procurement process
  - Provider executing a Provider Agreement with the State
  - Renewal or extension of the Provider Agreement
  - Within 35 days after any change in ownership of Provider
Section One continued

- Disclose persons convicted of a criminal offense involving any program under Medicare, Medicaid, or the Title XX programs
- The Inspector General of the HHS must be notified by DHS of any disclosures within 20 days from the date the information was received
- The Inspector General of HHS will be notified of any action DHS takes against the provider
Section One continued

• Providers must comply with the requirements of the False Claims Act

• Employees must have access to written policies about the False Claims Act including:
  o Detailed information about the provider’s policies and procedures for detecting and preventing waste, fraud, and abuse
  o The rights of employees to be protected as whistleblowers
Section One continued

• Providers acknowledge that payment of claims is from federal and state funds
• Any concealment or falsification is subject to prosecution
• Meet any licensure, certification or other regulatory requirements applicable to that provider type
Section two: Reimbursement

• All services rendered to enrolled members must be rendered by provider seeking payment
• The provider agrees to pursue other health coverage prior to submitting a claim to the IME
• The provider receiving payment shall accept payment from the IME as payment in full
  ○ Providers cannot bill, retain, or accept payments for any additional amounts beyond the primary payer
Provider Agreement

Section two: Reimbursement

• Providers agree to immediately repay any claims where payment was received after the IME paid
  o Repay any member if a payment was received prior to submitting the claim to the IME

• Providers agree to report and return any overpayment within 60 days from the date the overpayment is identified or by the date any corresponding cost report is due
Section two: Reimbursement

- The IME will adjust payments to satisfy any past-due obligations of a provider
  - Includes other providers under the same Tax ID
- The IME may withhold payments based on credible evidence of fraud
- The IME may notify the provider of the temporary suspension of their Agreement
  - Suspended provider may not bill for services rendered during suspension period
Section three: Notices

• All written notices delivered in person or sent to address on file are considered delivered.

• Providers must notify the IME within 35 days of any change including, but not limited to:
  o Changes in the provider’s license or certifications
  o Indictment, arrest or conviction for a criminal offense
  o Change in ownership or control, and
  o Change in address
  o Addition or removal of practitioners
Section four: Records

• Provider agrees to maintain records and documents for a minimum of 5 years from final payment or completed audit.

• Provider shall maintain adequate medical, financial and administrative records as outlined in sections 441-79.3 and 79.4 of the Iowa Administrative Code.

[link to Iowa Administrative Code]

www.legis.iowa.gov/docs/ACO/chapter/441.79.pdf
Section Five: Miscellaneous

• The Provider Enrollment Application signed and submitted is incorporated into the Agreement
• The Provider agrees to notify the IME within 30 days of a change in the Enrollment Application
• The provider is an independent contractor and not employed by the State, DHS, or the IME
• Agreement may be amended at any time by updating the website and releasing an informational letter
Section Six: Terminations

• Providers may terminate Agreement at any time
• The IME may terminate this Agreement with 30 days written advance notice after determining:
  o The provider is not complying with the provisions outlined in the Agreement
  o The provider has not submitted any claims for 24 months
  o Provider licensure or certification is terminated
• In accordance with IAC 441-79
Amendments

• Notice released that the provider agreement is being amended
• Clarifies the most recent laws, administrative rules, and other policies will be followed by the provider and the IME
• Clarified that all patient managers (MediPASS, Iowa Wellness, health home providers, and/or ACOs) are business associates of the IME
Summary

• The Provider Agreement is a legal document
• It addresses numerous points within the Iowa Administrative Code and several Federal regulations
• Please read it carefully
• Available electronically at:
Fraud, Waste, and Abuse
Fraud, Waste, and Abuse

Definitions

• Fraud: Any act that constitutes fraud under applicable Federal or State law. Any intentional deception or misrepresentation with the knowledge of a potential unauthorized benefit

• Waste: Practices that spend carelessly or inefficiently use resources, items, or services

• Abuse: Inconsistent fiscal, business, or medical practices that result in unnecessary cost or payment for services billed
Fraud, Waste and Abuse

Most Common Types

- Billing for services not performed
- Billing for unnecessary services
- Upcoding or unsubstantiated diagnosis
- Billing outpatient services as inpatient services
- Over-treating/lack of medical necessity
- Billing for unauthorized services
- Incorrect coding for the services provided
Identification and Prevention

- Office of Inspector General (OIG) is responsible for investigating fraud, waste, and abuse
- OIG’s mission is to protect the:
  - Integrity of health and human services programs in Iowa
  - Health and welfare of the recipients in those programs
Identification and Prevention

• OIG activities are designed to:
  o Identify and reduce waste, abuse, fraud, or misconduct
  o Improve efficiency and effectiveness throughout the HHS system
Reporting Fraud

• To report instances of possible fraud or abuse, contact one of the following:

• Medicaid Fraud Control Unit (MFCU)
  - 1-800-831-1394

• Iowa Medicaid Program Integrity
  - 1-877-446-3787 or 515-256-4615 (Des Moines area)
Fraud, Waste, and Abuse

**Medicaid Fraud Control Unit (MFCU)**

- Federal law requires each state to have a federally funded MFCU
- Investigate and prosecute Medicaid Provider fraud, patient abuse, & neglect by healthcare providers
  - Receive referrals from Program Integrity
  - Employs investigators, auditors, and attorneys
441- 79.4(249A): Reviews Performed by Program Integrity
Program Integrity Reviews

79.4(2) Review

- If the department has correctly paid
- If the provider has furnished billed services
- If provider records substantiate submitted claims
- If provided services were in accordance with policy
Program Integrity Reviews

79.4(2)b

- Form 470-4479, Documentation Checklist
- Lists specific documents to be requested for Program Integrity review
79.4(3)

- Records must be submitted within 30 days of written notification
- Extension of time limits up to 15 days when:
  - Established good cause
  - Request received before deadline
Program Integrity Reviews

79.4(3)

• Announced or unannounced on-site reviews occur regularly

• Review procedures may include:
  o Comparing clinical record against claim
  o Interviewing members & staff
  o Examining TPL records
  o Comparing usual & customary fees
79.4(4)

- Preliminary report of review findings
- If overpayment has occurred, a “preliminary report of a tentative overpayment” (PROTO) letter is issued
- Provider has opportunity to request reevaluation
Program Integrity Reviews

79.4(5)

- Disagreement with review findings
- Written reevaluation request received within 15 calendar days of notice date (PROTO)
- Provider can submit clarifying information or supplemental documentation within 30 days of the date of the PROTO letter
Program Integrity Reviews

79.4(6)

- Finding and order for repayment
- When reevaluation or expiration of deadlines has passed
  - Order for repayment of over payment
  - The IME may withhold payments from other claims
Medical Record Loss

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

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

• Only used for documents that were partially or completely destroyed
  - One form must be filled out & maintained for each member

• Must be supported by a disaster declaration by the Governor of Iowa
Home and Community Based Services HCBS Oversight
Unit Activities

- Oversight
- Incidents/Complaints
- Chapter 24
- Training

HCBS Oversight

- Provider Certification
- Technical Assistance
- IPES/MFP Surveys
Process

• Provider Self-Assessment

• Review types
  o Periodic
  o Certification
  o Focused
  o Targeted

• Incidents and Complaints
Health Insurance Premium Payment
HIPP Program
The HIPP program may be available to Medicaid eligible members including the Iowa Health and Wellness Plan.

- Can provide premium assistance for employer or private health insurance policies.

- When Medicaid members have other insurance it is a win, win, win for everyone:
  - Other coverage pays first-win
  - Provider is reimbursed at higher rates-win
  - Member has health insurance premiums paid-win
HIPP

Qualifying

• To qualify for HIPP an individual must:
  o Be Medicaid eligible or be a household family member of a Medicaid-eligible individual;
  o Be offered employer-sponsored coverage or have an individual policy; and
  o Qualify based on cost-effectiveness criteria.
Questions?
Contact:
Phone: 515-974-3282 or 888-346-9562
Fax: 515-725-0725
E-mail: HIPP@dhs.state.ia.us
US Mail: HIPP Unit
   PO Box 36476
   Des Moines IA 50315-9907
Information is also available on the website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Prior Authorization
PA
PA Types

- HCBS Waiver Prior Authorization
- High Tech Prior Authorization
- Medical Services Prior Authorization
  - Includes durable medical equipment (DME)
- Dental Prior Authorization
- Codes that require a PA are available here: http://dhs.iowa.gov/ime/providers/claims-and-billing
Prior Authorization

HCBS Waiver PA

• Implemented on October 1, 2010, to assist with service plan development
  o Consumer Directed Attendant Care
  o Home & Vehicle Modification
  o Prevocational Services
  o Environmental Modifications
  o Adaptive Devices

• Reviewers determine if the units in the service plan are medically necessary
High Tech

• Certain elective high tech radiologic tests
• Utilizes an online tool-McKesson’s Clear Coverage
• Requests that meet medical necessity automatically approved
  o Determination on other requests in 3-5 business days
• Not required for ER or inpatient visits
• Details available at:
  http://dhs.iowa.gov/ime/providers/claims-and-billing/HTRPA
Prior Authorization

General PA

• Certain services and supplies require prior authorization
  o Some Durable Medical Equipment (DME)
  o Some outpatient procedures
  o Some surgical procedures

• Codes that require a PA are listed here: http://dhs.iowa.gov/ime/providers/claims-and-billing
Prior Authorization

Dental PA

• Codes that require a PA are listed here: http://dhs.iowa.gov/ime/providers/claims-and-billing

• PA requests are faxed to the Medical Services Dental PA unit

• Fax number 515-725-0938

• Turnaround time is typically 5-10 business days
PA Form

- Form 470-0829 Available on theIME website: [http://dhs.iowa.gov/ime/providers/forms#PAPHD](http://dhs.iowa.gov/ime/providers/forms#PAPHD)
- Does not override
  - Eligibility
  - Primary Insurance
  - Claim Form Completion
- Questions - contact PA Unit directly at: 1-888-242-2070 or (515) 256-4624
Third Party Liability
TPL
Third Party Liability

TPL

- Third Party Liability is primary insurance
- Iowa Medicaid is the payer of last resort
- *Exception*- pay and chase
- TPL payment must be noted on the claim
- Two or more TPL, payments should be combined on the claim
TPL Denial

Insurance denial can be indicated when:

- Denial was received for the identical service in a previous month
- Denial is received by telephone and documented in records
- Insurance is a supplement to Medicare and Medicare denied
- All charges were applied to the deductible
- Final denial for non-coverage
TPL Denial

Insurance denial **cannot** be indicated when:

- Payment was made to the member or member’s family
- Denial was due to requested information not received
- Denial was made for claim completion errors
- Member did not follow TPL policies
- Due to the provider not requesting prior authorization from insurance
Updating TPL

- Members can call Member Services to update their insurance information

- Providers may complete the Insurance Questionnaire (IQ) found at http://dhs.iowa.gov/ime/providers/forms#PAPHD Form #470-2826

- The IQ form can be emailed to revcol@dhs.state.ia.us or faxed to 515-725-1352
Electronic Billing
Electronic Data Interchange

- Providers must enroll with Electronic Data Interchange Support Services (EDISS) through the EDI Connect Program
  - [www.edissweb.com/med/registration/](http://www.edissweb.com/med/registration/)
- PC-ACE Pro32-Free software available through DHS
- PC-Ace Pro32 Help Documents available at: [http://dhs.iowa.gov/ime/providers/forms#PAPHD](http://dhs.iowa.gov/ime/providers/forms#PAPHD)
Claim Attachments

- Supporting documentation for electronic claims may be submitted with Form 470-3969, Claim Attachment Control
- When completing the electronic claim, enter an Attachment Control Number (ACN) in the ACN field
- On PC-ACE Pro 32, the ACN box is located on the
  - Institutional claim on the Extended General tab
  - Professional claim, use the EXT Pat/Gen (2) tab
- The ACN field is loop 2300 segment PWK05-06
Explanation of Benefits
EOB
Remittance Advice (RA)

- Iowa Medicaid maintains two forms of RAs
  - Remittance Advice on Iowa Medicaid Portal Access (IMPA)
  - 835 electronic transaction
- Both maintain EOB information for providers
Remittance Advice (RA)

- IMPA RAs are available each Monday
- Historical RAs available for 18 months
- Providers register for access to IMPA
- Register on IMPA at:
  https://secureapp.dhs.state.ia.us/impa/
Explanation of Benefits

Electronic Remittance Advice (ERA)

• 835 electronic transaction
• Registration is done on EDI Connect at: https://connect.edissweb.com/
• FAQ at: www.edissweb.com/cgp/registration/faq-5010era.html
Explanation of Benefits

Top 10 Denial Reasons

- Exact duplicate
- Procedure/treating provider conflict
- Medicare paid amount is $0.00
- Invalid Managed Care provider referral
- Services not covered for recipient (member ineligible)
- Invalid procedure code/modifier
- TPL on recipient file not on claim
- Missing billing provider NPI (incorrect Taxonomy or zip)
- Medicare eligible member, claim not a crossover
Return To Provider

Top Reasons for Returned Claims

• Missing, unreadable, invalid National Provider Identifier (NPI)
• Multiple claims received with one set of documentation
• Claim is a photocopy
• Medicare Crossover Invoice is missing
• Double imprinter number

Total RTP letters created for calendar year 2013: 16,632
Transaction Control Number
TCN
### Transaction Control Number

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- Iowa Medicaid tracks claims with a 17 digit Transaction Control Number
- Each digit represents identification information
Transaction Control Number

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- **Field 1**
  
  1= Point of Sale Claim (Pharmacy)
  0=Paper Claim Submission
  3=Electronic Claim
  4=System Generated
  5=Specially Handled/Exception Claim
### Transaction Control Number

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- **Fields 2 through 6**: Julian Date
  - 2-3 Calendar Year
  - 4-6 Claim Receipt Date
## Transaction Control Number

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- Fields 7 and 8 Microfilm Reel
  - 7=Microfilm reel machine
  - 8=Microfilm reel number
- NOT currently utilized
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- 9 through 11 Batch number assignment
  - 001-499=Dakota Imaged claim
  - 500-599=Credit/Adjustment claim
  - 511-519=Medically Needy
  - 600-699=Mass Adjustment Claim
  - 700-799=Mass Provider Rate Change
  - 800-950=POS Claim
### TCN

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- **Field 12 Claim Type**
  - 0 = Original claim
  - 1 = Credit/Recoupment
  - 2 = Adjustment
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- **13** through **15** Claim Number

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Iowa Department of Human Services

71
### Transaction Control Number

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- 16 through 17 Line Number or Attachment Number
Verifying Eligibility
Verifying Eligibility

Voice Eligibility Verification System

ELVS
- Eligibility information available 24/7
- Eligibility information is not prospective

Providers can verify:
- Monthly eligibility
- Spenddown
- TPL insurance
- Managed Health Care information
- Other administrators (Marketplace Choice, Iowa Plan, Meridian, Delta Dental)
- Limited vision and dental history
- Current check amounts
Verifying Eligibility

ELVS

• Access ELVS at:
  • Time service is provided or requested
  • When a person presents a *Presumptive Eligibility* Notice of Action
  • Confirm member’s remaining spenddown amount

• Call one of these phone numbers:
  • Des Moines area: 515-323-9639
  • Toll Free: 1-800-338-7752
Verifying Eligibility

EDISS Web Portal

• The Web Portal is an online eligibility verification system
• Login ID and password obtained through EDI
• Multiple User Access available
• Web Portal link:
  https://ime-ediss5010.noridian.com/iowaxchange5010/LogonDisplay.do
Communication & Information

• IME Website- http://dhs.iowa.gov/ime
  o Provider manuals- updated!
  o Informational Letters
• Provider Services phone line
  o 1-800-338-7909 or (515) 256-4609 (7:30 AM – 4:30 PM)
• IMPA Remittance Advice comments
• Email Updates through IMEProviderCommunications@dhs.state.ia.us
Provider Services Outreach Staff

Offer the following services:

- On-site training
- Escalated claims issues
- Managed care education
- email imeproviderservices@dhs.state.ia.us