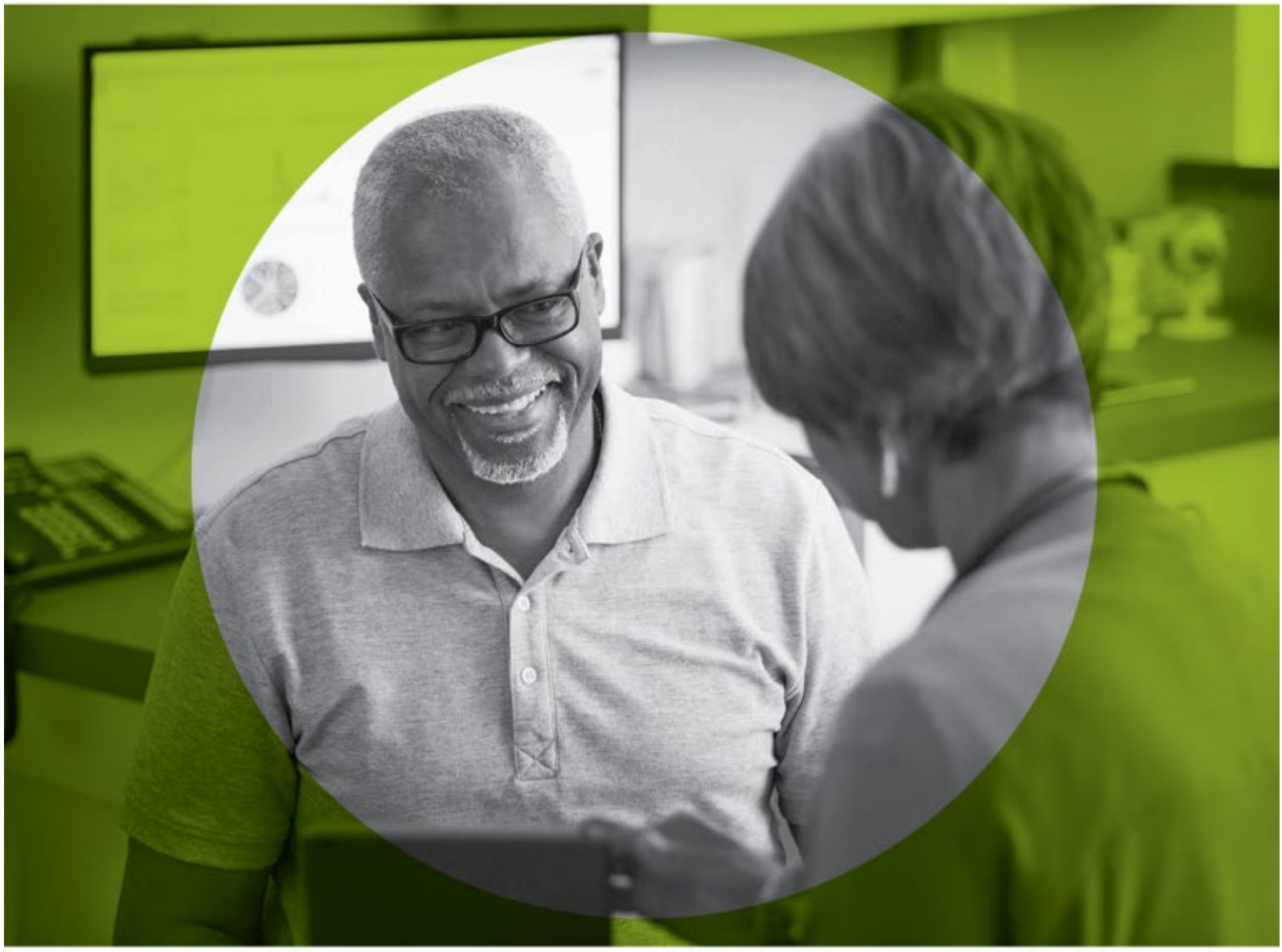
2024 Provider Manual



iowatotalcare.com

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Table of Contents

WELCOME

Welcome to Iowa Total Care! Thank you for being part of our network of healthcare professionals. We look forward to working with you to improve the health of our communities, one person at a time.

About Us

Iowa Total Care is a Managed Care Organization (MCO) health plan contracted with the State of Iowa of Health and Human Services (Iowa HHS) to serve Medicaid members enrolled in Iowa Health Link, the Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (Hawki).

As a subsidiary of Centene Corporation, Iowa Total Care's mission is to improve the health of our members through focused, compassionate, and coordinated care, one person at a time. Our approach is based on the core belief that quality healthcare is best delivered at the local level through regional and community-based care.

About This Manual

The Provider Manual contains comprehensive information about Iowa Total Care's operations, benefits, policies, and procedures. The most up-to-date version may be viewed in the "Provider Resources" section of our website: **https://www.iowatotalcare.com/providers/resources/forms-resources.html**.

Providers will be notified of updates by notices posted on our website and by bulletins. To obtain a hard copy of this Manual, contact Provider Services at the number provided in the Key Contacts section of this Manual.

Discrimination

Iowa Total Care complies with applicable federal civil rights laws and does not discriminate or treat people differently on the basis of race, color, national origin, age, disability, or sex.

KEY CONTACTS

The following chart includes several important telephone and fax numbers providers are likely to need. When calling Iowa Total Care, please have the following information available:

- National Provider Identifier (NPI) number.
- Tax ID number (TIN).
- Member's Iowa Total Care ID number or Medicaid ID number.

Health Plan Information		
Website	www.iowatotalcare.com	
Main Address	Iowa Total Care 1080 Jordan Creek Parkway Suite 400 South West Des Moines, IA 50266	
Department	**Toll Free Telephone Numbers**	**Fax Number**
Provider Services	1-833-404-1061 (TTY: 711)	1-833-208-1397
Member Services	1-833-404-1061 (TTY: 711)	N/A
Member Eligibility	1-833-404-1061 (TTY: 711)	N/A
Prior Authorization Request	Physical Health 1-833-404-1061 (TTY: 711) Behavioral Health 1-833-404-1061 (TTY: 711)	Physical Health IP and OP: 1-833-257-8327 Behavioral Health OP: 1-844-908-1170 Behavioral Health IP: 1-844-908-1169
Department	**Toll Free Telephone Numbers**	**Fax Number**
Concurrent Review	Physical Health 1-833-404-1061 (TTY: 711) Behavioral Health 1-833-404-1061 (TTY: 711)	Physical Health 1-833-257-8327 Behavioral Health OP: 1-844-908-1170 Behavioral Health IP: 1-844-908-1169

Retroactive Review	Physical Health 1-833-404-1061 (TTY: 711) Behavioral Health 1-833-404-1061 (TTY: 711)	Physical Health 1-833-257-8327 Behavioral Health 1-866-714-7991
Self-Referral	1-833-404-1061 (TTY: 711)	N/A
Care Management	1-833-404-1061 (TTY: 711)	N/A
Envolve Vision visionbenefits.envolvehealth.com	1-833-564-1205	N/A
Pharmacy Services (Centene) for providers and Prior Authorization assistance	1-866-399-0928	1-833-404-2392
Pharmacy Services (PBM) for pharmacies to call for assistance	Refer to number provided on the claim response or 1-833-750-4405	N/A
24-Hour Nurse Advice Line (24/7 Availability)	1-833-404-1061 (TTY: 711)	N/A
National Imaging Associates (NIA) **www.radmd.com**	1-866-493-9441	1-800-784-6864
Non-Emergency Medical Transportation (NEMT)	1-877-271-4819	N/A
Iowa Medicaid Provider Service **IMEProviderServices@dhs.state.ia.us**	1-800-338-7909	1-515-725-1155

Iowa Medicaid Member Services **IMEMemberServices@dhs.state.ia.us**	1-800-338-8366 (Toll Free) 1-515-256-4606 (Des Moines Area) For deaf, hard-of-hearing, deaf-blind, or for those who have difficulty speaking, call Relay Iowa TTY at 1-800-735-2942	1-515-725-1351
Hawki Member Services **Hawki@dhs.state.ia.us**	1-800-257-8563 (Toll Free)	
Iowa Total Care Admissions	N/A	1-833-257-8327
Iowa Total Care Assessments	N/A	1-833-257-8323
Iowa Total Care Prior Authorizations for Behavioral Health	N/A	Inpatient: 1-844-908-1169 Outpatient: 1-844-908-1170
Managed Care Ombudsman State Ombudsman	1-866-236-1430 1-888-426-6283	1-515-242-6007
Department	**Toll Free Telephone Numbers**	**Fax Number**
Ethics and Compliance Helpline	1-866-685-8664	N/A
Reporting suspected waste, fraud, and/or abuse to Iowa Total Care	1-866-685-8664	N/A

Language Access Services	1-833-404-1061 (TTY: 711)	N/A
Electronic Claims Submission		
Iowa Total Care c/o Centene EDI Department Payor ID: 68069 1-800-225-2573, ext. 6075525 or by email to: **EDIBA@centene.com**		
Iowa Total Care Claims Disputes		
Iowa Total Care Claims Disputes Attn: Claims Dept. P.O. Box 8030 Farmington, MO 63640-8030		

POPULATIONS SERVED

Iowa Total Care provides health coverage for enrollees of:

- Iowa Health Link.
- Iowa Health and Wellness Plan.
- Healthy and Well Kids in Iowa (Hawki).

Most members who get health coverage under Iowa Medicaid are enrolled in the Iowa Health Link managed care program. The Iowa Health and Wellness Plan provides health coverage at low or no cost to Iowans. Members are between the ages of 19 and 64. To participate and avoid monthly payments after the first year, members must get a wellness exam and a dental exam and complete a Health Risk Assessment (HRA) each year.

The Healthy and Well Kids Iowa (Hawki) program offers health insurance to children of working families who have no other health insurance or who do not qualify for Medicaid. Members are under age 19. No family pays more than $40 per month, and some families pay nothing at all.

VERIFYING ELIGIBILITY

Iowa Total Care providers should verify Member eligibility before every service is rendered, using one of the following methods:

Log on to our Secure Provider Web Portal at **www.iowatotalcare.com**. Using our secure Provider Portal, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth.

Call our automated Member eligibility interactive voice response (IVR) system. Call our toll-free Provider Services number at 1-833-404-1061 from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member Medicaid ID and the month of service to check eligibility.

If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-833-404-1061. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the member's name, Medicaid ID, and date of birth to check eligibility. Possession of an Iowa Total Care member ID card is not a guarantee of eligibility. Use one of the above methods to verify member eligibility on the date of service.

Iowa Total Care's Secure Provider Portal allows Primary Care Providers (PCPs) to access a list of eligible members who have selected their services or were assigned to them. The list of eligible members also provides other important information, including indicators for members whose claims data shows a gap in care, such as the need for an adult BMI assessment. To view this list, log on to **www.iowatotalcare.com**.

TIP Eligibility changes can occur throughout the month and the member eligibility list does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service.

TIP If Iowa Total Care has not been informed of a member's name change or if member has been adopted, claims and authorizations may not be processed properly. Members or providers need to notify Iowa Total Care if a name change or if an adoption has occurred to update Iowa Total Care's records.

Member Identification Card

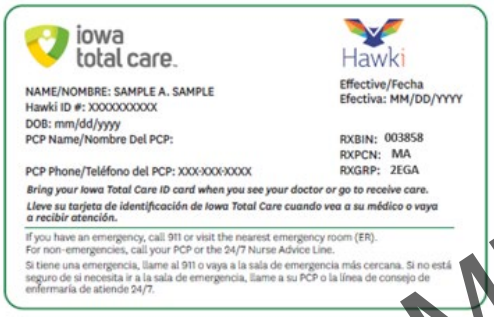
All new Iowa Total Care members receive an Iowa Total Care member ID card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card.

Providers are not able to access or print out a copy of the member ID card. Providers can verify member eligibility in the Provider Portal to provide services and should encourage the member to order a replacement ID card by calling Provider Services at 1-833-404-1061.

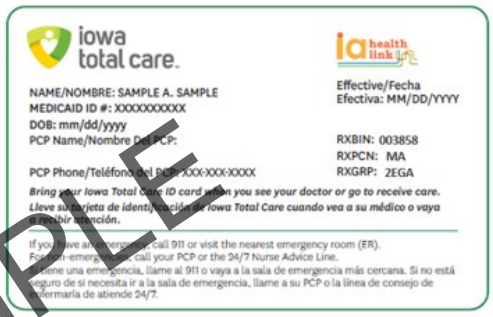
Whenever possible, members should present both their Iowa Total Care member ID card and a photo ID each time they seek services from a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification. If you suspect fraud, please contact Provider Services toll-free at **1-833-404-1061 (TTY: 711)** immediately.

Members must also keep their state-issued Medicaid ID card (pictured below) in order to receive benefits that are not covered by Iowa Total Care.

Hawki ID Front



Iowa Health Link ID Front



Hawki ID Back

Iowa Health Link ID Back

ONLINE RESOURCES

Iowa Total Care's website allows 24/7 access to provider and member information. The website is located at **www.iowatotalcare.com**. Providers can find the following information on the website:

- Sign Up for Provider Emails.
- Welcome to Iowa Total Care!
- Login.
- Become a Provider.
- Prior Authorization Check.
- Pharmacy.
- Contracting & Credentialing.
- Electronic Visit Verification.
- Provider Resources.
- Provider Trainings & Webinars.
- Quality Improvement Program.
- Forms, Manuals and Resources.
- Provider Alerts.
- Provider Newsletters.
- System Configuration Updates.
- Stakeholder Advisory Board.
- Coronavirus Information for Providers.
- Language Services
- Cultural Competency & Health Equity Toolkits

Please contact your Provider Relations Representative or Provider Services toll-free at **1-833-404-1061 (TTY: 711)** with any questions or concerns regarding the website.

SECURE PROVIDER WEB PORTAL

Iowa Total Care's Secure Provider Web Portal allows providers to check member eligibility and benefits, submit and check the status of claims, request authorizations, and send messages to communicate with Iowa Total Care staff.

Providers who are contracted with Iowa Total Care and are designated office staff may register to use the Provider Web Portal in four easy steps. Once registered, tools are available that make obtaining and sharing information easy.

Providers who are not contracted with Iowa Total Care and would like to become part of Iowa Total Care's network may start the process by visiting our **'Become a Provider'** webpage.

Go to **www.iowatotalcare.com** to register. On the Iowa Total Care home page, click on 'For Providers'. Once on the 'For Providers' page, under Portal Login, click on 'Login/Register'. Once on the log in page, click on 'Create New Account' button. Enter the required data and follow the prompts. Please allow 24-48 hours to have your request approved if you are a new provider. If you are a new provider and do not have an account manager, please reach out to your provider

relations representative to gain that access. Once you have been given access from the Account Manager of your Provider Group, that manager will need to approve your request.

A quick video is available by visiting our **'Provider Trainings & Webinars'** webpage under On-Demand Learning and selecting Provider Portal Training.

Providers may use the Provider Web Portal to:

- Check member eligibility.
- View member health records.
- View the patient list (for PCPs only).
- View and submit claims.
- Correct and resubmit a claim.
- Submit a dispute, reconsideration.
- Verify claim status.
- Verify proper coding guidelines.
- View payment history.
- View and submit Prior Authorizations.
- Check Prior Authorization requirements.
- Verify Prior Authorization status.
- View member gaps in care.
- Contact us securely and confidentially.
- Add/Remove account users.
- Determine payment/check clear dates.
- Add/Remove TINs from a user account.
- View and print Explanation of Payment (EOP).

Providers must agree that all health information, including that related to patient conditions, medical utilization, and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

PROVIDER GUIDELINES

Health Homes

Iowa Total Care is committed to supporting providers in achieving recognition as Health Homes and will promote and facilitate the capacity of primary care practices to function as Medical Homes by using systematic, patient-centered and coordinated Care Management processes.

Iowa Total Care will support providers in obtaining either NCQA's Patient-Centered Medical Home (PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

Health Homes provide better healthcare quality, improve member self-management of their own care and reduce avoidable costs over time. Iowa Total Care will actively partner with providers, community organizations, and groups representing our members to increase the number of providers who are recognized as Health Homes.

Iowa Total Care has dedicated resources to ensure its providers achieve the highest level of Medical Home recognition with a technical support model that will include:

- Readiness survey of contracted providers.
- Education on the process of becoming certified.
- Resources, tools, and best practices.

The Secure Provider Web Portal offers tools to help support PCMH accreditation elements. These tools include:

- Online care gap notification.
- Member panel roster (including Member detail information).

For more information on the Health Home model or how to become a Health Home, the provider's first stop is contacting Iowa Medicaid to enroll as a Health Home, then **contracting with Iowa Total Care** and contacting your Provider Relations Specialist if you have any questions and for assistance in portal enrollment and usage.

Integrated Health Homes

Iowa Total Care supports the Integrated Health Homes (IHHs) who serve members of any age who have Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) with a documented Functional Impairment (FI) provided by a licensed mental health professional. The IHH has a team of Health Care Professionals that are designed to deliver whole-person, patient-centered, coordinated care. This includes members who are enrolled in the 1915(i) Habilitation Program; adults diagnosed with a Serious and Persistent Mental Illness (SPMI); and the 1915© Children's Mental Health Waiver for children.

An IHH requires Iowa Medicaid (IM) registration and ongoing compliance with IHH standards of participation as set forth in the Iowa State Plan Amendment, Iowa Code and federal guidance.

The IHH provides:

- Comprehensive care management.
- Care coordination.
- Health promotion.
- Comprehensive transitional care and follow-up.
- Patient and family support.
- Referral to community and social support services.

State-Covered Services

Some services are carved out and covered by the state's fee-for-service (FFS) program instead of Iowa Total Care. While Iowa Total Care does not cover these services, providers and specialists must provide required referrals and assist in setting up these services. These include:

- Services included in the Program of All Inclusive Care for the Elderly (PACE).
- School-based services provided by the area education or local education agencies.
- Dental services provided outside a hospital setting.
- State of Iowa Veterans Home services.
- Money Follows the Person (MFP) grant-funded services.

For details on how and where to access these services, members can call the Iowa Medicaid Member Services Unit toll-free at **1-800-338-8366**, Monday through Friday from 8 a.m. to 5 p.m.

Accessibility

Iowa Total Care is committed to providing equal access to quality health care and services. In May 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by Iowa Total Care through an onsite Accessibility Site Review (ASR). Iowa Total Care's expectation, as communicated through the provider contract, is full compliance with all Federal and State disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above; the Americans with Disabilities Act; Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility", as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of Iowa Total Care providers.

Appointment Availability and Access Standards

Iowa Total Care follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Iowa Total Care monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Primary Care Providers	**Timeframe**
Emergency Medical Condition	Immediately upon presentation, twenty-four (24) hours a day, seven (7) days a week.
Urgent Medical Condition	Within twenty-four (24) hours.
Non-Urgent Sick Visits (w/persistent symptoms)	Within forty-eight (48) hours.
Routine Appointments	Not to exceed four (4) to six (6) weeks.
Specialists	**Timeframe**
Specialty Providers – Urgent	Within twenty-four (24) hours.
Specialty Providers – Routine	Within thirty (30) days.
Hospitals – Emergency	Twenty-four (24) hours a day, seven (7) days a week.

Behavioral Health –Emergency	Immediately upon presentation, twenty-four (24) hours a day, seven (7) days a week.
Behavioral Health – Mobile Crisis	Within one (1) hour of presentation or request.
Behavioral Health – Urgent	Within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with provider or Iowa Total Care.
Behavioral Health –Persistent Symptoms	Within forty-eight (48) hours of reporting symptoms.
Behavioral Health – Follow-up Appt or Routine	Within three (3) weeks of the request for an appointment.
Substance Use Disorder & Pregnancy	Members who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment.
Intravenous Drug Use	Admitted no later than fourteen (14) days after making the request for admission, or one-hundred and twenty (120) days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual no later than forty-eight (48) hours after such request.
Labs and X-Ray Services – Non-Urgent	Not to exceed three (3) weeks.
Labs and X-Ray Services – Urgent	Within forty-eight (48) hours.
General Optometry – Routine	Not to exceed three (3) weeks.
General Optometry – Urgent	Within forty-eight (48) hours.

Covering Providers

PCPs and specialists must arrange for coverage with another provider during scheduled or unscheduled time off, preferably with another Iowa Total Care network provider. In the event of unscheduled time off, please notify Provider Services of coverage arrangements as soon as possible. The covering provider is compensated in accordance with the fee schedule in their agreement, and, if not an Iowa Total Care network provider, they will be paid as a non-participating provider.

Telephone Arrangements

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and, when possible, reschedule canceled and no-show appointments.

- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, noncompliant individuals, or those with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
    - After-hours telephone care for non-emergent, symptomatic issues within thirty (30) minutes.
    - Same day for non-symptomatic concerns.
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record.

Iowa Total Care will monitor appointment and after-hours availability on an ongoing basis through its Quality Management/Quality Improvement (QM/QI) Program.

24-Hour Access

Iowa Total Care PCPs and specialists are required to maintain sufficient access to facilities and personnel in order to provide covered services and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- During after-hours, a provider must have arrangements for one of the following:
    - Access to a covering practitioner.
    - An answering service.
    - Triage service.
    - A voice message that provides a second phone number that is answered.
    - Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members.

Examples of unacceptable after-hours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours.
- The provider's office telephone is answered after-hours by a recording that tells patients to leave a message.
- The provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed.
- A clinician returning after-hours calls outside thirty (30) minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialist, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Iowa Total Care will monitor providers' offices after-hour coverage through surveys and through mystery shopper calls conducted by Iowa Total Care Provider Network staff.

Confidentiality Requirements

Providers must comply with all federal, state, local laws, and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to, the Federal Health Insurance Portability and Accountability Act (HIPAA), 42 C.F.R. Part 2, Iowa Administrative Codes (IAC) such as 217.30; 141A.9; 729.6; IAC Chapters 228, 229, 715C, as well as applicable contractual requirements. Providers are contractually required to safeguard and maintain confidentiality of data that addresses medical records, confidential provider information, and member information, whether oral or written, in any form or medium.

All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral is considered confidential. The privacy rule calls this information Protected Health Information (PHI). "Individually identifiable health information," including demographic data, is information that relates to:

- The individual's past, present or future physical or mental health or condition.
- The provision of healthcare to the individual.
- The past, present, or future payment for the provision of healthcare to the individual.
- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- Many common identifiers (e.g. name, address, birth date, Social Security number).

The privacy rule excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g.
Provider offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Iowa Total Care. This should include a knowledgeable Privacy Officer who is responsible for managing any issues related to privacy breaches and immediate reporting of the same to Iowa Total Care should a privacy breach impact health plan members. Reporting of these events may be conducted through the provider's associated Iowa Total Care Provider Relations Representative or by emailing Iowa Total Care's HIPAA mailbox at **HIPAA@IowaTotalCare.com**.

Release of confidential State information to third parties requires advance written approval from the Department of Human Services, except for releases of information for the purpose of individual care and coordination among Providers conforming with 45 C.F.R. Part 164 Subparts A and E, releases authorized by members or releases required by court order, subpoena, or law which do not require advance approval by the state before release.

Member Privacy Rights

Iowa Total Care privacy policy assures that all members are afforded the privacy rights permitted under HIPAA and other applicable Federal, State, and local laws and regulations, and applicable contractual requirements. Iowa Total Care's privacy policy conforms with 45 C.F.R. (Code of Federal Regulations), Parts 160 and 164 for relevant sections of HIPAA that provide member privacy rights and place restrictions on uses and disclosures of PHI, as well as the aforementioned State of Iowa laws and regulations.

Iowa Total Care's policy also assists our personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy requests, including:

Use and Disclosure Guidelines

Iowa Total Care is required to use and disclose only the minimum amount of protected health information necessary to accomplish the particular use or disclosure.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law. Iowa Total Care may deny a privacy request under any of the following conditions:

- Iowa Total Care does not maintain the records containing the PHI.
- The requester is not the member and we're unable to verify the members identity or authority to act as the member's authorized representative.
- The documents requested are not part of the designated record set (e.g., credentialing information).
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the member or another person.
- Iowa Total Care is not required by law to honor the particular request (e.g., accounting for certain disclosures).
- Accommodating the request would place excessive demands on us or our time and resources and is not contrary to HIPAA.

Health Equity & Cultural Competency

Iowa Total Care views Health Equity as the highest level of health for all people, where everyone has a just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that can affect access to care and health outcomes. Cultural Competency is the measure of a person's or organization's willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences

among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Health Equity & Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, and diverse populations. It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Iowa Total Care is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care.

As part of Iowa Total Care's Health Equity & Cultural Competency Program, providers must:

- Inform members of their right to access free, qualified medical interpreters and signers, accessible transportation, and TDD/TTY services.
- Facilitate member access to Cultural and Linguistic services.
- Document member requests for language services and/or refusal of professional language services in the medical record.
- Participate in cultural competency education and training at least annually.
- Provide medical care with consideration of the members' primary language, race, ethnicity, and culture.
- Ensure that office staff routinely interacting with members have been given the opportunity, and have participated in, health equity and/or cultural competency training.
- Ensure that treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on health care.

- Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

Iowa Total Care considers this mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program membership, physical or behavioral disabilities, except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered service or availability of a facility.
- Providing an Iowa Total Care member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times).

Iowa Total Care provides Health Equity & Cultural Competency related educational opportunities for providers on the Providers tab on the Iowa Total Care website at: **https://www.iowatotalcare.com/providers/resources/language-services.html**.

Providers are also encouraged to participate in training provided by other organizations. For additional information regarding resources and trainings, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: **https://cccm.thinkculturalhealth.hhs.gov/**
- Think Cultural Health's website includes classes, guides and tools to assist you in providing culturally competent care. The website is: **https://thinkculturalhealth.hhs.gov/**
- In addition, Iowa Total Care has developed a Health Literacy Cultural Competency Flyer. The flyer can be located on the Providers tab under the Manuals, Forms, and Resources page of the Iowa Total Care website at: **https://www.iowatotalcare.com/providers/resources/forms-resources.html**

Interpretation Services

Interpretation services are available at no cost to Iowa Total Care members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if linguistic needs are not met.

Providers may not request or require an individual with limited English proficiency to provide his or her own interpreter. Providers may not rely on staff other than qualified bilingual/multilingual

staff to communicate directly with individuals with limited English proficiency. Providers may not rely on an adult or minor child accompanying an individual with limited English proficiency to interpret or facilitate communication or on a minor child to interpret or facilitate communication. A minor child or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. An accompanying adult may be used to interpret or facilitate communication when the individual with limited English proficiency specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances. Providers are encouraged to document in the member's medical record any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

To obtain language services, members and providers must contact the Iowa Total Care Member Services Department at **1-833-404-1061 (TTY: 711)**. Members requiring in-person interpretation services are advised to contact Members Services 48 hours before the appointment. Additional information, including our language services request form, is available on our Language Services webpage: **https://www.iowatotalcare.com/members/medicaid/language-services.html**

For additional guidance on how to access interpretation services please review the Provider Language Access Services Request Form at: **https://www.iowatotalcare.com/providers/resources/language-services.html**.

For access to Iowa Total Care's Interpretation Services Poster, a tool created to help you identify your patients language and avoid delaying medical attention, please visit: **https://www.iowatotalcare.com/providers/resources/language-services.html**.

Americans with Disabilities Act

Provider Accessibility Initiative (PAI) is committed to providing equal access to quality health care and services that are physically and programmatically accessible for members living with disabilities and their companions. "Physical access", also known as "architectural access", refers to persons with a disability, ability to access buildings, structures, and the environment. "Programmatic access" refers to persons with a disability, ability to access goods, services, activities, and equipment. The goal of PAI is to increase percentage of practitioner locations within our network that meet minimum federal and state disability access standards.
PAI covers people with physical, mental, cognitive, or intellectual limitations such as difficulty walking, balancing, climbing, seeing, hearing, reading, understanding, or remembering.
As Iowa Total Care moves closer to full inclusion of people with disabilities through policy and practice integration, provider directory accessibility information display, and architecture barrier removal, it is important to understand that disability is just one aspect of a person's full complex life and each person should be seen as an individual, not a disability. The key to creating an

acceptable environment for providing health for people living with disabilities is to treat each individual with respect and equality.

- Do not be overly friendly or condescending toward individuals with disabilities.
- Use appropriate greetings, such as shaking hands.
- Challenge derogatory language and jokes.
- Take ownership for making everyone feel welcome and accepted.

When providing assistance:

- First, ask if help is needed.
- Be sure to understand what is needed and offer only what is needed.
- Don't take over; just help.
- Speak directly to the person rather than through someone else, such as a sign language interpreter.
- Don't be afraid to make a mistake.
    - Made a mistake? Apologize, correct, learn, and move on.
- Use common sense and a positive attitude.
- Always think of the person first.
- Be generous with yourself.
- Unsure of what to do or say? Ask!

Important Points to Remember: Word Choice

- Avoid words with negative connotations like "handicapped", "afflicted", "crippled", "victim", "sufferer", etc.
- Do not refer to individuals by their disability. A person is not a condition.
- Emphasize "person first" terminology:
    - Handicapped — A PERSON with a disability.
    - Deaf — A PERSON who is deaf.
    - Mute — A PERSON without speech.
    - Confined/Wheelchair-Bound — A PERSON who uses a wheelchair.

- If you happen to not have a disability at this time in your life, that DOES NOT make you "normal" or "able-bodied". It makes you "non-disabled".

Iowa Total Care strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and
- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services.

The term "disability" means, with respect to an individual:
A physical or mental condition that limits a person's movement, senses, or activities. These limitations may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. Disability is any substantial limitation of a person's life activities and may

be present from birth or may occur during a person's lifetime. Any individual meeting any of these conditions is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

Programmatic access to healthcare means that policies and practices that are part of the delivery of healthcare do not hinder the ability of members with disabilities to receive the same quality of care as other persons.

Policies for Communication and Access to Information:

- Provisions for intake forms to be completed by persons who are blind or with a low visual disability with the same confidentiality afforded other members.
    - Use of large print forms, electronic or online web-based forms, or in-person staff assistance in a private location.
- Provision for a presence of sign language interpreters to enable full communication with deaf or hard-of-hearing members who use sign language.
    - Professionalism and confidentiality require healthcare providers to take responsibility for the communication.
- Provision for making auditory information (e.g., automated messages) available via alternative means.
    - Written communication or secure web-based methods may be used as possible substitutes.
- Provision for communicating with deaf or hard-of-hearing members by telephone.
    - Use of telephone relay services (TRS), a TDD, or use of secure electronic means.

Policies for Scheduling and Waiting:

- Policies that allow scheduling additional time for the duration of appointments for members with disabilities who may require it.
    - Members may require more time than the standard because of multiple complexities. More time may be needed to conduct the examination or for communication through an interpreter as well as other communication issues.
- Policies to enable members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival.
    - Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious.
- Policies to allow flexibility in appointment times for members who use paratransit.
    - Members may arrive late at appointments because of delays or other problems with paratransit scheduling or reliability.
- Policies to enable compliance with federal law that guarantees access to provider offices for people with disabilities who use service animals.
    - Members with service animals expect the animal to accompany them into the waiting and examination rooms. This is protected under the Americans with Disabilities Act. This policy statement simply prepares staff to respond accordingly.

Policies for Conducting the Examination:

- Training of healthcare providers in operation of accessible equipment.
    - Staff must know how to operate accessible equipment, such as adjustable height exam tables and scales so they can be regularly and easily utilized.

Policies for Follow-up or Referral:

- Current or potential members, including people with disabilities, should only be referred to another provider for established medical reasons or specialized expertise.
    - Referral results in a delay of treatment and subject members to additional time, expense, and reduces member choice of providers.
- Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which members are referred.
    - Members may be unable to comply with medical referrals if referred location is not accessible and/or not prepared to provide the recommended service.

General Requirements

General prohibitions against discrimination:

- No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability;
- Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;
- Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
- Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
- Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;
- Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;
- Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

- Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Iowa Total Care, or opportunity enjoyed by others receiving the aid, benefit, or service.
- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
- That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
- That have the purpose or effect of defeating; or
- Substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
- That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same state.
- A public entity may not, in determining the site or location of a facility, make selections that have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
- That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
- That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be

shown to be necessary for the provision of the service, program, or activity being offered.

- Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
- A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
- Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.
- Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
- A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.
- A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

Mandatory Reporting of Suspected Child and Dependent Adult Abuse:
Iowa Total Care providers are mandatory reporters and are essential is protecting children and dependent adults from abuse. By law, IAC 232.69 and 235B.3(2), mandatory reporters must make a report of suspected abuse within 24 hours of becoming aware of the concern(s).

If you suspect a child under the age of 18 is abused or neglected, call the Abuse Hotline at 1-800-362-2178, available 24 hours a day, 7 days a week. More information is available at **hhs.iowa.gov/programs/CPS**.

To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call the Abuse Hotline at 1-800-362-2178, available 24 hours a day,7 days a week. More information is available at **hhs.iowa.gov/programs/programs-and-services/adult-protective-services**.

Advance Directives

Iowa Total Care providers are required to provide adult members with written information about the members' right to have an Advance Directive as defined in 42 C.F.R. 489.100. An Advance Directive is a legal document, such as a living will or Durable Power of Attorney, where a member may provide directions or express preferences concerning their medical care and/or may appoint someone to act on their behalf. Members can use Advance Directives when the member is unable to make or communicate decisions about their medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes the member to be unable to actively make a decision about their medical care.

Iowa Total Care is committed to ensuring that members are aware of and are able to avail themselves with information regarding their right to execute Advance Directives. Iowa Total Care is equally committed to ensuring its providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding Advance Directives.

Iowa Total Care will provide and ensure that providers are sharing written information with all adult members receiving medical care with respect to their rights under all applicable laws so members may make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.

Advance Directives are addressed by a provider with the member:

- When a member visits the provider's office.
- At a hospital at the time of a member's admission as an inpatient.
- At a skilled nursing facility at the time of a member's admission.
- Prior to or on the first visit when a member begins receiving care with a home health agency.
- At the time a member begins hospice care.

Neither Iowa Total Care nor providers will condition the authorization or provision of care or otherwise discriminate against a member based on whether or not the member has executed an Advance Directive. Iowa Total Care will facilitate communications between a member or member's authorized representative and the member's provider if the need is identified to ensure they are involved in decisions to withhold resuscitative services, or to forego or withdraw life-sustaining treatment.

Iowa Total Care is aligned with the HEDIS Care of Older Adults measure, which includes annual review of advanced care planning, medication review, functional status, and pain assessment. Iowa Total Care will annually assess and document the Advance Directive status in the Care Management systems for members who receive Long Term Services and Support. Providers must document that a member received information on Advance Directives that informed them of their right to execute and have one in the member's permanent medical record.

Iowa Total Care recommends the following:

- The first point of contact for the member in the PCP's office should ask if the member has executed an Advance Directive and the member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Advance Directive to the PCP's office and document this request in the member's medical record.
- An Advance Directive should be a part of the member's medical record and include mental health directives.

If an Advance Directive exists, the provider should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the Advance Directive and if available) and with the referring provider, if applicable. Any such discussion should be documented in the medical record.

Iowa Total Care requires contracted providers to maintain written policies and procedures regarding Advance Directives and provide staff education related to it.
Members can file a grievance regarding noncompliance with Advance Directive requirements with Iowa Total Care and/or with the Iowa HHS. Iowa Total Care provides information about Advance Directives to members in the Member Handbook, including the member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or healthcare Power of Attorney, and general instructions.

Primary Care Providers (PCP)

The Primary Care Provider (PCP) is a specific provider operating under the scope of the member licensure, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating, and monitoring other medical care; rehabilitative service; and maintaining continuity of care on behalf of a member. PCPs are the cornerstone of Iowa Total Care's service delivery model. The PCP serves as the "Medical Home" for the member. The Medical Home concept consists of establishing a member/provider relationship, supports continuity of care, and patient safety. This leads to the elimination of redundant services and results in cost-effective care and better health outcomes.

Iowa Total Care offers a robust network of PCPs to ensure every member has access to a Medical Home within the required travel distance standard (one within 30 minutes or 30 miles of each member's home where available).

Iowa Total Care requires PCPs and specialists to conduct reasonable outreach whenever a member misses an appointment and to document this in the member's medical record. An effort will be considered reasonable if it includes three (3) attempts to contact the member. Attempts may include, but are not limited to: written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow-up telephone call.

Provider Types That May Serve as PCPs

A PCP is a medical practitioner in our network and may be a:

- Family Practitioner.
- General Practitioner.
- Internist.
- Pediatrician.
- Advanced Registered Nurse Practitioner (ARNP).
- Obstetrician or Gynecologist (OB/GYN).
- Physician Assistant.

Member Panel Capacity

All PCPs reserve the right to determine the number of members they accept into their panel. Iowa Total Care **does not guarantee** any provider will receive a certain number of members. The PCP-to-member ratio shall not exceed 1,500 members per PCP.

PCPs interested in exceeding the member limit should contact their Provider Relations Representative to discuss providing satisfactory evidence of added capacity by use of physician extenders and/or extended office hours to accommodate additional members.

If a PCP declares a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact Iowa Total Care Provider Services toll-free at **1-833-404-1061**. A PCP shall not refuse to treat members as long as they have not reached their requested panel size.

Providers shall notify Iowa Total Care in writing at least forty-five (45) days in advance of their inability to accept additional Medicaid members under Iowa Total Care agreements. In no event shall any established patient who becomes an Iowa Total Care member be considered a new patient.

PCP Assignment

Iowa Total Care members have the freedom to choose a PCP from our comprehensive provider network. Within seven (7) days of enrollment, Iowa Total Care will send new members a letter encouraging them to select a PCP. For those members who have not selected a PCP during enrollment or within ten (10) calendar days of enrollment, Iowa Total Care will use a PCP auto-assignment algorithm to assign an initial PCP. Members reserve the right to change their PCP at any time. PCPs may be updated by calling our Member Services toll free at **1-833-404-1061 (TTY: 711)**.

The algorithm assigns members to a PCP according to the following criteria:

1. Member's previous PCP, if known.
2. Other family members' PCPs, if known.
3. Special healthcare needs, including pregnancy, if known.
4. Special language and cultural considerations, if known.
5. Member's geographic location.

Each month Iowa Total Care will review PCP assignments for all members and reattribute to the PCP in which they receive care. This will be determined based on claims data. Below is a high-level overview of the process:

If a member has an established relationship with a PCP not previously assigned to them, the member will be attributed to that PCP only if the provider is in-network with a valid primary care specialty.

If the member has been seeing an unassigned PCP and the PCP is within the same TIN as their previously assigned PCP, the member will not be reassigned. The member will be able to see the practitioners within that practice. This process also reviews those members with no claims data to ensure the assigned PCP is within a 30 mile/minute radius. Members who do not have claims, and have not chosen a PCP, will be reassigned to a PCP within a 30 mile/minute radius of their home address.

Members who are reassigned in this manner will receive a new ID card with the updated PCP name as well as a letter explaining why the change was made and the importance of selecting a PCP.

PCP Responsibilities

Iowa Total Care will monitor PCP actions for compliance with the following responsibilities:

- Providing primary and preventive care and acting as the member's advocate.
- Providing, recommending, and arranging for care.
- Complying with all federal and state disability access laws and regulations and providing physical and programmatic access to members with disabilities.
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds Iowa HHS data specifications.
- Ensuring and maintaining continuity of each member's healthcare, including behavioral health and long-term care services.
- When needed, effectively communicating with the member by using (free of charge to the member):
    - Sign language interpreters for those who are deaf or hard of hearing.
    - Oral interpreters for those individuals with (LEP) Limited English Proficiency.
- Maintaining a current medical record for the member, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.
- Arranging for Behavioral Health Services.
- Allowing Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as Healthcare Effectiveness Data and Information Set (HEDIS) and other contractual, regulatory, or other programs.
- Providers that screen enrolled members for risk factors and early signs of mental health or substance use disorder symptoms; the providers are to implement evidenced-based early interventions to remediate them.
- Ensuring the member receives appropriate prevention services for their age group.
- Referring a member for Behavioral Services based on the following indicators:
    - Suicidal/homicidal ideation or behavior;
    - At-risk of hospitalization due to a Behavioral Health condition;
    - Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;

- Trauma victims;
- Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;
- Request by member or authorized representative for Behavioral Health services;
- Clinical status that suggests the need for Behavioral Health services;
- Identified psychosocial stressors and precipitants;
- Treatment compliance complicated by behavioral characteristics;
- Behavioral and psychiatric factors influencing medical condition;
- Victims or perpetrators of abuse and/or neglect, and members suspected of being subject to abuse and/or neglect;
- Non-medical management of substance abuse;
- Follow-up to medical detoxification;
- An initial PCP contact or routine physical examination that indicates a substance abuse problem;
- A prenatal visit that indicates substance abuse problems;
- Positive response to questions that indicates substance abuse, observation of clinical indicators, or laboratory values that indicate substance abuse;
- A pattern of inappropriate use of medical, surgical, trauma, or emergency room services that could be related to substance abuse or other Behavioral Health conditions; and/or the persistence of serious functional impairment.

Specialist Responsibilities

Iowa Total Care encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the member's care and ensure the referred specialist is a participating provider within the Iowa Total Care network and that the PCP is aware of the additional service request. The specialist may order diagnostic tests without PCP involvement.

Female members will have direct access to an in-network OB/GYN, or other women's health specialist for routine OB/GYN services regardless of whether their PCP (general practitioner, family practitioner, or internist) provides such women's health services, including routine gynecological exams.

Emergency admissions will require notification to Iowa Total Care's Medical Management department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require prior authorization from Iowa Total Care.

The specialist must:

- Maintain contact with the PCP.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Obtain prior authorization from the Iowa Total Care Medical Management department if needed before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five (5) business days.
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care.
- Maintain the confidentiality of medical information.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- Providers that screen enrolled members for risk factors and early signs of mental health or substance use disorder symptoms; the providers are to implement evidenced-based early interventions to remediate them.

Iowa Total Care requires PCPs and specialists to conduct reasonable outreach whenever a member misses an appointment and to document this in the member's medical record. Such an effort shall be deemed to be reasonable if it includes three attempts to contact the member. Such attempts may include, but are not limited to: written attempts, telephone calls, and home visits. At least one such attempt must be a follow-up telephone call.

Hospital Responsibilities

Iowa Total Care utilizes a network of hospitals to provide services to Iowa Total Care members. Hospital Services Providers must be qualified to provide services under Medicaid. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the participating provider agreement.

Hospitals must:

- Notify the PCP immediately or at most no later than the close of the next business day after the member's Emergency Room (ER) visit.

- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify the Iowa Total Care Medical Management department by sending an electronic file of the ER admission within twenty-four (24) hours or the next business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, Date of Service (DOS), and member's phone number.
- Notify the Iowa Total Care Medical Management department of all admissions within one (1) business day.
- Notify the Iowa Total Care Medical Management department of all newborn deliveries within two (2) business days of the delivery.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.

Voluntarily Leaving the Network

Providers must give Iowa Total Care notice of voluntary termination following the terms in their participating agreement. For a termination to be considered valid, providers are required to send written notice 180 days prior to a voluntary termination via certified mail (return receipt requested) or overnight courier to:

Iowa Total Care
Attn: Network Management
1080 Jordan Creek Parkway
West Des Moines, IA 50266

In addition, Providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to Iowa Total Care or the member.

Iowa Total Care will notify affected members in writing of a provider's termination, within fifteen (15) calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely.

COVERED BENEFITS AND LIMITATIONS

Iowa Total Care network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Manual, please contact Provider Services toll-free at **1-833-404-1061**.

Iowa Total Care covers, at a minimum, those core benefits and services which includes Fee-for-Service (FFS) services covered under the Iowa Medicaid program specified in our agreement with the State of Iowa Department Human Services as set forth below:

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Preventive Services			
Affordable Care Act (ACA) preventive services	Covered	Covered	Covered
Routine check-ups	Covered	Covered; limitations may apply.	Covered
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Covered up to age 21	Covered up to age 21.	Not covered
Immunizations	Covered	Covered; limitations may apply.	Covered
Professional Office Services			
Primary Care Provider	Covered	Covered	Covered
Office visit	Covered	Covered	Covered
Allergy testing	Covered	Covered	Covered
Allergy serum and Injections	Covered	Covered	Covered
Certified nurse midwife services	Covered	Covered	Covered
Chiropractor	Covered; limitations may apply.	Covered; limitations may apply.	Covered; limitations may apply.
Contraceptive devices	Covered	Covered	Covered

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Diabetic self-management training	Covered; once per member, lifetime maximum.	Covered: 10 hours of outpatient self-management training within a 12-month period plus follow-up training of up to 2 hours annually.	Covered
Family planning and family planning related services	Covered	Covered	Covered
Gynecological exam	Covered	Covered; limited to one visit per year.	Covered
Injections	Covered; limitations may apply.	Covered; limitations may apply.	Covered; limitations may apply.
Laboratory tests	Covered	Covered	Covered
Child Care Medical Services	Covered	Not covered	Not covered
Newborn child-office visits	Covered	Covered	Covered
Podiatry	Covered; routine foot care is not covered unless it is part of a member's overall treatment related to certain health care conditions.	Covered; routine foot care is not covered unless it is part of a member's overall treatment related to certain health care conditions.	Covered

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Routine eye exam *One routine vision exam per calendar year.*	Covered	Covered	Covered
Routine hearing exam *One routine hearing exam per calendar year.*	Covered	Covered	Covered
Specialist office visit	Covered; PCP referral may be required.	Covered; PCP referral may be required.	Covered; PCP referral may be required.
Inpatient Hospital Services			
Preapproval of inpatient admissions	Covered; Required for non-emergent admissions.	Covered; Required for non-emergent admissions.	Covered; Required for non-emergent admissions.
Room and board	Covered	Covered	Covered
Inpatient physician services	Covered	Covered	Covered
Inpatient supplies	Covered	Covered	Covered
Inpatient surgery	Covered	Covered	Covered
Bariatric surgery for morbid obesity	Covered	Not covered	Covered; limitations may apply.
Breast construction, following breast cancer and mastectomy	Covered	Covered	Covered; Limitations may apply.

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Organ/bone marrow transplants	Covered; limitations apply.	Covered; limitations apply.	Covered; limitations apply.
Outpatient Hospital Services			
Abortions	Covered; Certain circumstances must apply. Contact Member Services. Prior Authorization required.	Covered; Certain circumstances must apply. Contact Member Services. Prior Authorization required.	Covered; Certain circumstances must apply. Contact Member Services. Prior Authorization required.
Ambulatory surgical center	Covered; includes anesthesia.	Covered; includes anesthesia.	Covered; includes anesthesia.
Chemotherapy	Covered	Covered	Covered
Dental treatment that cannot be completed in a normal dental office setting	Covered	Covered	Covered
Dialysis	Covered	Covered	Covered
Outpatient diagnostic lab, radiology	Covered	Covered	Covered
Emergency Care			
Ambulance	Covered	Covered	Covered
Urgent care center	Covered	Covered	Covered; may require authorization

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Hospital emergency room	Covered; $3.00 per visit for non-emergent medical services.	Covered; $3.00 per visit for non-emergent medical services.	Covered; emergency services for non-emergent conditions are subject to a $25 copay if the family pays a premium for the Hawki program.
Transportation Services			
Non-Emergency Medical Transportation (NEMT) includes taxi, paratransit, and stretcher van services, as well as bus pass and mileage reimbursement. Pick-up and drop-off services and mileage reimbursement is allowed from member's home, work, or school prior to and from a trip to a doctor's appointment or pharmacy.	Covered	Covered; medically exempt only.	Not covered
Waiver Transportation Program: Covered for HCBS members on Intellectual Disability (ID), Elderly, Brain Injury (BI) or Physical Disability (PD) Waivers who have transportation included in their service plan, additional transportation services may be available in addition to NEMT for the purposes of conducting business, essential shopping, traveling to and from work or day programs, and reducing social isolation.	Covered, when Case Managers write additional transportation benefits in addition to NEMT into the member's service plan based on need.	Not covered	Not covered
Behavioral Health Services			

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Assertive Community Treatment (ACT)	Covered	Covered when the member has been determined to be medically exempt pursuant to 441 IAC subrule 74.12(3).	Not covered
Behavioral Health Intervention Services (BHIS), including applied behavior analysis.	Covered	Covered;	Not Covered
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, and residential substance use treatment.)	Covered (MCO Members only.)	Covered; IHWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Not covered
Inpatient mental health and substance abuse treatment	Covered	Covered; limitations may apply. IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Covered

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Office visit	Covered	Covered; IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Covered
Outpatient mental health and substance abuse	Covered	Covered; IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Covered

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Psychiatric Medical Institutions for Children (PMIC)	Covered	Covered for 19 to 20-year-olds. Limitations may apply. IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Not covered
Crisis Response and Subacute Mental Health Services	Covered	Covered; IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Covered
Outpatient Therapy Services			
Cardiac rehabilitation	Covered; prior authorization may be required.	Covered	Covered; prior authorization may be required.
Occupational therapy	Covered; prior authorization may be required.	Limited to 60 visits per year.	Covered; prior authorization may be required.

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Oxygen therapy	Covered; prior authorization may be required.	Limited to 60 visits in a 12-month period.	Covered; prior authorization may be required.
Physical therapy	Covered; prior authorization may be required.	Limited to 60 visits per year.	Covered; prior authorization may be required.
Pulmonary therapy	Covered; prior authorization may be required.	Limited to 60 visits per year.	Covered; prior authorization may be required.
Respiratory therapy	Covered; prior authorization may be required.	Limited to 60 visits per year.	Covered; prior authorization may be required.
Speech therapy	Covered; prior authorization may be required.	Limited to 60 visits per year.	Covered; prior authorization may be required.
Radiology Services			
Mammography	Covered	Covered	Covered
Routine radiology screening and diagnostic services	Covered	Covered	Covered
Sleep study testing	Covered	Covered; limitations apply.	Covered
Laboratory Services			
Colorectal cancer screening	Covered	Covered	Covered
Diagnostic genetic testing	Covered	Covered; Prior Authorization required.	Covered
Pap smears	Covered	Covered	Covered
Pathology tests	Covered	Covered	Covered

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Routine laboratory screening and diagnostic services	Covered	Covered	Covered
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) testing	Covered	Covered	Covered
Durable Medical Equipment (DME)			
Medical equipment and supplies	Covered	Covered	Covered
Diabetes equipment and supplies	Covered	Covered; limitations may apply.	Covered
Eyeglasses	Covered; limitations may apply.	Covered for ages 19 to 20, limitations may apply.	Covered; limitations may apply.
Breast pumps	Covered	Covered	Not covered; certain circumstances must apply in order for this to be covered. Contact Member Services. Prior Authorizations required.
Hearing aids	Covered	Covered for ages 19 to 20, limitations may apply.	Covered; limitations may apply.
Orthotics	Covered; limitations may apply.	Not covered	Covered; limitations may apply and prior authorization required.

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Long-Term Services and Supports (LTSS) – Community-Based			
Case Management HCBS Waiver and HCBS Habilitation populations only	Covered	Not covered	Not covered
Section 1915I Home- and Community-Based Services (HCBS)	Covered	Not covered	Not covered
Section 1915(i) Habilitation Services	Covered	Covered; medically exempt only.	Not covered
Chronic Condition Health Homes	Covered	Covered; medically exempt only.	Not covered
Integrated Health Homes	Covered	Covered; medically exempt only.	Not covered
Long-Term Services and Support (LTSS) – Institutional			
ICF/ID (Intermediate Care Facility for Individuals with Intellectual Disabilities)	Covered; limitations apply.	Not covered	Not covered
ICF/MC (Intermediate Care Facility for Medically Complex)	Covered; limitations apply.	Not covered	Not covered
Nursing Facility (NF)	Covered; limitations apply.	Covered; medically exempt only.	Not covered
Nursing Facility for the Mentally Ill (NF/MI)	Covered; limitations apply.	Covered; medically exempt only.	Not covered
Skilled Nursing Facility (SNF)	Covered; limitations apply.	Covered; limitations apply, limited to120 day stays.	Not covered

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Skilled Nursing Facility Out of State (Skilled preapproval)	Covered; limitations apply.	Not covered	Not covered
Community-Based Neurobehavioral Rehabilitation Services	Covered	Covered; medically exempt only.	Not covered
Hospice			
Daily categories: • Routine care. • If member is residing in a Nursing Facility, room and board charges covered at 95%. • Facility respite. • Inpatient hospital. • Continuous.	Covered	Covered; limitations apply.	Authorize in lieu of acute care hospitalization within the service area. • 15 days per lifetime for inpatient hospice respite care. • 15 days per lifetime of outpatient hospice respite care. • Not more than 5 days of hospice respite care at a time.
Home Health			
Private duty nursing/Personal cares per EPSDT authority	Covered up to age 21 under EPSDT.	Covered; up to age 21 under EPSDT.	Not covered

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Home Health Aide	Covered	Covered	Covered
Occupational Therapy (OT)	Covered	Covered	Covered
Physical Therapy (PT)	Covered	Covered	Covered
Speech-Language Pathology	Covered	Covered	Covered
Skilled Nursing	Covered	Covered	Covered
Vision Services			
Exams	Covered; 1 complete preventive eye exam every 12 months.	Covered; 1 complete preventive eye exam every 12 months.	Covered; 1 complete preventive eye exam every 12 months.

Services	Iowa Health Link (Full Medicaid)	Iowa Health & Wellness Plan (IHAWP) (Medicaid Expansion, Low Income Adults)	Hawki (CHIP: Children's Health Insurance Program)
Eyewear	Covered: Age 1 and under: up to 3 pairs of eyeglasses every 12 months, up to 16 gas permeable contact lenses every 12 months. Age 1-3: up to 4 pairs of eyeglasses every 12 months, up to 8 gas permeable contact lenses every 12 months. Age 4-7: 1 pair of eyeglasses every 12 months, up to 6 gas permeable contact lenses every 12 months Age 8 and over: 1 pair of eyeglasses every 24 months, 2 gas permeable contact lenses every 24 months.	Covered Age 19 and 20 only: 1 pair of eyeglasses (frames and lenses) every 24 months.	Covered 100 retail allowance toward eyeglasses and contact lenses every 12 months.
Repairs	Covered; Age 20 and under: replacement for eyeglasses lost or damaged beyond repair is not limited. Age 21 and over: replacement for eyeglasses lost or damaged beyond repair is limited to once every 12 months.	Covered; Age 20 and under: replacement for eyeglasses lost or damaged beyond repair is not limited.	Not covered
For Coverage Questions call Envolve Vision at 1-833-564-1205.			

Urgent Care Services

Iowa Total Care defines Urgent Care as the existence of conditions due to an illness or injury which are not life threatening but require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

If a member is unsure as to whether or not their situation is an emergency, they may contact their PCP or Iowa Total Care's 24-hour Nurse Advice Hotline during regular or after business hours and on weekends; however, this is not a requirement to access these services.

Emergency Care Services

Emergency Care Services must be accessible 24 hours a day, seven days a week. They are provided in a hospital or comparable facility to stabilize the member and determine the severity of the condition and the appropriate treatment of acute symptoms.

Members may access emergency services at any time without Prior Authorization from Iowa Total Care.

Emergency services are covered by Iowa Total Care when provided by a qualified provider, including out-of-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Iowa Total Care. Iowa Total Care will not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition; or
2. A representative from the Plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, Iowa Total Care requires notification for hospital admission or Prior Authorization for follow-up care, as noted elsewhere in this manual.

Emergency Care Copayments

An eight-dollar ($8) copayment for Iowa Health and Wellness Plan members and a twenty-five-dollar ($25) copayment for Hawki members will be applied for use of a hospital Emergency Room (ER) to treat non-emergent conditions. A copayment shall not be imposed on Hawki Members who do not pay a premium.

Before providing non-emergency services and imposing copayments, the hospital providing care must:

- Conduct an appropriate medical screening to determine the member does not need emergency services.
- Inform the member of the amount of their copayment for non-emergency services provided in the hospital ER.
- Provide the member with the name and location of an available and accessible alternative non-emergency services provider.
- Determine that the alternative provider can provide services to the member in a timely manner with a lesser or no copayment.
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

If the member has been advised of the available alternative provider and of the amount of the copayment and chooses to continue to receive treatment for a non-emergency condition at the hospital ER, the hospital will assess the copayment. Emergency services rendered for emergent conditions are exempt from any copayment.

NETWORK DEVELOPMENT AND MAINTENANCE

Iowa Total Care maintains a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that follows Iowa HHS's access and availability requirements.

Iowa Total Care offers a network of PCPs to ensure every member has access to a Medical Home within the required travel distance standards.

In the event Iowa Total Care's network is unable to provide medically necessary services required under the Contract, Iowa Total Care will ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to Prior Authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for an Iowa Total Care member, please contact our Medical Management team at **1-833-404-1061 (TTY: 711)** and we will identify a provider to make the necessary referral.

Tertiary Care

Iowa Total Care offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical subspecialists available twenty-four (24) hours per day in the geographical service area. In the event Iowa Total Care's network is unable to provide the necessary tertiary care services required, Iowa Total Care will ensure timely and adequate coverage of these services through an out-of-network provider who is enrolled with the Iowa Medicaid (IM) until a network provider is contracted and will ensure coordination with respect to Prior Authorization and payment issues in these circumstances.

INTEGRATED HEALTH SERVICES

Overview

Iowa Total Care Medical Management department hours of operation are Monday through Friday from 8 a.m. to 5 p.m., CST (excluding holidays). After normal business hours, our 24/7 Nurse Advice Hotline staff is available to answer questions about Prior Authorization.

Integrated Health Services include the areas of Utilization Management, Care Management, Population Management, and Quality Review. Clinical services are overseen by the Iowa Total Care Medical Director. The Vice President of Population Health Clinical Operations (VPPHCO) has responsibility for direct supervision and operation of the department. To reach the Medical Director or VPPHCO, contact Medical Management toll-free at **1-833-404-1061 (TTY: 711)**.

Integrated Care

Iowa Total Care uses a multi-disciplinary Integrated Care Team (ICT) to offer and coordinate care. Our staff coordinates care with all the necessary individuals on the member's care team, including the member's primary and specialty providers, other care team members, and those identified as having a significant role in the member's life, as appropriate.

Our goal is to help each and every Iowa Total Care member achieve the highest possible levels of wellness, functional capacity, and quality of life, while demonstrating positive clinical results. Integrated care is an integral part of the range of services we provide to all members. We continually strive to achieve optimal health status through member engagement and behavioral change motivation using a comprehensive approach that includes:

- Strong support for the integration of both physical and behavioral health services.
- Assisting members in achieving optimum health, functional capability, and quality of life.
- Empowering members through assistance with referrals and access to available benefits and resources.
- Working collaboratively with members, family and significant others, providers, and community organizations to assist members using a holistic approach to care.
- Maximizing benefits and resources through oversight and cost-effective utilization management.

- Rapid and thorough identification and assessment; especially members with special healthcare needs.
- A team approach that includes staff with expertise and skills that span departments and services.
- Information technologies that support care coordination within plan staff and among a member's providers and caregivers.
- Multifaceted approach to engage members in self-care and improve outcomes.
- Continuous quality improvement processes that assess the effectiveness of integrated care and identify areas for enhancement to fully meet member priorities.
- Assessment of member's risk factors and needs.
- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members understand treatment recommendations.
- Active coordination of care for members with coexisting behavioral and physical health conditions, residential, social, and other support services where needed.
- Development of an integrated plan of care.
- Referrals and assistance to community resources and/or behavioral health providers.

The model emphasizes direct member contact (i.e.telephonic outreach, face-to-face meetings, and written educational materials). In some circumstances, face-to-face education is preferred because it more effectively engages members, allows staff to provide information that can address member questions in real time and better meets member needs. Participating members also receive preventive care and screening reminders, invitations to community events, and can call any time regarding healthcare and psychosocial questions or needs.

Medically Necessary

Medically necessary is defined differently for certain services in the Iowa Administrative Code (IAC)* and are specific to each individual. This means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

Medically necessary services:

- Will, or are reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or are reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition or disability.
- Will assist the member in achieving or maintaining maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities are appropriate for members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, must be

documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker and the PCP, as well as any other providers, programs, and agencies that have evaluated the member.

All such determinations must be made by qualified and trained healthcare providers.

*PD Nursing and Personal Care 441 IAC 78.9(10) / Behavioral Health Intervention Services (BHIS) 441 IAC 78.12(6) / Child Care Medical Services 441 IAC 78.57(5)

Care Management Program

Iowa Total Care will assign a specific Care Manager (CM) to each member who, when determined by assessment, would benefit from such services. A member may be assigned to Care Coordination, Complex Care Management, or Disease Management programs, as applicable. Services provided under varying levels of the Care Management Program may include:

- Development and implementation of a Person-Centered Care Plan (PCCP).
- Monitoring of the PCCP to determine if it is meeting the member's identified needs.
- Assessment of need for assignment to an Integrated Health Home/ Chronic Condition Health Home.
- Referring and connecting member to an appropriate Health Home when identified.
- Targeted Health Education regarding related health status, wellness and prevention.
- Annual Comprehensive Health Risk Assessment to determine if the PCCP is appropriate or if a higher or lower level of Care Management is needed.

Initial Health Risk Screening (HRS)/Annual Reassessments

Upon Enrollment, Iowa Total Care will conduct an Initial Health Risk Screening (HRS), using a tool approved by the Department of Human Services to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or needs for Service Coordination. Any member whose screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a Comprehensive Health Risk Assessment (CHRA). The HRS must be completed within the first ninety (90) days of enrollment and may be conducted by phone, electronically, by mail, or in person with ITC staff.

For reassessments, within the twelve (12) months after initial outreach or completed initial Health Risk Screening, Iowa Total Care will follow up and conduct a reassessment to obtain new, additional, or updated changes in status over the course of the year. The HRS outreach is achieved by phone, electronically, by mail, or in person with ITC staff.

Comprehensive Health Risk Assessment (CHRA)

The Comprehensive Health Risk Assessment (CHRA) will be scheduled within thirty (30) days of identification of potential need for Care Management. Reassessment will occur at a minimum of every twelve (12) months thereafter, unless there is a change in condition, significant health event, or requested by the member/caregiver. This CHRA is approved by the State of Iowa Department of Health and Human Services and is used to help identify supports and services the member may need. All support and services needs are reviewed and agreed upon by the member and their identified caregiver/support. All documentation is uploaded in Iowa Total Care's clinical documentation system, which supports the development of the PCCP. All PCCPs will require agreement and signature by the member or their designated representative; as well as, all providers that are part of the member's PCCP (unless the member requests to not share the PCCP with the provider(s)).

Care Managers will consult with the member's PCP, specialists, behavioral health providers, other providers and Interdisciplinary Team (IDT) experts; as needed, when developing the PCCP.

The Care Management team is available to help all providers manage their Iowa Total Care members. Listed below are programs and components of special services that are available and can be accessed through the Care Management team. If you have an Iowa Total Care patient and feel they could benefit from the addition of a Care Management team member, please let us know.

Programs and components are:

- Assist members in accessing PCP visits, including wellness and prevention appointments.
- Educate members about self-management of their condition.
- Ensure member awareness of and compliance with medications.
- Connect the member to needed community supports.
- Link members to a Medical Home.
- Transitions of Care Program discharge planning/care coordination.
- Follow Up after Hospitalization support.
- ER Diversion Program.
- Whole-Person Care Coordination.

To contact Care Management, call our toll-free number at **1-833-404-1061 (TTY: 711)**.

Maternity Management Pregnancy Program

The *Start Smart for Your Baby*® Program (Start Smart), incorporates care management and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age.

The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing care management to high and moderate-risk members through the postpartum period. A nurse care manager with obstetrical experience will serve as lead Care Manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead Care Managers for newborns being discharged from the NICU unit. The Care Manager will follow them through the first year of life, as needed, based on their specific condition or diagnosis.

The *Start Smart for Your Baby*® Maternity Team has provider oversight whose primary responsibility is advising the team on overcoming obstacles, helping identify high-risk members, and recommending interventions. These providers will give input to Iowa Total Care Medical Director on obstetrical care standards and use of newer preventive treatments.

Example:

The Iowa Medicaid Pharmacy Benefit includes several prenatal vitamin combinations to help support our members prior to, during, and following their pregnancies. Please refer to the Iowa Medicaid preferred drug list, at **http://iowamedicaidpdl.com/**, or contact the *Start Smart for Your Baby*® team at Iowa Total Care.

Provider Pregnancy Incentive Program

In an effort to increase member communication and reduce the recurrence of preterm births, Iowa Total Care launched a Provider Pregnancy Incentive Program effective January 1, 2020.

Notice of Pregnancy (NOP) forms are located on the Iowa Total Care Provider Portal and Iowa Total Care Provider website. You may submit NOP forms through the Iowa Total Care Provider Portal (**https://Provider.iowatotalcare.com**) or by fax 1-833-257-8323.

Members are to contact the Iowa Department of Health and Human Services (Iowa HHS) Income Maintenance Customer Service Center at 1-877-347-5678 to report a change in Medicaid due to pregnancy.

Submitted forms must be accurate and complete (i.e. member name, date of birth, member ID, full name of provider, gestation, initial OB visit date, Provider's Tax ID Number (TIN) and all pregnancy information (as able). Duplicate NOP forms will not qualify for multiple incentives.

MemberConnections® - Community Health Services Program

Iowa Total Care's outreach program is designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable.

The program components are integrated as a part of our Care Management program to link Iowa Total Care and the community we serve. The program recruits staff from the communities served to establish grassroots support and awareness of Iowa Total Care within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections® Community Health Services (CHS) through numerous sources. Members who call the Iowa Total Care Member Service department may be referred for more personalized discussion on the topic they are inquiring about. Care Managers may identify members who would benefit from one of the many MemberConnections® CHS program components and complete a referral request. Providers may request MemberConnections® CHS referrals directly to the MemberConnections® CHS Representative or their assigned Care Manager. Community groups may request that a MemberConnections® CHS Representative visit their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Care Coordination – Coaching

MemberConnections® CHS Representatives are available to work with members towards targeted health education; advocate, coach and foster the development of independent health skills, support in addressing any social service and concrete barriers that the member faces when working to achieve whole health and wellness. The MemberConnections® CHS Representative collaborates closely with the provider, nurse care manager, team nurse manager, and other members of the interdisciplinary care team. The MemberConnections® CHS Representative works with the member in the community settings, such as their home, community centers, and more, to provide culturally-fit health education and assistance. They are available whenever a need or request from a Care Manager, member, or provider is made, or when a member is recommended for a specific coaching program based on health status.

Navigation and Other Assistance

General assistance and navigation support may be provided to members and requested by a Care Manager, member, or provider as needed. Topics covered during these in-person visits include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive healthcare, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and reliable phone access through our Connections Plus®. Connections Plus® is a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan Care Manager, PCP, specialty provider, 24/7 Nurse Advice Hotline, 911, or other members of their healthcare team. MemberConnections® CHS Representatives may also ensure the member knows how to contact the health plan for assistance. Social needs may be addressed during these visits to ensure holistic care and removal of barriers to accessing the health care system. MemberConnections® CHS Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered, and any additional questions answered.

Building Community Capacity

MemberConnections® CHS Representatives are available to present to group settings during events initiated by state entities, community groups, clinics, or any other approved setting. These forms of community connections are extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care

is all about, overview of the services offered by Iowa Total Care, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers, Iowa Total Care, and health education. Targeted community events include Health Fairs where a MemberConnections® CHS Representative will actively promote healthy lifestyle activities related to disease prevention and health promotion. Health Fairs enable easy access to providers, other healthcare services and more.

S*tart Smart for Your Baby*® community baby showers promote health education and awareness for healthy pregnancies and healthy babies.

To contact the MemberConnections® CHS Team, call our toll-free number at **1-833-404-1061 (TTY: 711)**.

Members with Mental Health and Substance (Alcohol and Drug) Use Disorders

Iowa Total Care uses an intensive Care Management Program to address the unique needs of members related to Mental Health and Substance Use Disorders (SUD), including frequent co-morbid and co-occurring conditions, which require an integrated approach to all aspects of care coordination and treatment. The program incorporates interventions such as structured post-discharge telephonic or in-person contact, assessing satisfaction with outpatient providers, careful attention to compliance with prescribed medications; as well, as potential impact of each medication on all Physical Health (PH) and Behavioral Health (BH) conditions.

The following services can be initiated for members identified with needs related to Mental Health and SUD as indicated:

- Integrated Health Homes (IHH).
- Intensive Care Coordination including referrals to inpatient/outpatient services.
- Utilize Community Health Workers to engage members.
- Transition of Care from different care settings/levels.
- [Chronic Condition Health Homes (CCHH). **Note:** CCHH ends December 31, 2023.]

Upon enrollment, Iowa Total Care will conduct an initial Health Risk Screening (HRS) to confirm member needs related to Mental Health and/or SUD, assessing medical, Behavioral Health, social, and other needs. Within thirty (30) calendar days of identification of special healthcare needs, or sooner as dictated by member needs, a Care Manager will outreach to members identified to complete a Comprehensive Health Risk Assessment (CHRA), develop a care plan, and provide other needed assistance. Other outreach processes and initiatives include:

- Partnering with community care managers and peer supports to outreach to members with Serious Mental Illness (SMI), SUD, and other Behavioral Health needs.
- Identifying agencies serving the homeless population and coordinate with those agencies on initiatives geared toward identifying and connecting difficult-to-reach members with supportive resources and stable housing.

- Building relationships with local hospitals so they notify Iowa Total Care when our members visit the ER.
- Education and enrollment of eligible members into an IHH as applicable.

In an effort to support the Health Homes, staff may use the CHRA to identify members who could benefit from a Health Home referral and educate eligible members on available services, including member's choice to opt in or out of the Health Home program. For members who choose to enroll in a Health Home, the Care Manager will coordinate with the member's chosen Health Home provider to ensure continuity of care.

New provider orientation and the Iowa Total Care Provider Portal contains information on Behavioral Health and co-occurring conditions; as well as, the requirements and processes for screening, referring and coordinating care for individuals with these disorders. Iowa Total Care will provide PCPs with screening tools for mental health issues and SUD and provide training on their use.

Referrals for Care Management of members with needs related to Mental Health and/or SUD can be made via the Iowa Total Care Provider Portal or by calling Iowa Total Care toll-free at **1-833-404-1061 (TTY: 711)** and completing a referral telephonically.

24-Hour Nurse Advice Line

Members have many questions about their health, their PCP, and access to emergency care. Therefore; Iowa Total Care offers a Nurse Advice Line to help members proactively manage their health needs and decide on the most appropriate care. This service is made available to support your practice and offer members access to a registered nurse at any time—day or night. The toll-free telephone number is **1-833-404-1061 (TTY: 711).**

The Nurse Advice Line always is open and always available for members. Staffed by Registered Nurses (RNs), they often answer basic health questions, but they are also available to triage more complex health issues using nationally recognized protocols. Nurses will refer members with chronic problems; such as, asthma or diabetes, to the Care Management or Member Service departments for follow-up assistance, education, and encouragement to improve their health. Members can call the Nurse Advice Line to request information about providers and services available in their community after hours, when the Iowa Total Care Member Service department is closed. The staff is proficient in both English and Spanish and can provide interpretation services for other languages if necessary.

LONG-TERM SERVICES AND SUPPORTS (LTSS)

Iowa Total Care coverage includes services for members who require services and supports at a level that is provided in facility-based settings; such as, a nursing home or an intermediate care facility. This is referred to as Long-Term Care (LTC). When the same type of care is provided to members in their home and/or community (Home and Community-Based Services

or HCBS), in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID), or in a Nursing Facility or Skilled Nursing Facility, it is called Long-Term Services and Supports (LTSS).

The provider is responsible for supervising, coordinating, and providing all services authorized for their member in accordance with the member's Person-Centered Service Plan (PCSP). In addition, the provider is responsible for: ensuring the receipt of an authorization for all services approved as part of the member's PCSP, maintaining continuity of each member's care, and maintaining the member's medical record. This includes documentation of all services provided by the provider and the member or responsible party's signature for receipt of covered services.

Role of the Community-Based Case Manager (CBCM)

The CBCM's primary function is to assist the team in identifying needs, facilitate access to LTSS and other services, and monitor the member's health, safety, and services access. The CBCM is responsible to lead and oversee the implementation of the member's PCSP. The CBCM will ensure there is a Level of Care (LOC) assessment completed at least every 365 days and the CBCM, at a minimum, will hold a comprehensive PCSP meeting every 365 days. The CBCM will identify, coordinate, and assist the member in gaining access to all needed services, including: covered and non-covered services, medical, social, housing, educational, and other necessary services and supports. The CBCM is responsible for locating and coordinating traditional Medicaid providers, specialists, or other entities essential for service delivery. This includes seamless coordination between physical, behavioral, and support services. CBCMs work with the member and Interdisciplinary team to coordinate evaluations and reassessments, identify strengths and needs, create the member's person-centered goals through the PCSP process, and contact the member monthly and provider(s) at least quarterly to monitor progress on goals, health, and safety. The CBCM will work with the member to complete activities necessary to maintain LTSS eligibility. The CBCM will offer options, such as choices of traditional Medicaid Waiver providers, the availability of the Consumer Choices Option (CCO), and other LTSS services that may meet the member's needs. To contact a CBCM, call Iowa Total Care at **1-833-404-1061 (TTY: 711)**.

Provider's Role in Service Planning and Care Coordination

The service provider will work with CBCM and member's team to address necessary services and supports and participate in the PCSP process to ensure members' needs are addressed. Providers are expected to follow the PCSP as written by the Case Manager and approved by the member's service planning team. Traditional Medicaid providers, as well as CCO employees, should follow documentation standards as outlined in Iowa Administrative Code 441-79.3(249A). Providers must report major incidents to ITC using this link: **https://www.iowatotalcare.com/providers/resources/forms-resources.html** and report to the case manager as outlined in Iowa Administrative Code 441-77.30(18) using this link: **https://www.legis.iowa.gov/docs/iac/chapter/03-09-2022.441.77.pdf**

Service Request Process for LTSS

LTSS services require approval and Prior Authorization by Iowa Total Care. The PCSP is the request for prior authorization for LTSS services. The PCSP is completed by the Case Manager and sent to Utilization Management for review. After a decision has been made, a Notice of Action will be mailed to the member and provider. In the case of an adverse action, a reduction, termination, or denial of services, appeal rights will be included in the notification letter.

PCSPs are reviewed with members during regularly scheduled face-to-face visits at least every three (3) months and at the time of reassessment. If a member experiences a significant change in condition, has a change in level of needed support, or if the member requests a change in service(s) or provider, there may be a need to amend the PCSP. An amendment can be requested at any time to ensure the member's needs are met.

All services are subject to benefit coverage, limitations, and exclusions, as described in applicable State rules and regulations. Iowa Total Care providers are contractually prohibited from holding any Iowa Total Care member financially liable for any service administratively denied by Iowa Total Care. Continuity of Care coverage begins on the member's effective date of enrollment for any existing services and remains in effect until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented.

LTSS Provider Responsibilities

LTSS providers are required to adhere to the following responsibilities:

- Provide Iowa Total Care members with a professionally recognized level of care and efficiency consistent with community standards, the health plan's clinical and non-clinical guidelines, and within the practice of the provider's professional license.
- Abide by the terms of the Participating Provider Agreement.
- Comply with all plan policies, procedures, rules, and regulations, including those found in this manual.
- Maintain confidential medical records consistent with Iowa Total Care's medical records standards, medical record-keeping guidelines, IAC 79.3 sections (1), (2) and (3), and applicable HIPAA regulations.
- Maintain a facility that promotes enrollee safety.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Participate in Iowa Total Care's quality improvement program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of the provider's profession.

- Notify the plan if you are undergoing an investigation or agree to written orders by the state licensing agency.
- Notify the plan if there is a change of status with member eligibility.
- Ensure you have staff coverage to maintain service delivery to members.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.
- Continue to provide services to members whose services are being transitioned to another provider. Providers should continue provision of HCBS, in accordance with the member's plan of care, until the member has been transitioned to a new provider, which may exceed thirty (30) days from the date of the notice.

UTILIZATION MANAGEMENT

The Iowa Total Care Utilization Management Program (UMP) is designed to ensure members receive access to the right care at the right place and right time. The program is comprehensive and applies to all eligible members, age categories, and range of diagnoses. It provides for aggregate and individual analysis and feedback of providers and plan performance in providing access to care, the quality of care provided to members, and utilization of services. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, maternity care, and ancillary care.

Iowa Total Care UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and that meet professionally-recognized standards of care.

Program goals include:

- Monitoring utilization patterns to guard against over or under-utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of care and/or population management for members at risk for significant health costs or ongoing care.
- Development of an infrastructure to ensure members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self-management.

- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals.

Medically Necessary

Medically Necessary means a service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability such that it:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition or disability.
- Will assist the member in achieving or maintaining maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities are appropriate for members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker, and the PCP, as well as any other providers, programs, and agencies that have evaluated the member. All such determinations must be made by qualified and trained healthcare providers.

Prior Authorizations

Failure to obtain the required Prior Authorization for a service may result in claim denial(s). All services are subject to benefit coverage, limitations, and exclusions, as described in applicable plan coverage guidelines. Most out-of-network services require Prior Authorization. Some exceptions include family planning, Emergency Room, post-stabilization services, routine vision services, and tabletop X-rays. Visit the **Iowa Total Care website** to use the **Prior Authorization Check Tool** to verify authorization requirements.

Iowa Total Care providers are contractually prohibited from holding any Iowa Total Care member financially liable for any service administratively denied by Iowa Total Care for payment due to the provider's failure to obtain timely Prior Authorization.

Iowa Total Care does not require a prior authorization if one is not required by the primary payor.

Services That Require Prior Authorization

This list of services in this manual that require Prior Authorization is not all inclusive. Visit the **Iowa Total Care website** to use the **Prior Authorization Check Tool** to determine if a service requires Prior Authorization.

Ancillary Services

- Cochlear Implant.

- Durable Medical Equipment (DME) (includes medical supplies, enteral and parenteral pumps, wound vacs, bone growth stimulator, customized equipment [based on DME, orthotics, and prosthetics listing]).
- Fixed-Wing non-emergency air transport.
- Home healthcare (including infusions, home health aide, private duty nursing).
- Hospice services other than inpatient facility (authorization waived for 1st 90 days of outpatient hospice).
- Hyperbaric oxygen treatment (outpatient).
- Implantable devices (infusion pumps, intraocular implant/shunt, neuromuscular stimulator, spinal stimulator for pain management, testicular/penile prosthesis, vagas nerve stimulator).
- Orthotics and prosthetics (based on DME, orthotics, and prosthetics listing).

Behavioral Health

- Autism Spectrum Disorders and Habilitative Services diagnosis and treatment (CBH).
- Behavioral Health: inpatient and substance abuse admissions, Partial Hospital Program (PHP), Intensive Outpatient Program (IOP); and Community-Based Mental Health Services for youth and adults.

Home and Community-Based Waiver Services

Also see the Service Request Process for LTSS in the Long-Term Services and Supports section of this manual.

- Adult Day Care.
- Assistive Devices.
- Assisted Living.
- Behavioral Programming.
- Case Management Services (for all members utilizing IHH services including Habilitation and Children's Mental Health Waiver members).
- Case Management (for those that are receiving both 1915(i) and 1915(c) waiver services and not enrolled in an IHH).
- Chore.
- Consumer Choices Option (CCO).
- Consumer-Directed Attendant Care (CDAC).
- Counseling.
- Day Habilitation.
- Emergency Response.
- Environmental Modifications and Adaptive Devices.
- Family and Community Support.
- Family Counseling and Training.
- Home-Based Habilitation.
- Home-Delivered Meals.
- Home Health Aide.
- Homemaker.

- Home/Vehicle Modifications (HVM).
- In-Home Family Therapy.
- Interim Medical Monitoring and Treatment (IMMT).
- Mental Health Outreach.
- Nursing.
- Nutritional Counseling.
- Prevocational Services and Habilitation.
- Respite: Individualized, Group, Specialized.
- Senior Companion.
- Supported Community Living (SCL).
- Specialized Medical Equipment.
- Supported Community Living: Residential-Based (RBSCL) for Children.
- Supported Employment (SE).
- Transportation.

Facility Services

- Elective/planned hospitalizations (Notification at least five (5) business days prior to the scheduled date of admission).
- Emergency admissions and/or observation stay (Notification within one (1) business day of admission).
- Mental Health Institution (MHI).
- Skilled Nursing Facility.
- Intermediate Care Facility (ICF/ID) (Concurrent review Authorization required for state-approved stays).
- Nursing Home–permanent full-time resident (Concurrent review Authorization required for State-approved stays).
- Psychiatric Medical Institution for Children (PMIC).

Pharmaceuticals

- Specialty pharmaceuticals as per Prior Authorization list.
- Selected injectable therapy/biopharmaceuticals (e.g. Synagis, growth hormone), as per Prior Authorization list.

Practitioner Services

- Chiropractic.
- Infertility treatment.
- Transplants (surgery itself).

Radiology and Laboratory Services

- Genetic/Molecular diagnostic testing.
- MR-guided Focused Ultrasound (MRgFUS) to treat uterine fibroid.
- Quantitative drug screening.

Surgery & Procedures

- Ablative techniques for treating Barrett's Esophagus and for treating primary and metastatic liver malignancies.
- Bariatric surgery.
- Capsule endoscopy.
- Hyperhidrosis treatment.
- Joint replacement--outpatient and inpatient joint replacement procedures in addition to total hip and/or knee.
- Lung volume reduction surgery.
- Maze procedure (for treatment of atrial fibrillation).
- Muscle flap procedure.
- Orthognathic surgery (treatment of maxillofacial jaw functional impairment).
- Pain management services.
- Potentially cosmetic or plastic surgery (e.g. blepharoplasty, blepharoptosis repair, brow lift, breast surgery or reconstruction other than post mastectomy, cranial/facial/jaw procedures, nasal/sinus surgery, panniculectomy, and lipectomy/diastasis recti repair, vein procedures).
- Potentially experimental treatment/clinical trials.
- Sleep apnea procedures and surgeries.
- Facility sleep studies (home sleep studies do not require prior authorization).
- Spinal surgery.
- Surgeries/procedures performed in outpatient facilities or ambulatory surgery centers (e.g. arthroscopy, gender reassignment, joint replacement, obstructive sleep apnea surgery, potentially cosmetic or plastic surgery, TMJ, transcatheter, uterine, artery embolization, vein procedures, and others listed).
- Tonsillectomies.
- Uvulopalatopharyngoplasty (UPP).
- Ventriculectomy, cardiomyoplasty.
- Wearable cardioverter-defibrillators.

Therapy Services (PT, OT, ST)

- Physical Therapy (excluding 1st 4 visits per member per year).
- Occupational Therapy (excluding 1st 4 visits per member per year).
- Speech Therapy (excluding 1st 4 visits per member per year).

Requesting a Prior Authorization

- The preferred method for submitting Prior Authorizations is through our Secure Provider Web Portal at **provider.iowatotalcare.com**. The provider must be a registered user on the Secure Provider Web Portal. If the provider is not a registered user and needs assistance or training on submitting Prior Authorizations, the provider should contact their assigned Provider Relations Representative.

- Other methods for submitting Prior Authorization requests are as follows:

- By fax with the appropriate prior authorization form below. Note: faxes are not monitored after hours and will be responded to the next business day.

  - Inpatient Medicaid Prior Authorization Form
    - For Behavioral Health, this form is ONLY used for Psychiatric Admissions, Chemical/Substance Detoxification (in a hospital setting), and Psychiatric Medical Institute for Children (PMIC).
  - Outpatient Medicaid Prior Authorization Form
    - For Behavioral Health, this form used for services that are provided in a community-based setting (outside of a hospital or PMIC) including Residential Substance Use Disorder Treatment (ASAM 3.7, ASAM 3.5, and ASAM 3.1).

- By calling:

  - **For medical requests**: call the Medical Management Department toll-free at **1-833-404-1061 (TTY: 711)**. Normal business hours are Monday through Friday, 8 a.m. to 5 p.m. CST. Voicemails left after hours will be responded to on the next business day.
  - **For Behavioral Health requests**: call the Behavioral Health Referral Specialist Department toll-free at **1-833-404-1061 (TTY:711)**. Normal business hours are Monday through Friday, 8 a.m. to 5 p.m. CST. Voicemails left after hours will be responded to on the next business day.

Timeframes for Prior Authorization Requests and Notifications

Prior Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for Prior Authorization and notification:

Any Prior Authorization request that is faxed or sent via the Secure Provider Web Portal after normal business hours (Monday through Friday, 8 a.m. to 5 p.m., excluding holidays) will be processed the next business day.

Prior Authorization Timings

Failure to obtain Prior Authorization may result in claim denials.

Service Type	Timeframe
Scheduled Admissions/Elective Outpatient Services	Five (5) business days prior to service Behavioral Health is up to 30 days in advance for outpatient services.
Emergent Inpatient Admissions	Within twenty-four (24) hours or next business day of admission.
Observation	No authorization or notification required for in network providers.

Crisis Intervention	Within two (2) business days.
Delivery	Notification within two (2) business days of delivery. This is a notification only; prior authorization is not required.
Neonatal Intensive Care Unit (NICU) Admit	Within twenty-four (24) hours or next business day of admission.

Prior Authorization Determination Timelines

Iowa Total Care medical Prior Authorization decisions are made as expeditiously as the member's health condition requires, but shall not exceed the timeframes listed below:

Definition of Urgent:

Inpatient (IP) Urgent:

Medically necessary to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 24 hours.

Outpatient (OP) Urgent:

Medically necessary to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 72 hours.

Iowa Total Care Review Timings

Type	Timeframe
Standard Non-Urgent	Fourteen (14) calendar days.
Expedited Preservice/Urgent	Inpatient: Twenty-four (24) hours. Outpatient: Seventy-two (72) hours.
Inpatient/Concurrent review	Seventy-two (72) hours.
Retrospective review	Thirty (30) days.

Clinical Information

Iowa Total Care clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Iowa Total Care is entitled to request and receive Protected Health Information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Information necessary for Authorization of covered services may include, but, is not limited to:

- Member's name, member ID number.
- Provider's name and telephone number.
- Facility name, if the request is for inpatient admission or outpatient facility services.
- Provider location, if the request is for an ambulatory or office procedure.
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date).
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed).
- Admission date or proposed surgery date, if the request is for a surgical procedure.
- Treatment and discharge plans.
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to Iowa Total Care within two (2) business days.

If additional clinical information is required, an Iowa Total Care representative will notify the requestor of the specific information needed to complete the authorization process. If no additional information is received, Iowa Total Care will make the medical-necessity determination based on the information that has been received.

Clinical Decisions

Iowa Total Care affirms that Utilization Management (UM) decision-making is based on appropriateness of care and service and the existence of coverage. Iowa Total Care does not reward providers or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct Utilization Management (UM) activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The treating provider, in consultation with the Iowa Total Care UM Team, under the direction of the Medical Director, is responsible for making UM decisions in accordance with the member's plan of covered benefits and established Prior Authorization criteria. Failure to obtain Prior Authorization for services that require plan approval may result in payment denials.

Review Criteria

Iowa Total Care has adopted utilization review criteria developed by Change HealthCare's InterQual®, the American Society of Addiction Medicine (ASAM), and the State of Iowa Department of Health & Human Services, Iowa Code, and the Iowa Administrative Code, as indicated, to determine medical necessity for healthcare services. InterQual® appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual® criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. All criteria are utilized as screening guides and are not intended to be a substitute for provider judgment. The Medical Director, or another healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

LTSS including all HCBS services will be authorized in the context of member specific needs identified through a person-centered assessment and any member encounters in order to determine the appropriate type, scope, and volume of services to be authorized for each member. The needs of members are unique, and in the instance of complex healthcare needs that require additional input, a member's community-based Care Manager will collaborate with the ITC Chief Medical Officer as well as identified members of the care team to determine the services necessary to best support a member's needs to ensure successful, member-driven, outcomes.

Peer-to-Peer Review

Providers may obtain the criteria used to make a specific adverse determination by contacting Medical Management toll-free at **1-833-404-1061 (TTY: 711)** (for Behavioral Health contact 1-833-404-1061 (TTY: 711) to contact the Behavioral Health Referral Specialist Department). At the time of notification of an adverse decision, the requesting practitioner/facility will be offered the opportunity to schedule a conversation to discuss any adverse decisions with a physician or other appropriate reviewer. To set up an appointment to speak with the Medical Director, providers may contact Provider Services by calling **1-833-404-1061 (TTY: 711)**, and asking for a peer review with the Medical Director. The request for peer-to-peer review must be made within two (2) business days of denial notification. A Case Manager may also coordinate communication between the Medical Director and requesting provider. **Note:** This is not an option for Behavioral Health.

Appealing an Adverse Benefit Determination

Members, their authorized legal representatives, or a provider, with the member's written consent, may request an appeal related to an adverse benefit determination. Instructions for how to file an appeal are provided in the Grievances and Appeal Processes section of this manual and are included in all denial letters.

Second Opinion

Members or a healthcare professional, with the member's consent, may request and receive a second opinion from a qualified professional within the Iowa Total Care network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network providers do not require Prior Authorization by Iowa Total Care when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws require that an assistant surgeon be present for a designated procedure are not, in and of themselves, grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

Iowa Total Care aligns the coverage of new technology to the Health Plan benefit defined by the Iowa Medicaid. Requests made to Iowa Total Care for coverage of new technologies will be referred to the Iowa Medicaid Medical Director. This includes medical procedures, drugs and/or devices. The Centene Clinical Practice Committee (CPC) reviews new technologies and develops medical necessity policies to guide their utilization.

Inpatient Utilization Management Process and Discharge Planning

Utilization Managers conduct concurrent reviews for inpatient admissions with the hospital's utilization and discharge planning departments and when necessary, with the member's attending physician. The Utilization Manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent Review decisions will be made within seventy-two (72) hours of receipt of clinical information. For a length of stay extension request, clinical information must be submitted on the day review is due. Verbal, written, or electronic notification includes the number of days of service approved, level of care approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review. However, the hospital must notify Iowa Total Care within two (2) business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which Prior Authorization and/or timely notification to Iowa Total Care was not obtained due to extenuating circumstances (e.g. member was unconscious at presentation, member did not have their Medicaid ID card or otherwise-indicated Medicaid coverage, services authorized by another payor who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within thirty (30) calendar days following receipt of request.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by NIA's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Iowa Total Care and NIA will continue to not require authorization for the first four (4) therapy visits per member per year, allowing time for evaluation, formulation of a plan of care, and authorization submission and review. Additional services for any ongoing care require authorization through NIA. NIA will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under terms of the agreement between Iowa Total Care, Inc. and NIA, Iowa Total Care, Inc. oversees the NIA Therapy Management program and continues to be responsible for claims adjudication. If NIA therapy peer reviewers determine that the care provided fails to meet the criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

For additional information on this new program, call NIA's Provider Services Line at 1-866-493-9441.

For additional questions, please contact Iowa Total Care at 1-833-404-1061 (TTY: 711).

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to members, Iowa Total Care is using National Imaging Associates (NIA) to provide Prior Authorization services and utilization of advanced diagnostic imaging. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior Authorization is required for the following outpatient radiology procedures:

- CT/CTA.
- MRI/MRA.
- PET Scans.
- Nuclear Radiology.

Key Provisions

- Emergency Room, observation, and inpatient imaging procedures do not require Prior Authorization.
- It is the responsibility of the ordering provider to obtain Prior Authorization.
- Providers rendering the above services should verify that the necessary Prior Authorization has been obtained. Failure to do so may result in claim non-payment.

To reach NIA and obtain Prior Authorization, call our toll-free number at **1-833-404-1061 (TTY: 711)** and follow the prompt for radiology Prior Authorizations. NIA also provides an interactive website which may be used to obtain online Prior Authorizations. Visit **RadMD.com** for more information or call our Provider Services department.

Cardiac Solutions

Iowa Total Care is using National Imaging Associates (NIA) to provide Prior Authorization services and utilization of some cardiac services. Under this program, Prior Authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment, and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, NIA addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

NIA has developed proprietary Utilization Management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. NIA also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient.
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed.
- Quality assessment of imaging providers to ensure the highest technical and professional standards.

How the Program Works

In addition to the other procedures that currently require Prior Authorization for members, Prior Authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI).
- MUGA Scan.
- Echocardiography.
- Stress Echocardiography.

The following services do not require Prior Authorization through NIA:

- Inpatient advanced radiology services.
- Observation setting advanced radiology services.
- Emergency Room radiology services.

To reach NIA and obtain Prior Authorization, call our toll-free number at **1-833-404-1061 (TTY: 711)** and follow the prompt for Radiology and Cardiac Prior Authorizations. NIA also provides an interactive website, which may be used to obtain online Prior Authorizations. Visit **RadMD.com** for more information.

Interventional Pain Management

NIA manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain prior authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal epidural injections.
- Paravertebral facet joint injections or blocks.
- Paravertebral facet joint denervation (Radiofrequency Neurolysis).
- Sympathetic nerve blocks.

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through NIA for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required by Iowa Total Care. To obtain authorization through NIA, visit RadMD.com or call Iowa Total Care at **1-833-404-1061 (TTY: 711).**

Pharmacy

Iowa Total Care provides pharmacy benefits through its Centene Pharmacy Services and the Pharmacy Benefits Manager (PBM). Iowa Total Care adheres to the state of Iowa Preferred Drug List (PDL) to determine medications covered under the Iowa Total Care Pharmacy Benefit, as well as medications that may require Prior Authorization (PA). Please visit the Iowa Total Care website at **www.iowatotalcare.com** for a link to the state's current PDL and PA criteria.

Some members may have copayment or cost share when utilizing their prescription benefits. Refer to the Iowa Total Care Member ID card for information or call Iowa Total Care at **1-833-404-1061 (TTY: 711)**.

Who Receives Pharmacy Benefits Through Iowa Total Care

Iowa Total Care administers the Medicaid pharmacy benefit. Medicaid benefits are always paid "last". That is, if a member has another insurance plan in addition to Iowa Total Care, that other insurance plan will be primary. If the primary plan is a commercial insurer, Medicaid benefits may cover the remaining portion (copay) after the primary insurance has paid. Medicaid will not cover the remaining portion if the service is not a covered pharmacy benefit (such as for drugs to treat infertility or erectile dysfunction).

If a member has both Medicaid and Medicare, they are dual-eligible. Dual-eligible members have their pharmacy benefit through Medicare Part D Plans, and because they qualify for Medicaid, they automatically qualify for the "extra help" feature that is available to low income Medicare recipients. The terms of their coverage (which drugs are covered, days supply offered, etc.) is determined by the Medicare Part D Plan. Dual-eligible members do not have pharmacy benefits administered through Iowa Total Care with the exception of certain over-the-counter items that are part of the Medicaid benefit but not part of the Medicare benefit.

Preferred Drug List (PDL)

Iowa Total Care adheres to the State of Iowa Preferred Drug List (PDL) to determine medications that are covered under the Iowa Total Care Pharmacy Benefit, as well as which medications may require Prior Authorization. Visit the Iowa Total Care website at **www.iowatotalcare.com** for a link to the state's current PDL and criteria.

The Preferred Drug List does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the independent professional judgment of a provider or pharmacist.
- Relieve the provider or pharmacist of any obligation to the member or others.

The State of Iowa PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a notation throughout the PDL.

In addition to the State of Iowa PDL, a voluntary list known as the Recommended Drug List (RDL) is available on the posted State of Iowa PDL. Recommended drug means a drug placed on a voluntary list designed to inform prescribers of cost-effective alternatives and, if used, will result in a cost savings to the Medicaid program. The drug does not require a Prior Authorization unless noted.

Covered drugs are those that are identified as being rebate eligible by CMS. This applies both to the point-of-sale pharmacy benefit and to physician-administered drugs. It is expected that providers will follow the guidance on appropriate billing, as given in Iowa Medicaid Informational Letters 1663 and 1897. Additionally, for claims that have been paid and Iowa Medicaid was unable to collect the expected rebate, there will have to be a claims correction performed. At the direction of the State, and/or their contractor, we will expect providers to work with us to correct and resubmit claims so that the rebate may be collected.

Working With the Pharmacy Benefit Manager (PBM)

Iowa Total Care works with Pharmacy Services (Centene) to administer pharmacy benefits, including the Prior Authorization process. Certain drugs require Prior Authorization to be approved for payment by Iowa Total Care.

These include:

- Non-preferred medications, notated with an 'N' on the Preferred Drug List.
- Some State of Iowa preferred drugs, notated with a 'P' and/or code '11' in the comments column on the Preferred Drug List.

Pharmacy Prior Authorization

The State of Iowa PDL includes a broad spectrum of brand name and generic drugs. Prescribers are encouraged to prescribe from the State of Iowa PDL for their patients who are members of Iowa Total Care. Some drugs will require PA (Prior Authorization).

All reviews are performed using the PA criteria established by the State of Iowa Drug Utilization Review (DUR) Commission. Once approved, Pharmacy Services (Centene) notifies the prescriber by fax. If the clinical information provided does not meet the medical necessity and/or Prior Authorization guidelines for the requested medication, Iowa Total Care will notify the member and the prescriber of medication alternatives, when applicable, in addition to providing information for the appeal process.

Drug Prior Authorization requests can be submitted to Pharmacy Services (Centene) through the **www.covermymeds.com** website which is the preferred route or by faxing to 1-833-404-2392. To ensure timeliness of our members' pharmacy needs, Iowa Total Care has a strict twenty-four (24) hour turnaround time requirement to process these requests.

Phone

The Pharmacy Services (Centene) help desk is staffed with PA triage specialists Monday through Friday, 9 a.m. to 8 p.m. (CST). Prescribers may call Pharmacy Services (Centene) to initiate a PA by calling **1-866-399-0928**.

During regular business hours, licensed clinical pharmacists and pharmacy technicians are available to answer questions and assist providers. For assistance outside of regular business hours, providers can call the Nurse Advice Line at **1-833-404-1061 (TTY: 711).**

Fax

Iowa Total Care Pharmacy Services (Centene) authorization request forms can be found on **iowatotalcare.com.** The forms are located under the Pharmacy section under the Provider heading. Upon completing the form, fax it to Pharmacy Services (Centene) at 1-833-404-2392.

Prescribers and pharmacies may and are encouraged to utilize **covermymeds.com** to submit pharmacy Prior Authorization requests.

Once approved, Pharmacy Services (Centene) will notify prescriber by fax.

When medical necessity criteria is not met based on the clinical information submitted, the prescriber will be notified of the reason by fax. The notification will include PDL alternatives, if applicable.

If a Prior Authorization is denied, a member may request an appeal. A member can call us at 1-833-404-1061 (TTY: 711). If a member wishes to mail the appeal, the address is:

Iowa Total Care
ATTN: Appeals
1080 Jordan Creek Parkway, Suite 400 South
West Des Moines, IA 50266

A member may also have a provider make an appeal on their behalf, if the member gives the provider written consent. More information on the appeal process can be found on page [97] of this manual.

Compounds

Compounded prescriptions must be submitted online and each ingredient must have an active, covered and valid National Drug Code (NDC). Compounded medications may be subject to Prior Authorization based on ingredients submitted. Compounds that have a commercially available product are not reimbursable.

72-Hour Emergency Supply of Medications

Federal law allows dispensing of a 72-hour supply of medication in an emergency. Iowa Total Care will allow a 72-hour supply of medication to any patient awaiting a Prior Authorization determination, unless the Prior Authorization criteria does not allow. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication (unless Prior Authorization criteria does not allow), whether or not the Prior Authorization request is ultimately approved or denied. The pharmacy will contact the Pharmacy Services (Centene) Help Desk at toll-free **1-833-587-2012** for a prescription override to submit the 72-hour supply of medication. The pharmacy help desk call center is available 24 hours a day, seven (7) days a week.

Some behavioral health medications may allow for seven (7) days supply. Refer to State of Iowa PDL for information.

Newly Approved Products

New FDA approved drugs will be evaluated by the Iowa Medicaid Pharmacy and Therapeutics (P&T) Committee at the next scheduled meeting. They will require a Prior Authorization before the Iowa Medicaid P&T Committee review. If Iowa Total Care does not grant Prior Authorization, the member and prescriber will be notified and given information regarding the appeal process.

Step Therapy

Some medications listed on the State of Iowa PDL may require specific medications to be used before the member can receive the requested medication. If Iowa Total Care has a record that the required medication met the Step Therapy criteria, the medications are automatically covered. If Iowa Total Care does not have a record that the specific medication was tried, the member or prescriber may be required to provide additional information. If Iowa Total Care does not grant authorization, the member and prescriber will be notified and provided information regarding the appeal process.

Benefit Exclusions

The following drug categories are not part of the Iowa Total Care benefit and are not covered:

- Fertility-enhancing drugs.
- Anorexia, weight-loss or weight-gain drugs.
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective.
- Drugs and other agents used for cosmetic purposes or for hair growth.
- Erectile dysfunction drugs prescribed to treat impotence.

So-called DESI (Drug Efficacy Study Implementation) drug products are not covered as part of the Medicaid pharmacy benefit, because they are not recognized as being safe and effective (by the FDA), and there is not a compelling justification for their use.

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum thirty-one (31) day supply. Some contraceptives can be filled up to a ninety (90) day supply. Dispensing outside the Quantity Limit (QL) or Age Limit (AL) requires prior authorization. Iowa Total Care may limit how much of a medication a member can get at one time.

If the prescriber recommends a member receive a higher quantity limit due to a medical reason, the prescriber can submit for Prior Authorization. If Iowa Total Care does not grant a Prior Authorization approval, the member and prescriber will be notified and provided with information regarding the appeal process.

Some medications on the State of Iowa PDL may have age limits. These are set for certain drugs based on FDA-approved labeling and for safety concerns, as well as current medically accepted quality standards of care as supported by clinical literature. There is always consideration for an exception during the PA review for medically necessary treatments.

Over-the-Counter Medications (OTC)

The pharmacy program covers approved OTC medications listed in the State of Iowa PDL. Some OTC medications may require prior authorizations. All OTC medications must be written on a valid prescription by a licensed prescriber to be reimbursed. Refer to the State of Iowa PDL for a list of covered OTC products using the link provided on the Iowa Total Care website, **www.iowatotalcare.com**.

Not all OTC medications are required to participate in the rebate program. For OTC products that are subject to rebate program, claims that have been paid and Iowa Medicaid was unable to collect the expected rebate, there will have to be a claims correction performed. At the direction of the state, and/or their contractor, we will expect providers to work with us to correct and resubmit claims so that the rebate may be collected.

CLINICAL PRACTICE GUIDELINES

Iowa Total Care's clinical and quality programs are founded on evidence-based prevention and clinical practice guidelines. Whenever possible, Iowa Total Care adopts guidelines that are published by nationally recognized organizations, government agencies, state-wide collaboratives, and/or consensus guidelines from healthcare professionals in the applicable field. Iowa Total Care providers are expected to follow these guidelines.

Medical policies serve as one set of guidelines for determining what medical services, procedures, devices and drugs may be considered medically necessary. Iowa Total Care uses the following guidelines to make medically necessary decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

- Federal law.
- State law/guidelines.
- Iowa Total Care-specific clinical policy, and
- Centene clinical policy.

Centene's clinical policies reflect current scientific research and evidence-based clinical standards. They are maintained by a Clinical Policy Committee that ensures the clinical policies provide a guide to medical necessity, are reviewed and approved by appropriately qualitied physicians, and are available to all Centene Health plans. If no specific clinical policy has been adopted by Iowa Total Care or Centene, then InterQual® criteria are used to evaluate whether a medical procedure or equipment is medically necessary. InterQual® is a nationally recognized clinical decision support tool that is produced using a rigorous development process based on the principles of evidence-based medicine.

Additional resources used by Iowa Total Care clinical and quality programs include the following representative samples of nationally recognized guidelines.

- American Cancer Society Guidelines for the Early Detection of Cancer (Revised May 2018).
- Institute for Clinical Systems Improvement Health Care Guideline: Adult Acute and Subacute Low Back Pain Diagnosis Algorithm (Revised March 2018).
- CDC Advisory Committee on Immunization Practices Recommended Immunization Schedules: Adult and Child.
- The National Comprehensive Cancer Network® (NCCN®) Guidelines.
- The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.
- Hayes Evidence Analysis.
- IBM Micromedex®.

For links to the most current version of the clinical policies used by Iowa Total Care, visit our website at **www.iowatotalcare.com**. A paper copy of the individual Centene Clinical Policies listed is available by calling Provider Services toll-free at **1-833-404-1061 (TTY: 711)**.

PROVIDER RELATIONS AND SERVICES

Provider Relations

Iowa Total Care's Provider Relations is committed to supporting providers as they care for our members. Through provider orientation, ongoing training, and support of daily business operations, we will strive to be your partners in good care. Upon credentialing approval and contracting, each provider will have a Provider Relations Specialist assigned to them by region and serve as the primary liaison between Iowa Total Care and the network providers. The Provider Relations Specialist will contact the provider to schedule an orientation. Providers may also identify their assigned Provider Relations Specialist by accessing the Provider Relations Specialists Territory Map by visiting Iowa Total Care website, **www.iowatotalcare.com**.

Reasons to Contact a Provider Relations Specialist:

- Report any changes to your practice (locations, NPI, TIN numbers).
- Initiate credentialing of a new practitioner.
- Schedule an in-service training for new staff.
- Conduct ongoing education for existing staff.
- Obtain clarification of policies and procedures.
- Obtain clarification of a provider contract.
- Request fee schedule information.
- Obtain member roster.
- Obtaining Provider Profiles.
- Learn to use electronic solutions on web authorizations, claims submissions and member eligibility.
- Open/close patient panel.

Provider Services

Iowa Total Care Provider Services team is available to assist providers toll free at **1-833-404-1061 (TTY: 711)** Monday through Friday 7:30 a.m. to 6 p.m. CST.
Closed on State holidays.

CREDENTIALING AND RE-CREDENTIALING

Iowa Total Care maintains a high-quality healthcare delivery system, and our credentialing and re-credentialing processes help us achieve this by validating the professional competency and conduct of our providers.

The process includes verifying the provider's enrollment with the Iowa Medicaid, their licensure, board certification, education, and the identification of adverse actions, including malpractice or negligence claims, through checks with applicable state and federal agencies and the National Practitioner Data Bank.

Iowa Total Care requires re-credentialing every three (3) years to maintain up-to-date provider professional information. Providers are also required to notify Iowa Total Care of any changes to their credentialing information in a timely manner. This information is essential for Iowa Total Care's members, who depend on the accuracy of the provider directory.

Any changes can be sent to **NetworkManagement@IowaTotalCare.com**.

Which Providers Must Be Credentialed?

The following providers are required to be credentialed:

Medical Practitioners

- Medical Doctors.
- Chiropractors.
- Osteopathic Doctors.
- Podiatrists.
- Nurse Practitioners.
- Physician Assistants.
- Other Medical Practitioners.

Behavioral Health Practitioners

- Psychiatrists and other Physicians.
- Addiction Medicine Specialists.
- Doctoral or Master's Level Psychologists.
- Master's Level Clinical Social Workers.
- Master's Level Clinical Nurse Specialists or Psychiatric Nurse Practitioners.
- Other Behavioral Healthcare Specialists.

Facility and Other Providers

- Hospitals, Home Health agencies, Skilled Nursing Facilities, FQHCs, RHCs, laboratory testing/diagnostic facilities, rehabilitation centers, Durable Medical Equipment providers, and freestanding surgical centers.
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.
- Other atypical long-term services and supports (LTSS) providers, including home and community-based services (HCBS) and long-term care (LTC), institutional-based services providers.

Information Provided at Credentialing

All new providers and those adding providers to their practice must be enrolled through the Iowa Medicaid and submit, at a **minimum,** the following information when applying for participation in Iowa Total Care's network:

- Completed, signed and dated Iowa State Universal Practitioner Credentialing Application no older than one hundred and twenty (120) days ***or***
- Authorize Iowa Total Care to access applicant's information on file with the Council for Affordable Quality Health Care (CAQH) at **www.caqh.org**.
- Current malpractice insurance coverage detailed on the credentialing application *or* a copy of provider's current malpractice insurance policy face-sheet that includes expiration dates, amounts of coverage and provider's name, *or* evidence of compliance with applicable Iowa regulations regarding malpractice coverage *or* alternative coverage.
- Copy of current Drug Enforcement Administration (DEA) registration Certificate, if applicable.
- Copy of current Iowa Controlled Substance registration certificate, if applicable.
- Hospital admitting privileges or arrangements for the following practitioner types: MD, DO, DPM, CMW, NP, and PA.
- Completed and signed W-9 form.
- Curriculum vitae listing, at a minimum, a five-year work history (not required if work history is completed on the application).
- Proof of highest level of education: copy of certificate or letter certifying formal post-graduate training.
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable.

All providers (hospital, facility, group, clinic or ancillary provider) must be enrolled through the Iowa Medicaid and submit the following:

- Completed, signed, and dated Iowa Total Care Facility Application with the attachments requested that is no older than 365 calendar days.
- Copy of State Operational License.
- Copy of Accreditation Certificates by a nationally recognized accrediting body, (e.g. TJC/JCAHO), if applicable.
    - If not accredited, a copy of the provider's most recent state or CMS survey, including response to any corrective actions, and response from surveyor recognizing corrective action taken by provider.
- Completed and signed W-9 form.
- Other applicable State/Federal Licensures (e.g.: such as CLIA, DEA, Pharmacy, or Department of Health).
- Roster (in an approved Iowa Total Care format) or CAQH data form for each practitioner employed by the provider.
- Current malpractice and/or general liability insurance coverage detailed on the credentialing application, or a copy of their current malpractice insurance policy factsheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with applicable Iowa regulations regarding malpractice coverage, or alternate coverage.

All HCBS providers must be enrolled through the Iowa Medicaid and submit the following:

- Completed, signed, and dated Iowa Total Care HCBS Waiver Provider Application.
- For Consumer-Directed Attendant Care (CDAC) Agency only: Completed Iowa Total Care Provider Attestation Statement.
    - Copy of Certificate and/or Licensures, as applicable.
- Other applicable State/Federal Licensures (e.g. CLIA, DEA, Pharmacy, or Department of Health).
- Completed and signed W-9 form.
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage) that meets the minimum required amount set by the State of Iowa, as applicable to the services each HCBS waiver provider is contracting to provide.

Credentialing Committee

The Credentialing Committee establishes and adopts criteria for provider participation in Iowa Total Care's network. The committee also oversees all credentialing procedures including provider participation, denial, and termination. Iowa Total Care ensures that the credentialing of all providers applying to our network is completed as follows: eighty-five (85) percent within thirty (30) days; ninety-eight (98) percent within forty-five (45) days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the decision regarding their application.

Providers must be credentialed prior to accepting or treating members, unless Prior Authorization has been obtained to treat the member as an out-of-network provider. PCPs cannot accept member assignments until they are fully credentialed.

Site visits are performed at provider offices within sixty (60) days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the provider's site visit score is less than eighty (80) percent, the provider may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices, and safety procedures.

Committee meetings are held no less than ten (10) times per year and more often as deemed necessary.

Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Re-Credentialing Process

To comply with accreditation standards, Iowa Total Care re-credentials all providers at least every three years from the date of the initial credentialing decision to identify any changes in the provider's licensure, sanctions, certification, competence, or health status that may affect their ability to perform services.

In between credentialing cycles, Iowa Total Care conducts ongoing monthly monitoring activities on all network providers. This includes an inquiry to the appropriate state licensing agency to identify newly disciplined providers or those with a change in their licensure status. This helps make certain that providers are maintaining a current, active, unrestricted license to practice between credentialing cycles. Additionally, Iowa Total Care reviews monthly reports from the Office of Inspector General (OIG), SAM, and Medicare Opt-Out to identify network providers who are newly sanctioned or excluded from participation in Federal and State programs.

All roster formats can be found on the Iowa Total Care website under the following link: **https://www.iowatotalcare.com/providers/contracting---credentialing/contracting---credentialing-forms.html**.

An Iowa Total Care roster should be submitted/completed anytime a provider is added, removed, or if any demographic changes have been made. It is important to complete all required fields on the roster so Iowa Total Care can appropriately update our network. For provider adds please submit at least thirty (30) days prior to the effective date.

Please forward all completed rosters to the network management inbox at: **NetworkManagement@IowaTotalCare.com** and allow 15 to 30 days for processing.

In addition to all regular roster updates, delegated entities must also provide a full quarterly roster.

For smaller providers applications are available and can be used in place of a roster. All applications are also available at: **https://www.iowatotalcare.com/providers/contracting---credentialing/contracting---credentialing-forms.html**.

Any questions regarding provider enrollment/credentialing can be directed to you Provider Relations Representative or **NetworkManagement@IowaTotalCare.com**.

Loss of Network Participation

A provider's agreement may be terminated at any time if Iowa Total Care's Credentialing Committee determines the provider no longer meets credentialing requirements.

Upon notification from regulatory agencies or state licensing boards that a provider is suspended or terminated from participation in Medicaid or Medicare Programs, Iowa Total Care will immediately act to terminate the provider from participation in its network. Terminations for loss of licensure and criminal convictions will coincide with the effective date of the action.

Right to Review and Correct Information

All providers participating within the Iowa Total Care network have the right to review information obtained by the Health Plan that was used to evaluate the providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, malpractice insurance carriers, and state licensing agencies. This does not allow a provider to examine peer review protected information, such as references, personal recommendations, or other information.

If a provider identifies any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the provider, the provider has the right to correct any erroneous information submitted by another party. To request release of such information, a provider must submit a written request to Iowa Total Care's Credentialing Department at:

Iowa Total Care Credentialing Manager
7700 Forsyth Boulevard
St. Louis, MO 63105

Upon receipt of this information, the provider has fourteen (14) days to provide a written explanation detailing the error or the difference in information. The Iowa Total Care Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

Right To Be Informed of Application Status

Providers who have submitted an application to join Iowa Total Care's network have the right to be informed of the status of their application upon request. To obtain status, contact your Provider Network Specialist at **NetworkManagement@IowaTotalCare.com** or call the Provider Services line toll-free at **1-833-404-1061 (TTY: 711)**.

Right To Appeal Adverse Credentialing Decisions

Iowa Total Care may decline an applicant's participation for reasons such as quality of care or liability claims issues. In such cases, the provider has the right to request reconsideration in writing within fourteen (14) days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration. The Credentialing Committee will review the reconsideration request at its next regularly scheduled meeting, but no later than sixty (60) days from the receipt of the additional documentation. Iowa Total Care will send a written response to the provider within two (2) weeks of the final decision.

The applicant will be sent a written response to their request within two (2) weeks of the final decision. A written request for appeal should be sent to:

Credentialing Manager
7700 Forsyth Blvd.
St. Louis, MO 63105

MEMBER AND PROVIDER RIGHTS AND RESPONSIBILITIES

Member Rights

Iowa Total Care expects providers to respect and honor members' rights, including the right to:

- Be treated with respect, dignity, and privacy.
- To take part in the community and work, live and learn to the fullest extent possible.
- To receive healthcare services as stated in federal regulations.
- Know that the member's medical records and discussions with providers will be private and confidential.
- Receive information on all available treatment options and alternatives, including treatment in the least restrictive setting, presented in a manner appropriate to the member's condition and ability to understand.
- Have access to creating and using an Advance Directive.
- Be able to receive Covered Services in a fair manner.
- Be able to make decisions regarding their health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as stated in federal regulations.
- Have access to their medical records and be able to request corrections.
- Be able to choose a representative to help with making care decisions.
- Be able to provide informed consent.
- A right to express a concern or appeal about Iowa Total Care or the care that it provides. To receive a response in a reasonable period of time.
- Be able to choose from available contracted providers that follow Iowa Total Care's Prior Authorization requirements.
- Be able to receive information about Iowa Total Care including covered services, contracted providers and how to access them.
- Be able to receive information about Iowa Total Care, its services, providers and members rights and responsibilities.
- Be able to request co-payment totals paid. If there is a disagreement about the totals, the member is able to appeal this information.
- Be free from harassment by Iowa Total Care or its contracted providers.

- Have an open discussion with the member's provider about their treatment options, regardless of cost or benefit coverage.
- A right to get information on care options in a way that they can understand, regardless of cost or coverage.
- Be able to take an active part in understanding physical and behavioral health problems and setting treatment goals with their provider.
- Be able to receive recommendations regarding Iowa Total Care's member rights and responsibilities.

Member Responsibilities

Members have certain responsibilities to:

- Notify Iowa Medicaid if:
    - Their family size changes.
    - Their phone number changes.
    - They move out of the state or have other address changes.
    - They get or have health coverage under another policy, other third party, or there are changes to that coverage.
- Work on improving their own health.
- Tell Iowa Total Care when they go to the emergency room.
- Treat providers and staff with dignity and respect.
- Talk to their provider about preauthorization of services they recommend.
- Be aware of cost-sharing responsibilities. Make payments that they are responsible for.
- Inform Iowa Total Care if their member ID card is lost or stolen.
- Show their Iowa Total Care member ID card when getting health care services.
- To choose a Primary Care Provider (PCP).
- To keep appointments and follow-up appointments. To access preventive care services.
- To live healthy lifestyles and avoid behaviors known to be harmful.
- Know Iowa Total Care procedures, coverage rules and restrictions the best that they can.
- Contact Iowa Total Care when they need information or have questions.
- Give providers and Iowa Total Care accurate and complete medical information so they can be provided appropriate care.
- To follow care prescribed by the provider or to let the provider know why treatment cannot by followed, as soon as possible.

- Ask their providers questions to help them understand treatment. Learn about the possible risks, benefits, and costs of treatment alternatives. Make care decisions after they have thought about all of these things.
- To make their Primary Care Provider (PCP) aware of all other providers who are treating them. This is to ensure communication and coordination in care. This also includes behavioral health providers.
- Be actively involved in their treatment. Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Follow the grievance process if they have concerns about their care.

Provider Rights

Iowa Total Care providers have the right to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments.
    - Provide information regarding the nature of treatment options.
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered.
    - Be informed of the risks and consequences associated with each treatment option, or choosing to forego treatment, as well as the benefits of such treatment options.
- Be treated by their patients and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have their patients act in a way that supports the care given to other patients and does not interfere with their operations.
- Expect other network providers to act as partners in members' treatment plans.
- File a dispute with Iowa Total Care for payment issues and/or utilization management, or a general complaint with Iowa Total Care and/or a member.
- File a grievance or an appeal with Iowa Total Care on behalf of a member, with the member's written consent.
- Have access to information about Iowa Total Care Quality Management/Quality Improvement (QM/QI) programs, including program goals, processes, and outcomes that relate to member care and services.
- Contact Iowa Total Care Provider Services with any questions, comments, or problems.

- Collaborate with other healthcare professionals who are involved in the care of members.
- Not be discriminated against by Iowa Total Care based solely on any characteristic protected under state or federal non-discriminate laws. Iowa Total Care does not, and has never, had a policy of terminating a provider who:
    - Advocated on behalf of a member.
    - Filed a complaint against us.
    - Appealed a decision of ours.
- Not be discriminated against by Iowa Total Care in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. This does not require Iowa Total Care to contract with providers beyond the number necessary to meet the needs of members, preclude Iowa Total Care from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Iowa Total Care from establishing measures that are designed to maintain quality of services and control costs, or consistency with responsibilities to members.
- Not be discriminated against for: serving high-risk populations or specializing in the treatment of costly conditions, filing a grievance on behalf of, and with the written consent of an enrollee, or helping an enrollee to file a grievance, protesting a plan decision, policy, or practice the healthcare provider believes interferes with their ability to provide medically necessary and appropriate healthcare.
- Not be discriminated against based on any of the following: race/ethnicity, color, national origin, gender, age, lifestyle, disability, religion, sexual orientation, specialty/licensure type, geographic location, patient type in which the practitioner specializes, financial status, or on the basis of the provider's association with any member of the aforementioned protected classes.

Provider Responsibilities

Iowa Total Care providers have the responsibility to:

- Treat members with fairness, dignity, and respect.
- Not discriminate against members on the basis of race, color, national origin, age, religion, mental or physical disability, or limited English proficiency.
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.

- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restriction on the use and disclosure of their personal health information.
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records, and be able to request that they be amended or corrected as specified in 45 CFR §164.524 and §164.526.
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Respect members' Advance Directives and include these documents in the members' medical record.
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allow members to obtain a second opinion and answer members' questions about how to access healthcare services appropriately.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Participate in Iowa Total Care data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- Review clinical practice guidelines distributed by Iowa Total Care.
- Comply with Iowa Total Care Medical Management program as outlined in this manual.
- Disclose overpayments or improper payments to Iowa Total Care.
- Not deny services to a member due to inability to pay the copayment if the household income is at or below 100% Federal Poverty Level.
- Reimburse copayments to members who have been incorrectly overcharged.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Iowa Total Care information regarding other insurance coverage.
- Notify Iowa Total Care in writing if the provider is leaving or closing a practice.

- Update their enrollment information/status with the Iowa Medicaid program if there is any change in their location, licensure or certification, or status via the Iowa Medicaid's Provider Web Portal.
- Contact Iowa Total Care to verify member eligibility or coverage for services, if appropriate.
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems they may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Office hours of operation offered to Medicaid members will be no less than those offered to commercial members.
- Not be excluded, penalized, or terminated from participating with Iowa Total Care for having developed or accumulated a substantial number of patients in Iowa Total Care with high-cost medical conditions.
- Coordinate and cooperate with other service providers who serve Medicaid members, such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, and school-based programs as appropriate.
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- Disclose to Iowa Total Care, on an annual basis, any Physician Incentive Plan (PIP) or risk arrangements the Provider or Provider Group may have with providers either within its group practice or other providers not associated with the group practice, even if there is no substantial financial risk between Iowa Total Care and the provider or provider group.
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.
- Review and follow clinical practice guidelines distributed by Iowa Total Care.
    - Document medical chart with up to three outreach attempts by phone to members who have not completed an office visit in the past twelve (12) months or more.
    - Have been discharged from an inpatient stay within the last twenty-four (24) hours since notification.
    - Have a gap-in-care overdue by thirty (30) or more days.

- Develop report based on Iowa Total Care specifications to submit monthly clinical data feed from the Electronic Medical Record (EMR) system within one (1) year of enrolling in the Iowa Total Care Provider Network.
- Comply with Iowa Risk Adjustment programs that rely on complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines.
- Providers must allow for and process voluntary payroll deductions of fringe benefits or wage supplements for any employee who requests it, in accordance with the Wage Payments and Collection Law (43 P.S. §§ 260.2a and 260.3).
- Report all suspected physical and/or sexual abuse and neglect.
- Providers/Prescribers beginning October 1, 2021, will be required to check the Prescription Monitoring Program (PMP) database before prescribing a controlled substance for a member.
- Report communicable disease to Iowa Total Care:
    - Iowa Total Care must work with Iowa HHS State and District Office epidemiologists in partnership with the designated county or municipal health department staffs to appropriately communicate reportable conditions.

MEMBER GRIEVANCE AND APPEALS PROCESSES

A member, a member's authorized representative, or a member's provider (**with written consent from the member**), may file an appeal or grievance either verbally or in writing.

Iowa Total Care gives members reasonable assistance in completing all forms and taking other procedural steps of the appeal and grievance process, including, but not limited to, providing interpretation or translation services to facilitate communication in non-English languages and toll-free numbers with TTY/TDD.

Grievances

Grievances are defined as any expression of dissatisfaction about any matter other than an adverse benefit determination provided to Iowa Total Care by a member and their authorized representative. Examples of these type of complaints include, but are not limited to:

- Unclear and inaccurate information from staff.
- Quality of care or services provided to a member.
- Rudeness of a provider or employee.
- Failure to respect a member's rights.
- Harmful administrative processes or operations.
- Disagreements with the decision to extend an appeal timeframe.

Iowa Total Care wants to resolve member concerns. We will not hold it against the member if they file a grievance. We will not treat members differently.

A provider, with written consent from the member, may assist a member in filing a grievance on any matter, or in filing an appeal if the member receives an adverse benefit determination. For the appeal Authorized Representative Designation form please visit: **https://www.iowatotalcare.com/providers/resources/grievance-process.html**

How To File a Grievance

A member may file a grievance at any time by doing one of the following:

- Call Member Services toll-free at **1-833- 404-1061 (TTY: 711)**.
- Send a fax to **1-833- 809-3868**.
- Send an email to **AppealsGrievances@IowaTotalCare.com.**
- Mail to us at:

  Iowa Total Care
  ATTN: Grievances
  1080 Jordan Creek Parkway
  Suite 400 South
  West Des Moines, IA 50266

Be sure to include:

- Member first and last name.
- Member Medicaid ID number.
- Member address and telephone number.
- Member's complaint about why they are unhappy.
- What the member would like to have happen to resolve the complaint. Iowa Total Care will send a letter within three (3) business days to acknowledge receipt of the grievance.

If another person files a grievance for a member, Iowa Total Care must have written permission from the member for that person to act on the member's behalf unless that person is the member's legal authorized representative. No one can act on a member's behalf without written permission.

If filing a grievance on behalf of a member, you will need to provide a Release of Information form, signed by the member, to Iowa Total Care. To obtain this form, contact Member Services or find it on the Iowa Total Care website at **www.iowatotalcare.com**. You or the member can return it by mail or fax. Members can also call Member Services for assistance.

A member may have additional information supporting their grievance. If so, please send it along with the grievance so we can add it to our information. Members may ask to receive copies free of charge of any documentation Iowa Total Care uses to make the decision about the member's grievance.

Iowa Total Care will work to resolve the grievance as expeditiously as the member's condition warrants and will send a resolution notice within thirty (30) calendar days of receipt of the grievance.

Appeals

An appeal is a request for Iowa Total Care to review an adverse benefit determination made by Iowa Total Care. Members may appeal a service that has been denied, limited, reduced, or terminated.

Appeals may be filed by a member (parent or guardian of a minor member) or authorized representative with the written consent of the member to act on their behalf. Appeals may be filed verbally or in writing.

When Iowa Total Care issues a “Notice of Adverse Benefit Determination” to the member, the member may file an appeal within sixty (60) calendar days from the date on the notice.

Members can request copies of any documentation Iowa Total Care used to make the decision about their care or appeal. Members can also request a copy of their member records. These copies will be free of charge. We will not hold it against a member if they file an appeal. We will not treat members differently in any way.

How To File an Appeal

Members may file an appeal by doing one of the following:

- Call Member Services toll-free at **1-833-404-1061 (TTY: 711)**.
- Send it electronically by fax to **1-833-809-3868**.
- Send an email to **AppealsGrievances@IowaTotalCare.com**.
- Mail to us at:

  Iowa Total Care
  ATTN: Appeals
  1080 Jordan Creek Parkway
  Suite 400 South
  West Des Moines, IA 50266

How to File an Appeal for Behavioral Health

Pre-service (Member still in care) Appeal:
Note: *The Authorized Representative Designation (ARD) form must be completed. For the Authorized Representative Designation form please visit:*
https://www.iowatotalcare.com/providers/resources/grievance-process.html

- Call Member Services toll-free at **1-833-404-1061 (TTY: 711)** and ask for the Behavioral Health Referral Specialist Department.
- Send it electronically by fax to **1-866-714-7991**.
- Mail to us at:

  Iowa Total Care
  ATTN: Appeals Department
  PO Box 10378
  Van Nuys, CA 91410-0378

Post-service (Member no longer in care):
Note: *The Authorized Representative Designation (ARD) form must be completed. For the Authorized Representative Designation form please visit:*
https://www.iowatotalcare.com/providers/resources/grievance-process.html

- Follow the Claim Dispute Process for a claim appeal outlined in another section of this manual.

After we receive a member's call, written, or electronic appeal, we will send a letter within three (3) business days of receipt of the appeal acknowledging the appeal has been received.

Iowa Total Care will send an appeal resolution letter within thirty (30) calendar days of receipt of an appeal request. Iowa Total Care wants to resolve appeal concerns quickly and will resolve member appeals within thirty (30) calendar days of filing with us. If we cannot resolve the member's appeal in thirty (30) calendar days, we may extend the timeframe by up to fourteen (14) calendar days to gather more information to assist in our decision. If Iowa Total Care needs more than thirty (30) calendar days to resolve the appeal, with approval of the state, Iowa Total Care will notify the member in writing of the reason for the delay within two (2) calendar days.

Members may also request an extension. To request an extension, call Member Services toll-free at **1-833-404-1061 (TTY: 711)**. The Authorized Representative Designation Form must be sent in with the appeal and must be received within sixty (60) days from the date of the Adverse Benefit Determination notice.

If a member needs help filing an appeal, call Member Services at **1-833-404-1061 (TTY: 711)**. We have representatives to help members Monday through Friday, 7:30 a.m. to 6 p.m. CST.

Continuation of Benefits During the Appeal Process

Members may request services continue while Iowa Total Care reviews their appeal and during the State Fair Hearing process, if it is not resolved at the first appeal level. Members must request to continue services within ten (10) days of the effective date on the Adverse Benefit Determination notice.

IMPORTANT: If the final resolution of the appeal or State Fair Hearing is adverse to the member, that is, upholds Iowa Total Cares adverse benefit determination, Iowa Total Care may recover the cost of services furnished to the member while the appeal and State Fair Hearing was pending to the extent that they were provided during the appeal and State Fair Hearing process.

Expedited Appeal Decisions

If the member's health or function is at immediate risk, an expedited appeal may be requested. An Authorized Representative Designation form must be sent in with the expedited appeal request. For the Authorized Representative Designation form please visit: **https://www.iowatotalcare.com/providers/resources/grievance-process.html**.

Expedited appeals will be reviewed as soon as the member's condition warrants and no later than within seventy-two (72) hours of receiving the request. The member has a right to submit additional information to support the appeal prior to the appeal being reviewed in person or in writing. The timeframe to submit this additional information to Iowa Total Care is limited. The member will be notified of the due date for this information. If Iowa Total Care does not receive it, the appeal will be continued without it.

To request an expedited appeal, call Iowa Total Care at **1-833-404-1061 (TTY: 711)** or fax the Authorized Representative Designation form signed by the member and the appeal clinical documentation to **1-833-809-3868**. To request a Behavioral Health appeal, fax the Authorized Representative Designation form signed by the member and the appeal clinical documentation to **1-866-714-7991**. Iowa Total Care will make reasonable efforts to verbally notify the requestor and the member of the expedited appeal decision. **Note:** Behavioral Health does not make attempts to notify the member.

State Fair Hearings

If a member is not satisfied with an Iowa Total Care appeal decision, they have the right to request a State Fair Hearing. Members must exhaust Iowa Total Care's internal appeal process before they can file a request for a State Fair Hearing. Members have one hundred and twenty (120) calendar days from the date on the appeal decision notice to request a State Fair Hearing. Members may request their services to continue during the State Fair Hearing process.

The member or their authorized representative can ask the State of Iowa Department of Health and Human Services for a State Fair Hearing. Requests for a State Fair Hearing can be submitted in person, online, by telephone or in writing.

To file online visit: **hhs.iowa.gov/programs/appeals**

To file in writing submit requests to:

Department of Human Services
Appeals Section, 5th Floor
1305 E. Walnut
Des Moines, IA 50319-0114

If you need help filing a State Fair Hearing request or want to file by telephone, contact the Iowa HHS Appeals Section at **1-515-281-3094**.

PROVIDER COMPLAINTS

Complaint Process

Iowa Total Care maintains written policies and procedures for the filing of provider complaints. A provider has the right to file a complaint with us. Provider complaints will be resolved within thirty (30) calendar days. If the provider complaint is not resolved within thirty (30) calendar days, we shall request a fourteen (14) calendar day extension from the provider. If the provider requests the extension, the extension will be approved by us.

Providers may file a formal complaint using the Provider Formal Administrative Complaint form found on the **Manuals, Forms and Resources webpage** under the Forms section. Complaints are spoken or written expressions of dissatisfaction.

Iowa Total Care wants to resolve provider concerns. We will not hold it against the provider if they file a complaint. We will not treat providers differently.

How To File a Complaint

Providers can file a complaint in any way that works best for them by doing one of the following:

- Call Provider Services at **1-833-404-1061 (TTY: 711)**.

Or complete the Provider Formal Administrative Complaint Form and send via:

- Fax to **1-833-208-1397**.
- Email to **Providerrelations@IowaTotalCare.com**.
- Mail to:

Iowa Total Care
ATTN: Complaints
1080 Jordan Creek Parkway
West Des Moines, IA 50266

FRAUD, WASTE, AND ABUSE

Iowa Total Care takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with state and federal laws.

Fraud means the intentional deception or misrepresentation an individual or entity makes knowing that that the misrepresentation could result in some unauthorized benefit to the individual, or the entity, or to some other party. This includes “reckless disregard” of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

Waste means the incorrect submission of claims due to factors such as uneducated office staff, coding illiteracy, staff turnover, or keying errors. Wasteful billing can typically be resolved after the provider, or subcontractor, and office staff are educated on proper billing requirements and/or claim submission.

Abuse means practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the health plan. It includes billing for services that are not covered or medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes enrollee and provider practices that result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive.

Iowa Total Care operates a Special Investigations Unit (SIU) with dedicated staff that reside in Iowa. This unit routinely inspects claims submitted to assure that Iowa Total Care is paying appropriately for covered services. Iowa Total Care performs front- and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, review the Billing section located within this manual. Iowa Total Care also performs retrospective audits which, in some cases, may result in taking actions against providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include, but are not limited to:

- Remedial education and/or training to prevent the billing irregularity.
- More stringent utilization review.
- Recoupment of previously paid monies.
- Termination of provider agreement or other contractual arrangement.
- Referral to the Iowa Program Integrity Unit.
- Referral to the Medicaid Fraud Control Unit.
- Onsite investigations.
- Corrective action plan.
- Any other remedies available to rectify the issue.

Iowa Total Care instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations including, but not limited to, the following:

- Federal and State False Claims Act.

- Qui Tam Provisions (Whistleblower).
- Anti-Kickback Statute.
- Physician Self-Referral Law (Stark Law).
- HIPAA.
- Social Security Act.
- U.S. Criminal Codes.

Iowa Total Care requires all contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, and persons or entities providing care or services to all Iowa Total Care members. Examples of such violations include: bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal healthcare fraud investigation, money laundering, failure to provide medically-necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft, or members' medication fraud.

Training is available via our company website at **www.iowatotalcare.com** that providers can download in PDF format. We also include FWA training in our Provider Orientation packets. To report any fraud, waste and/or abuse concerns call the Fraud and Abuse Line at **1-866-685-8664**.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Iowa Total Care auditors request medical records for a defined review period. Providers have thirty (30) days to respond to the request. If the provider fails to respond to the request for medical records, or if services for which claims have been paid are not documented in the medical record, Iowa Total Care will recover all amounts paid for the services in question.

Iowa Total Care auditors review cases for common FWA practices, including:

- Unbundling of codes.
- Up-coding services.
- Add-on codes billed without primary CPT.
- Diagnosis and/or procedure code not consistent with the member's age/gender.
- Use of exclusion codes.
- Excessive use of units.
- Misuse of benefits.
- Claims for services not rendered.

Iowa Total Care auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like-specialty may also review specific cases to determine if billing is

appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Iowa Total Care will seek recovery of all overpayments. Depending on the number of services provided during the review period, Iowa Total Care may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard contractors, CMS Recovery Audit contractors, and Medicaid Fraud Control units in calculating overpayments, and is recommended by the Office of Inspector General's (OIG) Health Care Fraud Self-Disclosure Protocol (November 8, 2021).

Suspected Inappropriate Billing

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, call our anonymous and confidential FWA hotline at **1-866-685-8664**. Iowa Total Care takes all reports of potential fraud, waste, and/or abuse very seriously and investigates all reported issues.

Due to the evolving nature of fraudulent, wasteful, and abusive billing, Iowa Total Care may enhance the FWA program at any time. These enhancements may include; but are not limited to, creating, customizing, or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Fraud, Waste and Abuse Reporting

Providers may voluntarily disclose any suspected fraud, waste and/or abuse by using the reporting tool on the Iowa HHS website: **hhs.iowa.gov/report-abuse-fraud**

QUALITY MANAGEMENT

Iowa Total Care’s culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Management/Quality Improvement (QM/QI) program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members.

This system provides a continuous cycle for assessing and analyzing the quality of care and service among plan initiatives including: primary, secondary, and tertiary care, preventive health, acute and/or chronic care, over-and underutilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. The system allows for systemic analysis and remeasurement of barriers to care, the quality of care, and utilization of services over time.

Iowa Total Care recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most

appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health outcomes for our members.

Where the member's condition is not likely to improve, Iowa Total Care will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions.

Whenever possible, the Iowa Total Care QM/QI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of members.

Program Structure

The Iowa Total Care Board of Directors (BoD) has the ultimate authority and oversight of the development, implementation, and evaluation of the Quality Program and is accountable for oversight of the Quality of Care and services provided to members. The BoD oversees the QM/QI Program and has established various committees and ad hoc committees to monitor and support the QM/QI Program.

The Quality Improvement Committee (QIC) is a senior management committee with Iowa Total Care network physician representation that is directly accountable to the BoD. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring, the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the quality and medical management programs.

The following committees report directly to the Quality Improvement Committee (QIC):

- Medical Management Committee (MMC).
- Credentialing Committee (CC).
- Performance Improvement Team.
- Joint Operations Committee.
- Cultural Competency Committee.
- Peer Review Committee (ad hoc Committee).

In addition to the committees reporting to the QIC, Iowa Total Care has sub-committees and workgroups that report to the above committees including, but not limited to:

- Quality Measure Steering Committee.
- Stakeholder Advisory Board.
- Community Advisory Committee.
- Ad hoc committees may also include *regional level* committees for Member Advisory and/or Community Advisory based on distribution of membership.

Provider Involvement

Iowa Total Care recognizes the integral role provider involvement plays in the success of its QM/QI program. Provider involvement in various levels of the process is highly encouraged through provider representation and participation on the Quality Committees.

Quality Management/Quality Improvement (QM/QI) Program Scope

The scope of the QM/QI program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Iowa Total Care members. Iowa Total Care's QM/QI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including: preventive care; primary care; specialty care; acute care; short-term care; ancillary services; and operations.

Goals

Iowa Total Care's primary QM/QI program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

The Iowa Total Care QM/QI program monitors the following:

- Acute and chronic care coordination.
- Behavioral Health care.
- Compliance with member confidentiality laws and regulation.
- Compliance with preventive health guidelines and clinical practice guidelines.
- Continuity and coordination of care.
- Delegated entity oversight.
- Department performance and service.
- Employee and provider cultural competency.
- Marketing practices.
- Member enrollment and disenrollment.
- Member grievances and appeals.
- Member experience.
- Medical Management, including population health management.
- Member safety.
- Primary Care provider changes.
- Pharmacy.
- PCP after-hours telephone accessibility.
- Provider appointment availability.
- Provider complaint system.
- Provider network adequacy and capacity.
- Provider experience.
- Selection and retention of providers (credentialing and re-credentialing).
- Utilization Management, including over-and under-utilization.

Patient Safety and Quality of Care

Patient Safety is a key focus of Iowa Total Care's QM/QI program. Monitoring and promoting member safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including death of a member.

Iowa Total Care employees (including Medical Management, Member Services, Provider Services, Appeal Coordinators, etc.), panel providers, facilities or ancillary providers, members or member representatives, medical directors or the BoD may advise the Quality Management (QM) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to, and including, review by the Peer Review Committee (ad hoc Committee) as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

For any questions relative to Quality of Care or CIRs, please contact us at **QOCCIR@IowaTotalCare.com** and fax **1-833-205-1251**.

Performance Improvement Process

Iowa Total Care QIC reviews and adopts an annual QM/QI Program and Work Plan aligned with Iowa Total Care's vision and goals and appropriate industry standards. The QM Department implements quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving member health outcomes, quality of access to care, and services.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each performance improvement initiative is also designed to allow Iowa Total Care to monitor improvement over time. Quality performance measures have been identified based on the potential to improve healthcare for Iowa Total Care members. The measures are HEDIS measures, integrated behavioral health care, along with identified state metrics. Performance is measured against established benchmarks and progress to performance goals.

Annually, Iowa Total Care develops a QM/QI Work Plan for the upcoming year. The QM/QI Work Plan serves as a working document to guide quality improvement efforts on a continuous

basis. The Work Plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service). It also includes timelines for completion and reporting to the QIC and requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QM/QI Work Plan.

Iowa Total Care communicates activities and outcomes of its QM/QI Program to both members and providers through avenues such as the member newsletter, provider newsletter, and the Iowa Total Care web portal at **www.iowatotalcare.com**.

At any time, Iowa Total Care providers may request additional information on the Health Plan programs, including a description of the QM/QI Program and a report on Iowa Total Care progress in meeting the QAPI Program Goals, by contacting the QI Department.

Feedback on Provider-Specific Performance

As part of the quality improvement process, performance data at an individual provider, practice, or site level is reviewed and evaluated. This performance data may be used for quality improvement activities, including use by Iowa Total Care quality committees. This review of provider-specific performance data may include, but is not limited to:

- Site evaluation results, including: medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
- Preventive care, including: wellness exams, immunizations, prenatal care, lead screening, cervical cancer screening, breast cancer screening, and other age-appropriate screenings for detection of chronic diseases or conditions.
- Member appeal and grievance data.
- Utilization management data, including ER visits/1000 and bed days/1000 reports.
- Critical Incident reporting, sentinel events and adverse outcome.
- Compliance with clinical practice guidelines.
- Pharmacy data, including use of generics or specific drugs.

As part of its motivational incentive strategies, Iowa Total Care systematically profiles the quality of care delivered by high-volume PCPs to improve provider compliance with preventive health and clinical practice guidelines and clinical performance indicators. The profiling system is developed with network providers to ensure the process has value to providers, members, and Iowa Total Care, and may include a financial component

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the State of Iowa Department of Health and Human Services.

As both Iowa and federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important; not only to the health plan, but to

the individual provider. Iowa purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Provider-specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for provider incentive programs, such as "Pay for Performance." These programs reward providers based on scoring of such quality indicators used in HEDIS.

How HEDIS Rates ARE Calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data.

- Administrative data consists of claims submitted to the health plan. Measures calculated using administrative data may include: annual mammogram, annual Chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.
- Hybrid rates consist of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered that were not reported to the Health Plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate procedure and diagnosis codes can reduce the necessity of Medical Record Reviews (MRR).
- See Iowa Total Care's website and HEDIS brochure for more information on reducing HEDIS medical record reviews and improving HEDIS scores.

When Medical Record Reviews (MRR) Occur for HEDIS?

MRR audits for HEDIS are usually conducted February through May each year. Iowa Total Care QM representatives, or a national MRR vendor contracted to conduct the HEDIS MRR on Iowa Total Care's behalf, may contact you if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA-compliant Business Associate Agreement with Iowa Total Care which allows them to collect PHI on our behalf.

Who Conducts Medical Record Reviews (MRR) for HEDIS

Iowa Total Care may contract with an independent national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted from February through May each year. At that time, if any member medical records are selected for review, the provider will receive a call and/or letter from a medical record review representative. Prompt cooperation with the representative is greatly needed and appreciated.

How to Improve HEDIS Scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill or report by encounter submission for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as, Body Mass Index (BMI) calculations, eye exam results, and blood pressure readings.

For questions, comments, or concerns related to the annual HEDIS project or the MRRs, contact the Quality Improvement Department toll-free **1-844-738-5019**.

MEDICAL RECORDS REVIEW (MRR)

Iowa Total Care providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Iowa Total Care to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records must be kept in a secure location.

Iowa Total Care requires providers to maintain all records for members for at least ten (10) years. See the Member Rights section of this manual for policies on member access to medical records. Iowa Total Care may conduct medical record reviews for the purposes including, but not limited to, utilization review, quality management, medical claim review, and member grievance/appeal investigation. Providers must meet eighty percent (80%) of the requirements for medical record keeping. Elements scoring below eighty percent (80%) are considered deficient and in need of improvement. Iowa Total Care will work with any provider who scores less than eighty percent (80%) to develop an action plan for improvement. MRR results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re-credentialing.

Required Information

Medical records mean the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating PCP or provider that document all medical services received by the member. Services include inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable State rules and regulations, and signed by the provider rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data (e.g., employer, home telephone number, spouse, next-of-kin, legal guardianship, primary language, etc.).
- Prominent notation of preferred spoken language or need for interpretation or translation services, or other communication assistance.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medications, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An appropriate history of immunizations is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Iowa Total Care's practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting appeal is documented in the history and physical.
- Past medical history (for members seen three (3) or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.

- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented, including follow-up of outcomes and summaries of treatment rendered elsewhere. These include family-planning services, preventive services and treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- Appropriate notations concerning use of tobacco, alcohol and substance use. For members seen three (3) or more times, substance abuse history should be queried.
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an Advance Directive has been offered to adults 18 years of age and older. Additionally, the LTSS Comprehensive Medical and Service Record should contain:
    - Medication Record and Person-Centered Service Plan (PCSP/), where applicable.
    - Provider Acknowledgement of PCSP.

Nursing Facility records will also include:

- Substantiation of Pre-Admission Screening and Resident Review (PASRR). Documentation of specialized services delivery.
- Evidence of education regarding Patient Rights and Responsibilities.
- Acknowledgement that the member was informed of any patient pay liability.
- Documentation of financial eligibility, including audit of personal assets and authentication of known personal care accounts.
- Other processes identified by either Iowa Total Care or the Department of Human Services.

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a member's authorized representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA-compliant Business Associate Agreement with Iowa Total Care which allows them to collect PHI on our behalf.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record, attempts to obtain historical medical records for all newly assigned Iowa Total Care members. If the member or member's authorized representative is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, this should also be noted in the medical record.

Billing Information

INTRODUCTORY BILLING INFORMATION

Billing Instructions

Iowa Total Care follows CMS rules and regulations, specifically the federal requirements set forth in 42 USC § 1396a(a)(37)(A), 42 CFR § 447.45 and 42 CFR § 447.46; and in accordance with state laws and regulations, as applicable.

General Billing Guidelines

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Iowa Total Care for payment of covered services.

It is important that providers ensure Iowa Total Care has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form).
- National Provider Identifier (NPI).
- Tax Identification Number (TIN).
- Medicaid Number.
- Taxonomy code.
- Physical location address (as noted on current W-9 form).
- Billing name and address.

All providers billing Iowa Total Care must be registered with Iowa Medicaid in order to receive payment. This includes billing, rendering, attending, operating and referring providers, though not all NPIs are required on all types of claims. All providers must bill with their NPI number in box 24J (b) (rendering provider) with the exception of FQHC, RHC, Indian Health, Chapter 24 providers or providers with an atypical NPI. Providers with these exceptions may either use the billing NPI in box 24J (b) or leave that box blank. We encourage our providers to also bill their taxonomy code in box 24Ja and the Member's Medicaid number in box 1a on the CMS 1500, to avoid possible delays in processing. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

We recommend that providers notify Iowa Total Care thirty (30) days in advance of changes pertaining to billing information. To notify Iowa Total Care of changes pertaining to billing information please follow the Provider Change Form instructions found on the **Contracting & Credentialing Forms webpage**. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form. Claims eligible for payment must meet the following requirements:

- The Member must be effective on the date of service (see information below on identifying the Member),
- The service provided must be a covered benefit under the Member's contract on the date of service, and
- Referral and prior authorization processes must be followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

When submitting your claim, you need to identify the Member via the Medicaid Number provided by the state and found on the Member ID card or the provider portal.

Vision claims must be submitted to Envolve Vision. Please contact Envolve Vision regarding questions related to claims or claims payments. All claims billed by Optometrists must be billed to Envolve Vision. Ophthalmologists must bill routine vision claims (see the list of procedure codes and diagnosis codes required to be sent to Envolve Vision) to Envolve Vision. For coverage questions call Envolve Vision at 1-833-564-1205 or visit: **https://visionbenefits.envolvehealth.com/**.

Dental claims must be submitted to Delta Dental. Please contact Delta Dental regarding questions related to claims or claims payments by calling at 1-800-544-0718.

Pharmacy point of sale claims must be submitted to Pharmacy Benefits Manager (PBM). Please contact Pharmacy Benefits Manager (PBM), regarding questions related to claims or claims payments by calling at 1-833-587-2012.

Claim Forms

Iowa Total Care accepted the CMS 1500 (2/12) and CMS 1450 (UB-04). Paper claims were accepted until October 1, 2019, after which paper claims were no longer accepted. The Targeted Medical Care (TMC) Form 470-2486 was allowed to be submitted on paper until the implementation of the Electronic Visit Verification System on January 1, 2021. All claims must be submitted to Iowa Total Care electronically through a clearinghouse, by utilizing the provider web portal found at iowatotalcare.com, or through CareBridge.

Handwritten claims were not accepted, except for the TMC Form 470-2486 used for Consumer-Directed Attendant Care (CDAC) found on the Iowa Medicaid (IM) website at **hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/claims-and-billing**. The TMC Form 470-2486 was no longer accepted after January 1, 2021, when the EVV system became required for claim submission. Claim Form Instructions for claims received prior to the above-mentioned dates can also be found at this location. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (2/12) form and institutional providers complete the CMS 1450 (UB-04) claim form. If you have questions regarding what type of form to complete, contact Iowa Total Care at our Toll-Free number: 1-833-404-1061.

Billing Codes

Iowa Total Care requires claims to be submitted using codes from the current version of, ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered, as per correct coding guidelines. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service.
- Code is inappropriate for the age or sex of the Member.
- Diagnosis code is missing digits.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary.
- Code billed is inappropriate for the location or specialty billed.
- Code billed is a part of a more comprehensive code billed on same date of service.

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Iowa Total Care.

CPT® Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Encounters vs Claim

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided Iowa Total Care Members. For example; if you are the Primary Medical Professional (PMP) for a Member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a ""proxy claim") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollar amounts. It is mandatory that your office submits encounter data. Iowa Total Care utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HSD and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an Explanation of Payment (EOP).

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an

EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to an Iowa Total Care Member. The encounter or claim file structure and content definition requirements shall adhere to those standards defined by the State of Iowa Department of Health and Human Services as revised from time-to-time.

Clean Claim Definition

A clean claim means a claim received by Iowa Total Care for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Iowa Total Care.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Rejection versus Denial

All paper claims sent to the claims office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

REJECTION: A list of common upfront rejections can be found on page [122]. Rejections will not enter our claims adjudication system, so there will be no Explanation. A REJECTION is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. The provider will receive a letter or a rejection report if the claim was submitted electronically.

DENIAL: If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed minimum edits and is entered into the system, however, has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A comprehensive list of common delays and denials can be found below.

Claim Payment

First time clean claims submissions will be adjudicated (finalized as paid or denied) at the following levels:

- 90% within 30 Calendar Days of receipt
- 95% within 45 Calendar Days of receipt
- 99% within 90 Calendar Days of receipt

Note: All adjustment timeframes after the initial payment/denial are business days.

Contact Information

Plan Address / Administrative Office:
Iowa Total Care
1080 Jordan Creek Parkway, Suite 400 South
West Des Moines, IA 50266

Claims Submission Address:
Iowa Total Care
Attn: Claims
PO Box 8030
Farmington MO 63640

Customer Service:
1-833-404-1061, Iowa Total Care
ITC Duals: 1-833-765-8507
ITC Foster Care: 1-833-222-4832

TYY Users 1-833-404-1061; Open Monday through Friday from 8 a.m. to 5 p.m.

CLAIMS PAYMENT INFORMATION

- Systems used to pay claims.

Iowa Total Care uses three main systems to process reimbursement on a claim. Those systems are:

- Amisys
- DST Pricer
- Rate Manager
- Electronic Visit Verification (EVV/CareBridge)

Amisys

Our core system; All claims are processed from this system and structures are maintained to meet the needs of our provider contracts. However, we are not limited within the bounds of this one system. We utilize multiple systems to expand our universe of possibilities and better meet the needs of our business partners.

DST Pricer

The DST Pricer is a system outside our core system where we have some flexibility on addressing your contractual needs. It allows us to be more responsive to the market demands. It houses both Fee Schedules and procedure codes and mirrors our Amisys system, but with a more attention to detail.

Rate Manager

Rate Manager's primary function is to price Facility claims. It can price inpatient DRG or Outpatient APC. Inpatient claims are based on the type of DRG and the version. Each Hospital in the country is assigned a base rate and add-ons by Medicaid and Medicare based on state or federal guidelines. The basic DRG calculation is:

Hospital Base Rate x APC Relative weight

The payment can be affected by discharge status, length of stay and other allowed charges.

Outpatient hospital claims, other than Critical Access Hospitals, are based on APC pricing. APC stands for Ambulatory Payment Classification system. This is a prospective payment system for outpatient services based on HCPCS and CPT codes. APCs are groups or CPT/HCPCS which make up groups of common types of services or delivery methods. Weights are assigned similar to DRGs, but unlike DRGs, more than one APC can be assigned per claim. Outpatient claims for Critical Access Hospitals are paid on a Cost-to-Charge Ratio basis (CCR).

Electronic Visit Verification (EVV)

EVV is a way of recording information such as check-in and check-out times for certain services provided to Medicaid members in their home and community. EVV uses technology like smart devices and landline phones. EVV is required by a law called the 21st Century Cures Act and all states have to use it.

Services Provider Affected

Any service provider who provides the following service codes are required to bill these services through EVV:

- S5125 Attendant Care Services, per 15 minutes.
- S5130 Homemaker, per 15 minutes.
- S5131 Homemaker, per diem.
- T1019 Personal Care Services, per 15 minutes.

EVV Vendors

CareBridge is the chosen EVV vendor for Iowa. Providers can utilize this EVV option directly or choose to utilize another 21st Century Cures Act compliant EVV vendor. If a third party EVV vendor is utilized, this vendor must work with CareBridge to aggregate data from the third party EVV vendor to CareBridge. ALL claims for EVV services must be generated by CareBridge to then be sent to Iowa Total Care. Any claims with dates of service on or after February 1, 2021, for EVV related services that do not come in via CareBridge will be denied. Currently an exception is granted to Assisted Living Facilities and Residential Care Facilities as those provider types will be require billing through CareBridge for dates of service on or after July 1, 2021.

Process

Providers will utilize a 21st Century Cures Act EVV vendor to check in and out of visits with their members. Please work with the member's case manager to ensure services are in the member's Person-Centered Service Plan (PCSP). The PCSP will be a guide for what services are appropriate to provide. For CDAC services, a CDAC agreement will be included as part of the service plan to fully explain what tasks can be done for the member during CDAC time.

- The provider will ensure there are no prebilling errors found with the visits entered. If prebilling errors are found, they will need to be corrected before the visits can be generated in to claims.
- If there are no prebilling errors or all previous billing errors are now corrected, these visits can now be rolled into claims. For agency providers, this process will be done manually at the agency's convenience. For Individual CDAC providers, available visits with no prebilling errors will be automatically generated to claims weekly. The Individual CDAC provider can also bill more often than once per week if they so choose.
- Claims will be electronically sent to Iowa Total Care for processing. After Iowa Total Care has made a decision on the claim, the CareBridge provider portal will updated with the status– rejected, approved or denied.

Getting Started

To get started with EVV, providers should contact CareBridge. They will provide training opportunities and assist in getting the provider ready to use the system. For questions, comments, or concerns related to EVV use the following resources and contact information for CareBridge:

- Resource Page: **https://carebridgehealth.zendesk.com/hc/en-us/categories/360004330014-IOWA**
- Requesting login credentials: **http://evv.carebridgehealth.com/loginrequest**
- Email: **iaevv@carebridgehealth.com**
- Phone: 1-844-343-3653, Monday through Friday, 7 a.m. to 5 p.m.

Electronic Claims Submission

Network providers are required to participate in Iowa Total Care's electronic claims/encounter filing program. Iowa Total Care can receive ANSI X12N 837 professional, institutional or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). All claims are subject to timely filing requirements.

Providers must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Iowa Total Care's payor ID 68069. Our preferred Clearinghouse is Availity. Please visit our website for our electronic Companion Guide, which offers more instructions. For questions or more information on electronic filing please contact:

Iowa Total Care
c/o Centene EDI Department
1-800-225-2573, extension 25525

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Iowa Total Care provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straight forward reconciliation of payments. As a Provider, you can gain the following benefits from using EFT and ERA:

1. Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.

2. Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow.

3. Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported.

4. Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily.

For more information on our EFT and ERA services, please contact our Provider Services Department at:

Iowa Total Care
1080 Jordan Creek Parkway, Suite 400 South
West Des Moines, IA 50266
1-833-404-1061

Common Causes of Claims Processing Delays and Denials

- Incorrect Form Type.
- Diagnosis Code missing digits.
- Missing or Invalid Procedure or Modifier Codes.
- Missing or Invalid DRG Code.
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete.
- Invalid Member ID.
- Invalid Place of Service Code.
- Provider TIN and NPI Do Not Match.
- Invalid Revenue Code.
- Dates of Service Span Do Not Match Listed Days/Units.
- Invalid TIN.
- Missing or Incomplete Third Party Liability Information.
- Missing or incomplete consent forms.
- Missing or incomplete CPT/HCPCS Codes.
- Missing or invalid POA/HAC Codes.
- Missing or incomplete Type of Bill.

Iowa Total Care will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

Common Causes of Up-Front Rejections

- Missing or Incorrect Member Date of Birth.
- Missing or Incomplete Member Name or Identification Number.
- Missing Provider Name, Tax ID, or NPI Number, or one that does not match records on file.
- Missing Medicaid Number if required.

- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, 65, 66, or 72 or missing from box 76 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service is prior to Member's effective date.
- Date of Service or Date Span is missing from required fields.
- Invalid or Missing Type of Bill.
- Missing, Invalid or Incomplete Diagnosis Code.
- Missing Service Line Detail.
- Member Not Effective on The Date of Service.
- Admission Type is Missing.
- Missing Patient Status.
- Missing or Invalid Occurrence Code or Date.
- Missing or Invalid Revenue Code.
- Missing or Invalid CPT/Procedure Code.
- Incorrect Form Type.
- Modifiers are missing or invalid.
- Institutional Claim (UB-04) exceeded the maximum 97 service line limit.
- Professional Claim (CMS-1500) exceeded the maximum 50 service line limit.

Iowa Total Care will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection. See Appendix I for a complete list.

Clinical Laboratory Improvement Amendment (CLIA) Accreditation

The Centers for Medicare and Medicaid (CMS) regulates all laboratory testing on humans through the CLIA program, which ensures quality lab testing through established laboratory standards. Independent Labs that participate in Medicare or Medicaid with Iowa Total Care must be CLIA accredited and registered with CMS. Requirements for laboratory accreditation are contained in the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB), which may be accessed on the website at: **https://www.jcrinc.com/products-and-services/publications/manuals/**. Iowa Medicaid Guidelines require that the CLIA Number be submitted at the header level of each claim where procedure codes requiring a CLIA number or CLIA Waiver are present.

How to Submit a CLIA Claim

Via EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4.

Note: The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4. When the referring laboratory is the billing laboratory, the reference laboratory's name, NPI, address, and Zip Code shall be reported in loop 2310C. The 2420C loop is required if different then information provided in loop 2310C. The 2420C would contain Laboratory name and NPI. In all cases, a CLIA number is required at the header level of the claim.

Via AHA Provider Portal

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

Note: When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Timely Filing

Providers must submit all claims and encounters within 180 calendar days of the date of service. All retroactive eligibility claims need to be received at Iowa Total Care within 365 days of the notice date. When Iowa Total Care is the secondary payor, claims must be received within 365 calendar days of the final determination of the primary payor. Corrected Claims or reconsiderations are allowed 365 days from the last date of adjudication on the original claim for receipt of a corrected claim not to exceed two (2) years from the last date of service on the claim. Please reference the timely filing requirements below:

Claim Submission Type	Timely Filing Guidelines
Initial Claim Submission	180 days*.
Initial Claim Submission with Third Party Liability (TPL)	365 days from last date of EOP form primary carrier.
Corrected Claim Submission	365 days from the last adjudication date up to two years from the date of service.
Disputes/First Level Appeal	180 days from EOB for first level dispute/Appeal.
Second Level Appeal	30 days from the original decision notated on the provider remittance advice from the Dispute/first level Appeal.

*Initial Claim Submission requirements during the Public Health Emergency for COVID 19 are extended to 270 days.

Third Party Liability / Coordination of Benefits

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the Member. All other insurance, including Medicare, is always primary to Medicaid coverage.

Iowa Total Care, like all Medicaid programs, is always the payor of last resort. Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Iowa Total Care Members. If a Member has other insurance that is primary, providers must submit the claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for a Member with insurance primary to Medicaid, the claim will pend and/or deny until this information is received. If a Member has more than one primary insurance (Medicaid would be the third payor), the claim cannot be submitted through EDI or the secure web portal and must be submitted on a paper claim.

If the provider is unsuccessful in obtaining necessary cooperation from a Member to identify potential third party coverage, the provider shall inform the health plan that efforts have been unsuccessful. Iowa Total Care will make every effort to work with the provider to determine liability coverage.

For Medicare Claims, Iowa Total Care will pay the Member's coinsurance, deductibles, co-payments and other cost-sharing expenses up to the allowed amount.

For Commercial Insurers, Iowa Total Care will pay the remaining balance, up to the Medicaid allowed amount, after third party payment.

If third party liability coverage is determined after services are rendered, the health plan will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Iowa Total Care will not coordinate benefits when the primary insurer denies for the following administrative reasons:

- No Authorization.
- Untimely Filing.
- Duplicate Denial.

If the primary insurer denies for an authorization related denial, the provider would be required to obtain a prior authorization for any service Iowa Total Care would require an authorization for if Medicaid were the primary payor. The provider is encouraged to obtain an authorization for the following potential denials:

- Noncovered Service.
- Benefits Exhausted.

Medicare with Other Insurance

If a member has Medicare coverage and other insurance, bill the other sources before submitting a bill to Medicaid.

You may submit the bill to Medicaid for consideration if the payment is not made within sixty (60) days of the Explanation of Benefits (EOB).

Crossover / COBA

Iowa Total Care processes crossover claims for members enrolled in both its Medicare and Medicaid plans. It also participates in coordination of benefits agreement (COBA) to process claims received directly from Centers for Medicare and Medicaid Services (CMS). With either process, claim crossover between Medicare and Medicaid is automatic. Providers do not need to submit a claim directly to Iowa Total Care when Medicare is primary. These claims are automatically received in the COBA crossover process. If a claim is received directly from the provider it could result in a duplicate denial or an overpayment, subject to pay and chase recovery initiatives.

Receiving a TPL Payment after Iowa Total Care Payment

If a provider receives payment from a third party after Iowa Total Care has made payment to the provider, the provider must reimburse Iowa Total Care. The provider needs to submit a corrected claim and attach the EOB/EOP from the primary payor to indicate the TPL payment received.

No Response from Other Insurance

If a provider bills a third-party insurer and, after thirty (30) days, has not received a written or electronic response to the claim from the third-party insurer, the provider can submit the claim within twelve (12) months from the service date to Iowa Total Care as a denial from the insurance company.

- When submitting electronically, the documentation must be kept on file as proof of prior billing to the third-party insurer and available upon request.

This 30-day stipulation does not apply to:

- Self-insured employer plans.
- Medicare/Medicare supplement policies.
- Other Medicaid MCOs.
- Workers' compensation.
- Federal employee plans.
- Vision or drug plans.
- Disability income.
- Medical claims paid by auto or homeowners insurance.

If the third-party insurer sends any requests to the provider for additional information, the provider must respond appropriately. If the provider complies with the requests for additional information and, after ninety (90) days from the date of the original claim to the third-party insurer has not received payment or denial from the third-party insurer, then the provider can submit the claim within twelve (12) months of the service date to Iowa Total Care as a denial from the insurance company.

Note: This does not apply to the insurance plan types listed above.

Documentation Requirements

Adequate documentation is important for claims with TPL. Attachment of acceptable proof of payment or denial is required for claim submissions. Providers are not required to submit documentation for electronic submissions, but documentation must be retained in the patient's file and is subject to request and review by the state.

The only acceptable forms of documentation proving that another insurer was billed first are an RA or EOB from the other insurer. The provider can use a copy of the claim filed with the insurance company by the provider or the policyholder as proof of billing, if the other insurance company does not respond. When submitting a corrected claim, please ensure an EOB is submitted along with the corrected claim even if the EOB was already submitted with the first time claim to ensure correct processing and avoid TPL related denials.

Acceptable Proof of Payment or Denial

Documentation of proper payment or denial of TPL is considered acceptable if it corresponds with the member name, dates of service, charges, and TPL payment listed on the Iowa Total Care claim. Exception: If there is a reason why the charges do not match (such as another insurer requires another code to be billed, which generates a different charge), the provider should note this on the EOB.

Acceptable documentation:

- Insurance carrier's EOB.
- Insurance carrier's RA.
- Correspondence from insurance carrier indicating payment.
- Copy of provider's ledger account.

Client Participation / Aggregate Share of Cost

Generally, Iowa Total Care, their providers, contractors and subcontractors shall not require cost sharing for covered services at this time. However, members residing in an institutional setting or members participating in 1915(c) HCBS Waiver services may be subject to Client Participation. For members living in an institutional setting, Iowa Total Care will use the NPI listed on the state file in determining which claims to remove the member's share of cost from. For members accessing waiver services, the member, Community-Based Case Manager and Interdisciplinary team will discuss which Long-Term Care provider the Client Participation amount will be applied to. That provider will be notified via Notice of Decision of the Client Participation and amount.

Client participation is the amount of income the member must pay before Medicaid reimbursement for services is available. The State of Iowa Department of Health and Human Services (Iowa HHS) has the responsibility of determining the member liability amount for each member. Through the Iowa HHS eligibility and enrollment files, the state will notify Iowa Total Care of any applicable member liability amounts. Providers will be required to collect this amount from the member and bill gross/full charges. Iowa Total Care will adjudicate the claim and deduct the patient liability amount. In the event the sum of any applicable third-party payment and a member's client participation equals or exceeds the reimbursement amount established for services, Iowa Total Care will make no payment to the provider.

Some Iowa Total Care members are subject to a co-payment for certain services (see Emergency Care Co-payments below), which are tracked by Iowa Total Care (Aggregate Share of Cost). This will be indicated on their ID card. Member co-payments are capped at 5% of household income, and may not be collected after members have paid/reached that amount. Prior to collecting co-payments from any member, and in conjunction with eligibility verification, providers should verify a member's co-payment status before collecting any co-payments.

Emergency Care Co-payments

An eight dollar ($8) copayment for Iowa Total Care Plan Members and a twenty-five dollar ($25) copayment for Hawki Members will be applied for use of a hospital Emergency Department (ED) to treat non-emergent conditions. A copayment shall not be imposed on Hawki Members whose family income is less than 182 percent of the federal poverty level.

Before providing non-emergency services and imposing co-payments, the hospital providing care must:

- Conduct an appropriate medical screening to determine that the member does not need emergency services.
- Inform the member of the amount of his or her co-payment obligation for non-emergency services provided in the hospital ED.
- Provide the member with the name and location of an available and accessible alternative non-emergency services provider.
- Determine that the alternative provider can provide services to the member in a timely manner with the imposition of a lesser or no co-payment.
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

If the member has been advised of the available alternative provider and of the amount of the co-payment, and chooses to continue to receive treatment for a non-emergency condition at the hospital ED, the hospital will assess the co-payment.

Emergency services rendered for emergent conditions are exempt from any copayment.

Missed Appointments

Providers are prohibited from billing Members for missed appointments.

Billing the Member / Member Acknowledgement Statement

Iowa Total Care reimburses only services that are medically necessary and covered through the Iowa Medicaid program. Providers are not allowed to “balance bill” for covered services if the provider’s usually and customary charge for covered services is greater than the fee schedule amount.

Providers may bill members for services NOT covered by either Medicaid or Iowa Total Care or for applicable copayments, deductibles or coinsurance as defined by the State of Iowa.

In order for a provider to bill a member for services not covered under the program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgment following this language (the Member Acknowledgement Statement):
I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Program as being reasonable and medically necessary for my care. I understand that Iowa Total Care through its contract with the Iowa Medicaid determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

EMERGENCY ROOM SERVICES

Iowa Total Care follows the Iowa Medicaid policy to modify the reimbursement methodology to either reduce or deny payment for nonemergency services rendered in a hospital emergency room. Status Indicator V, clinic or emergency department visit, if covered by Iowa Medicaid, is paid under Outpatient Prospective Payment System Ambulatory Payment Classifications (OPPS APC) with separate APC payment, subject to limits on nonemergency services provided in an emergency room as described below:

Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Iowa Total Care will cover and pay for emergency services regardless of if provider is in network. Payment for treatment of an Iowa Total Care member in an emergency room shall be made as follows:

- If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided. Critical access hospitals (CAH) are exempt from this requirement.
- If the emergency room visit does not result in an inpatient hospital admission but involved emergency services as defined by the IA Emergent Diagnosis list, payment for treatment provided in the emergency room shall be made at the full APC/CCR payment

for the treatment provided when the emergent diagnosis is indicated in the primary or secondary position. If an emergent diagnosis is not indicated in the primary or secondary diagnosis fields, claims payments will be reduced in accordance with Iowa Medicaid Guidelines.

- Payment reductions for non-emergent emergency room visits depend on whether the member had a referral to the emergency room from the member's primary care provider (PCP) or other appropriate medical personnel and the referring provider's NPI is present on the claim:

    - Payment for treatment provided in the emergency room shall be made at seventy percent (75%) of the APC/CCR payment for the treatment provided.

    - For members who were not referred to the emergency room by their primary care physician/appropriate medical personnel or the referring provider's NPI is not present on the ER claim, payment for treatment provided in the emergency room shall be made at fifty percent (50%) of the APC/CCR payment for the treatment provided.

Diagnosis codes used to determine emergency room payment are located on the IM Website: **Medicaid Claims and Billing** (hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/claims-and-billing).

Iowa Total Care will cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with us.

Iowa Total Care shall not deny payment for treatment obtained under either of the following circumstances:

i. A member has an emergency medical condition, including cases in which the absence of immediate medical attention will not result in:
    a. Placing the health of the individual in serious jeopardy; for pregnant women, the health of the women or unborn child.
    b. Serious impairment to bodily functions.
    c. Serious dysfunction of any bodily organ or part.

ii. A representative of Iowa Total Care instructs the member to seek emergency care.

THIRTY (30) DAY HOSPITAL READMISSIONS

Iowa Total Care follows the Iowa Medicaid 30-day readmission policy to exclude readmissions that are planned for repetitive or staged treatments and to clarify that the policy does not apply to critical access hospitals. We may review hospital admissions on a specific Member if it appears that two or more admissions are related based on same or similar conditions. The claim review, which includes a review of medical records if requested from the provider, may result in necessary adjustments. If so, Iowa Total Care will make all necessary adjustments to the claim (including recovery of payments) not supported by the medical record. Providers who do not submit the requested medical records or who do not remit the overpayment amount identified by us may be subject to a recoupment resulting in a negative balance on future EOPs.

LESSOR OF BILLED

Where applicable, lessor of billed charges will be applied in claims processing. In cases where the billed charges are less than the Medicaid allowable, claims payments will be reduced to the billed amount on the claim. When a claim or claim line is billed with $0.00 or $0.01, the claim line will be paid at $0. Usual and customary charges are recommended to allow for automatic reprocessing in the event of retroactive rate increases. Information relating to usual and customary charges can be found in Informational letter 1785.

IOWA TOTAL CARE CODE AUDITING AND EDITING

Iowa Total Care uses HIPAA compliant clinical claims auditing software for physician and outpatient facility coding verification. The software will detect, correct, and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding "rule." When the software audits a claim that does not adhere to a coding rule, a recommendation known as an "edit" is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code auditing software is a useful tool to ensure provider compliance with correct coding, a fully automated code auditing software application will not wholly evaluate all clinical patient scenarios. Consequently, the health plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted.

Moreover, Iowa Total Care may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the HealthCare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

Level I HCPCS Codes (CPT)

This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a five-digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.

Level II HCPCS

The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics and prosthetics and etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.

Miscellaneous/Unlisted Codes

The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

Temporary National Codes

These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

HCPCS Code Modifiers

Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion; certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD 10)

These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems.

Revenue Codes

Revenue codes are required on all institutional claims and all claims where billing on a UB-04 is required. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims editing software application contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research and etc.

The software applies edits that are based on the following sources:

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits includes column 1/column 2, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments. Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- CMS Claims Processing Manual.
- CMS Medicaid NCCI Policy Manual.
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals).
- CMS coding resources such as, HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals.
- AMA resources:
    - CPT Manual.
    - AMA Website.
    - Principles of CPT Coding.
    - Coding with Modifiers.
    - CPT Assistant.
    - CPT Insider's View.
    - CPT Assistant Archives.
    - CPT Procedural Code Definitions.
    - HCPCS Procedural Code Definitions.
- Billing Guidelines Published by Specialty Provider Associations

- Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG).
- Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS).

- State-specific policies and procedures for billing professional and facility claims.
- Health Plan policies and provider contract considerations.

Code Auditing and the Claims Adjudication Cycle

Code auditing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

Code Auditing Rules

As a claim progresses through the code auditing cycle, each service line on the claim is processed through the code auditing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

Deny

Code auditing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with dispute/appeal instructions. Please include medical records or appropriate documentation on your dispute/appeal. If this was a billing error, please submit a corrected claim.

Pend

Code auditing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.

Code Auditing Principles

The below principles do not represent an all-inclusive list of the available code auditing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims. A full listing of code auditing principles applied to Iowa claims can be found on the Iowa Total Care Website:
https://www.iowatotalcare.com/providers/resources/clinical-payment-policies.html.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- **Procedure code invalid rules:** Evaluates claims for invalid procedure and revenue or diagnosis codes.
- **Deleted Codes:** Evaluates claims for procedure codes which have been deleted.
- **Modifier to procedure code validation:** Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58, and -59.
- **Age Rules:** Identifies procedures inconsistent with member's age.
- **Gender Procedure:** Identifies procedures inconsistent with member's gender.
- **Gender Diagnosis:** Identifies diagnosis codes inconsistent with member's gender.
- **Incomplete/invalid diagnosis codes:** Identifies diagnosis codes incomplete or invalid.

Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1," Furthermore, public-domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). Iowa Total Care's clinical validation team uses the information on the claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

MODIFIER 59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier 59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier 59 as follows: "Modifier 59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate

incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers are routinely assigning modifier 59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier 59 related to the portion of the definition that allows its use to describe “different procedure or surgery”. NCCI guidelines state that providers should not use modifier 59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier 59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

Iowa Total Care uses the following guidelines to determine if modifier 59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated;
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately.

To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

MODIFIER 25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a “significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service”. Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify

reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

Iowa Total Care uses the following guidelines to determine whether or not modifier 25 was used appropriately.

If any one of the following conditions is met, then the clinical nurse reviewer will recommend reimbursement for the E/M service.

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition.
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed.
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services.
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member's need for additional services.
- To avoid incorrect denials providers should assign all applicable diagnosis codes that support additional E/M services.

INPATIENT FACILITY CLAIM EDITING

Potentially Preventable Readmissions Edit

This edit identifies readmissions (excluding planned readmissions) within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as thirty (30) days; however, this rule is highly customizable by state rules and provider contracts. For additional information, review Informational Letter 2386-MC-FFS at: **https://secureapp.dhs.state.ia.us/IMPA/Information/Bulletins.aspx**.

Payment and Coverage Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective audits. These policies are

posted on each health plan's provider portal when appropriate. These policies are highly customizable and may not be applicable to all health plans.

Claim Disputes Related to Code Auditing and Editing

Claims disputes resulting from claim-editing are handled per the provider claims dispute process outlined in this manual. When submitting a claim dispute, please submit medical records, invoices, and all related information to assist with the claim dispute review (reconsideration). Refer to the Provider Claims Dispute Process section within this manual.

If you disagree with a code audit or edit and request a claim reconsideration, you must submit medical documentation (medical record) related to the dispute. If medical documentation is not received, the original code audit or edit will be upheld.

VIEWING CLAIM CODING EDITS

Code Editing Assistant (Claims Audit Tool)

A web-based claims auditing reference tool designed to "mirror" how the code auditing product(s) evaluate code and code combinations during the auditing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking "Claim Auditing Tool" in our secure provider portal.

This tool offers many benefits:

- PROSPECTIVELY access the appropriate coding and supporting clinical edit clarifications for services BEFORE claims are submitted.
- PROACTIVELY determine the appropriate code/code combination representing the service for accurate billing purposes.

The tool will review what was entered, and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate.

The code editing assistant can be accessed from the provider web portal.

Disclaimer

This tool is used to apply coding logic **ONLY**. It will not take into account individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

"Lesser of" Language

Unless specifically contracted otherwise, Iowa Total Care's policy is to pay the lesser of billed charges and negotiated rate.

- Example 1 – Code 12345 – Billed $600. Negotiated Rate is $500. MCO pays $500 negotiated rate.
- Example 2 – Code 12345 – Billed $500. Negotiated Rate is $600. MCO pays $500 billed rate.

Certified Psychiatric and Rehabilitation Stays Billed with a Non-certified Unit Stay

When a member stay includes a stay in both the certified psychiatric or rehab units and a non-certified stay, the claims must be billed separately with a disposition of 30 indicated on the claim. This allows for the certified days to be paid at the per diem rate and the non-certified days at the DRG rate. The disposition of 30 indicates the member is still an active patient.

PAYMENT INTEGRITY

What is a Payment Integrity Program?

Payment Integrity Programs review claims with the intent of validating the appropriateness of the rendered services and payments made for those services. Iowa Total Care may contract the services of vendors with domain expertise to manage the review process for our payment integrity programs. These third parties utilize reviewers with varied experience from across the industry, including registered nurses, coding specialists, claims operations experts, network managers, quality experts, contract managers and more. These programs are in accordance with contracts that exists between you and the Health Plan.

Payment Integrity Program Process

Post-payment claims data is reviewed for payment accuracy by Iowa Total Care or third party vendors. Underpayments will be adjusted and paid via your typical payment method with an adjusted Explanation of Payment (EOP). Overpayments will be processed through notification of recovery/initial request.

Initial Request

Should medical records be required, payment integrity program vendors may request specific documentation. In the request, the vendor will specify the timeframe for the requested documentation along with instructions on how and where to send the information.

- If medical records are not required or the review of medical records received confirm payment inaccuracy, a notice of overpayment will be sent. Details of the findings will be provided for your review within the notification.
    - If you agree with the findings, direction will be included on how to make repayment or overpayments will be taken from future claim submissions.

- If you disagree with these findings, you will have the opportunity to appeal the results.

Appeal Process

A payment integrity program appeal is a request for reconsideration of the determination resulting from a claim payment accuracy review. All appeals relating to payment integrity programs must be submitted in writing and include all necessary documentation. Appeals must be sent directly to the vendor; submission instructions will be supplied in the determination letter. The appeal must be received within thirty (30) days from the date on the determination letter.

- All submitted appeals should include as much information as possible so Iowa Total Care or the third party vendor can understand why the reconsideration determination was in error.
- We will work to resolve all claim payment appeals within (thirty) 30 business days of receipt of all information.
- A determination letter from Iowa Total Care or the third party vendor will be issued detailing the appeal decision including statement of and reason for action taken.

If the final decision results in a claim adjustment, payment and EOP's will be sent to you.

PROVIDER CLAIM DISPUTE PROCESS

All requests for claim payment disputes/appeals must be submitted within 180 days (or as required by law or your participation agreement) from the date of the Explanation of Payment (EOP) or Provider Remittance Advice (PRA) utilizing the Provider Dispute/appeal Form (The paper Provider Dispute Form can be downloaded from **iowatotalcare.com**.

A **Claim Payment Dispute/First Level Appeal** is defined as a finalized claim in which the provider disagrees with the outcome. Claim payment disputes are submitted for numerous reasons, including, but not limited to:

- Contractual payment Issues.
- Reduced or Zero-Paid claims disagreements.
- Post-service authorizations.
- Claim code-editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.

  Note: Retro-eligibility issues for Behavioral Health, send a fax to 1-866-714-7991 with extenuating circumstances clearly documented along with clinical documentation for a retroactive medical necessity review and determination.
- Timely filing issues.
  - Iowa Total Care will consider reimbursement of a claim that has been denied due to meeting timely filing guidelines if provided documentation that the claim was submitted within the timely filing guidelines or can validate good cause.

Claim related issues that are ***NOT*** considered for claim disputes are as follows:

- Claim Inquiry - a question related to a claim but not requesting a change to the claim payment.
- Claim Correspondence - if Iowa Total Care requests further information to finalize a claim (i.e. medical records, itemized bills, or information about other insurance Member may have).
- Medical Necessity Appeals - a pre-service appeal for a denied prior authorization for which a claim has not yet been.

A determination will be issued on the provider's EOP indicating the reconsideration decision. If the determination indicated on the EOP indicates the decision was upheld the provider can submit a second level claim appeal within the thirty (30) days of the date of the EOP indicating the decision was upheld.

Claim Payment Second Level Appeal may be submitted by Provider if there is disagreement on the Dispute/First Level Appeal decision. The process is described as follows:

- Claim payment appeals are accepted in writing within thirty (30) calendar days from the date of EOP/PRA stating the decision was upheld.
- Any appeal submitted after the thirty (30) calendar days will be considered as untimely and denied unless good cause can be validated.
- All submitted appeals should include as much information as possible so Iowa Total Care can understand why the dispute/first level appeal determination was in error.
- Iowa Total Care will work to resolve all claim payment appeals within thirty (30) calendar days of receipt of all information.
- A determination letter from Iowa Total Care will be issued detailing the appeal decision including statement of and reason for action by Iowa Total Care.
- If final decision results in a claim adjustment, payment and EOP will be sent separately.

Important Information about Your Dispute Rights

Refer to the Provider Rights section of the ITC Provider Manual for details on your dispute rights. Disputes/Appeals should be submitted to:

Iowa Total Care
Attn: Claim Disputes
PO Box 8030,
Farmington, MO 63640-0830

Note: All Disputes/Appeals ***must be*** sent to the above address. Any Disputes/Appeals sent directly to the Iowa Total Care Des Moines office will be returned to the provider for resubmission to the above address.

Important Information about Overpayment Refund Checks

To ensure the payment is applied to the appropriate claim, claim information ***must be*** sent with the refund check. Overpayment refund checks should be submitted to:

Iowa Total Care, Inc.
PO Box 958092,
St. Louis, MO 63195-8092

OTHER RELEVANT BILLING INFORMATION

Interim Claims

Interim hospital encounters are allowed if the length of stay is greater than thirty (30) days. However; the second, third, fourth, and final interim encounters must be submitted as an adjustment to the original claim and must contain all dates of service from admission through the last service date. Only one interim claim is allowed, the remaining must be adjusted to the original claim.

HCBS Programs Billing Information

The Home and Community-Based Services (HCBS) programs are designed to meet the needs of Members who would be institutionalized without these services. The variety of services are designed to provide the most integrated means for maintaining overall health, socialization, independence, and community integration of those Members with the desire to live outside of an institution.

HCBS – Habilitation Services

The Medicaid Home and Community-Based Services Habilitation program provides service funding and individualized supports to maintain eligible members in their own homes or communities who require assistance due to functional limitations typically associated with chronic mental illness. Provision of these services must be cost effective. See the Iowa Medicaid's HCBS Habilitation Manual (**https://hhs.iowa.gov/sites/default/files/Habilitation.pdf**).

HCBS – Elderly Waiver

The Medicaid Home- and Community-Based Services Elderly Waiver (HCBS Elderly) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community-Based Services Provider Manual (**https://hhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840**).

HCBS – Physical Disability (PD) Waiver

The Medicaid Home and Community-Based Services Physical Disability Waiver (HCBS PD) provides service funding and individualized supports to maintain eligible persons in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community-Based Services Provider Manual (**https://hhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840**).

HCBS – Brain Injury Waiver

The Medicaid Home and Community-Based Services Brain Injury Waiver (HCBS BI) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community-Based Services Provider Manual (**https://hhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840**).

HCBS – Intellectual/Developmental Disabilities Waiver

The Medicaid Home and Community-Based Services Intellectual Disability Waiver (HCBS ID) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community-Based Services Provider Manual
(**https://hhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840**).

HCBS - AIDS/HIV (AH) Waiver

The Medicaid Home and Community-Based Services Acquired Immunodeficiency Syndrome/ Human Immunodeficiency Virus Waiver (HCBS AIDS/HIV) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community-Based Services Provider Manual
(**https://hhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840**).

HCBS - Children's Mental Health (CMH) Waiver

The intent of the Medicaid Home and Community-Based Services Children’s Mental Health Waiver (HCBS CMH) is to identify services and supports that are not available through other mental health programs and services that can be used in conjunction with traditional services to develop a comprehensive support system for children with serious emotional disturbance. These services will allow children in this targeted population to remain in their own homes and communities. Provision of these services must be cost effective. See the Home and Community-Based Services Provider Manual
(**https://hhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840**).

HCBS - Health and Disability (HD) Waiver

The Medicaid Home and Community-Based Services Health and Disability Waiver (HCBS HD) provides service funding and individualized supports to maintain eligible persons in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community-Based Services Provider Manual (**https://hhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840**).

Date Span Billing with Examples (Waivers)

- Span billing means you should bill for services over a range of dates within the same month. The number of units do not have to match the total number of days in the date span billed however the number of units cannot be greater than the number of days in date span. Examples of the correct way to bill with date spans are below:

  (Example – H2016 has a max of 31 units a month)

DATES OF SERVICE	PROCEDURE CODE	BILLED UNITS
1/1/22 – 1/31/22	H2016	31 units
1/1/22 – 1/5/22	H2016	5 units
1/1/22 – 1/1/22	H2016	1 unit
1/6/22 – 1/12/22	H2016	3 units
1/1/22 – 1/31/22	H2016	27 units

- You must bill within the same calendar month, and you cannot overlap any given calendar month, e.g., 01/15/22 through 02/10/22 – this would be two claims, one for January and one for February.
- Residential Services (H2016) – Residential Supports H2016 – allows thirty-one (31) days maximum per calendar month. Residential Services should not be billed on the same claim with Day Supports.
- Day and Residential Services must be billed as separate claims.

Integrated Health Home (IHH)

Integrated Health Home (IHH) may be billed by participating providers one time per month per member (PMPM) with a correlating informational code indicating the level of services provided. Claims that are submitted without these informational codes will be denied. For the most current guidance visit Iowa Department of Health and Human Services (Iowa HHS) Informational Letters repository at:
https://secureapp.dhs.state.ia.us/IMPA/Information/Bulletins.aspx.

Obstetrical and Gynecological Billing Guidelines

The global obstetric (OB) code should be billed whenever one practitioner or practitioners of the same group provide all components of the patient's obstetrical care, including; four (4) or more antepartum visits, delivery and postpartum care. The number of antepartum visits may vary from

patient to patient, however, if global OB care (more than three (3) antepartum visits, delivery and postpartum care) is provided, ALL pregnancy related visits (excluding inpatient hospital visits for complications of pregnancy) should be billed under the global OB code. Individual E/M codes should NOT be billed to report pregnancy related E/M visits.

Source:

hhs.iowa.gov/programs/welcome-iowa-medicaid/policies-rules-and-regulations/covered-services-rates-and-payments

FQHC/RHC

- FQHC and RHC providers are reimbursed at the Benefits Improvement and Protection Act of 2000 (BIPA) rate or the interim rate if a BIPA rate has not been determined.
- Bill with correct place of service (50 – FQHC; 72–HC).
- Bill with appropriate encounter codes and CPT Codes.
- Bill with the group NPI in box 24J or leave the box blank.

Hospice

- Hospice providers billing services for Members residing in a Skilled Nursing Facility, nursing facility or intermediate care facility for persons with an intellectual disability. Providers must bill Rev Code 658 on the UB-04.
- The nursing facility or intermediate care facility NPI is required in box 77 on the UB-04 claim form.

Date Span Billing – When billing for hospice room and board services, bill consecutive hospice days on one claim line. If there is a gap in the room and board days bill the next date span on line 2 of the claim not to overlap months.

Hospitals

- For all hospitals, outpatient procedures (including, but not limited to, surgery, X- rays, and EKGs) provided within three (3) days of a hospital admission for the same or similar diagnosis are considered content of service and must be billed on the same inpatient hospital claim. The outpatient procedure date should be changed on the claim to correspond with the actual hospital admission date. There is one exception to this policy—complications from outpatient sterilization resulting in an inpatient admission.

In this instance, the outpatient charges and the inpatient charges should be billed on two separate claims. This is necessary in order for the service dates on the claim form to match the service dates on the Sterilization Consent Form.

- For all hospitals, the appropriate CPT/HCPCS codes are required to be billed for each service reported.
- Hospitals billing for lifeline services must use the correct NPI on the claim submission to avoid processing delays or denials.

- Certified psychiatric or certified rehabilitation days billed in the same stay as a non-certified stay must be billed on separate claims with disposition 30.

Immunization/Vaccines/Injections

- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered.
- In field 24D, enter the injection code, strength, and dosage.

Interim Billing

- When interim billing, be sure to enter the appropriate Type of Bill code (e.g., 112, 113, 114). A Patient Status code of 30 (still a patient) must use the appropriate Type of Bill code (e.g., 112, 113, 114). A Patient Status code of 30 (still a patient) must be indicated when Type of Bill is 112 or 113.

Modifiers

- Modifiers mirror the IME Procedure Code Modifier Listing.
    - **hhs.iowa.gov/programs/welcome-iowa-medicaid/policies-rules-and-regulations/covered-services-rates-and-payments/fee-schedules**
- GN, GO, GP Modifiers – therapy modifiers required for speech, occupational and physical therapy.

Newborn Billing

- Providers should not bill claims until the newborn is issued a Medicaid State ID. EDI will reject these claims upfront.
- Newborn services are considered procedure codes that specifically state “newborn” in the code description according to the CPT® manual or revenue codes 170–179. These services must be billed with a newborn diagnosis code in order to receive payment.

NDC Requirements

- Iowa Total Care has mirrored the NDC requirements that the State of Iowa has in place. All drugs must be billed with an NDC that indicates that the drug is eligible for a rebate.

Nursing Facility (NF/ICF/Bed Hold)

- Nursing facility (NF) and intermediate care facility (ICF) providers must bill using the UB-04 claim form.
- Intermediate care facilities should bill with Type of Bill 65X or 66X.
- Nursing Facilities should bill with Type of Bill 21X or 22X.
- Date Span Billing – When billing for hospice room and board services, bill consecutive hospice days on one claim line. If there is a gap in the room and board days bill the next date span on line 2 of the claim not to overlap months.

Room and board is not billable by the nursing facility when a Member elects hospice benefits. The hospice provider bills for the room and board.

Observation Room

- Code G0378 should be used to bill for outpatient services. This code replaces 99218ET.
- Observation room should not be billed for the following:
    - Recovery room services following inpatient or outpatient surgery
    - Recovery/observation following scheduled diagnostic tests such as arteriograms, cardiac catheterization, etc.
- Medical supplies and injections (99070, J7030-J7130) are considered content of service of the observation room services.

Out of Network Providers

If Iowa Total Care is unable to provide medically necessary covered services to a particular Member using contract providers, Iowa Total Care shall adequately and timely cover these services using non-contract providers.

- Out-of-network providers shall be reimbursed at 80% of the rate of reimbursement to in-network providers.
- Provider will not bill Members for all or any part of the cost of treatment, except as allowed for Title XIX cost sharing and patient liability.

POA Indicator

- All claims involving inpatient admissions to general acute care hospitals will require submission of present on admission (POA) indicator(s). POA is defined as present at the time the order for inpatient admission occurs– conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The POA indicator is assigned to principal and secondary or other diagnoses and the external cause of injury codes. The validity of the POA indicator will be audited, and claims are subject to denial when the POA indicator is invalid. The hospital will need to supply the correct POA indicator(s) and resubmit the claim. A POA indicator for the external cause of injury code is not required unless it is being reported as an “other diagnosis” on the UB-04.
- Definitions:
    - Y (for yes): Present at the time of inpatient admission.
    - N (for no): Not present at the time of inpatient admission.
    - U (for unknown): The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
    - W (for clinically undetermined): The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.
    - Exempt from POA reporting: 5010 claim billing an exempt diagnosis code, leave the POA indicator field blank.
    - The ICD10-CM Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting.

Professional Fees

- The only physician services that can be billed by the hospital on the UB-04 claim form are those provided by hospital-based physicians assigned to the emergency department.

Prosthetic and Orthotic

- Hospitals must enroll as prosthetic and orthotic (P&O) providers and bill on the professional claim form (CMS-1500) or 837 professional transaction when providing these services.
- Prosthetic and orthotic items cannot be billed as ancillary services on the UB-04 claim form.
    - Exception: Prosthesis implanted by a surgical procedure may be billed on the hospital claim form for inpatient services.

Readmissions

- When an Iowa Medicaid member is discharged prematurely and subsequently readmitted within thirty (30) days with the same DRG or similar diagnosis at the same hospital, only the DRG payment for the first stay will be reimbursed (excluding planned readmissions). Critical Access Hospitals are not subject to this policy.
- If the discharging and readmitting hospitals are not the same, only the readmitting hospital will be reimbursed.

Swing Bed Nursing Facility

- The appropriate revenue code applicable to the patient's level of care must be entered.
- Room and board must be billed on a UB-04 claim form.
- Bill the total number of days (units).
- Indicate the total charges for the number of days billed.
- Ancillary charges cannot be billed on the Swing Bed NF facility claim. They must be billed on another UB-04 claim form with an outpatient type of bill.
- Claims must include both revenue codes and HCPCS codes.

Behavioral Health and Substance Abuse Services

Behavioral Health and Substance Abuse services may be billed by Community Mental Health Centers and other Behavioral Health Service Providers. More information can be found on the web site at: **https://hhs.iowa.gov/policy-manuals/medicaid-provider**.

Applied Behavioral Analysis (ABA)

- Iowa Total Care covers ABA services for members with a diagnosis of Autism Spectrum Disorder. These services focus on increasing positive behaviors and decreasing negative or interfering behaviors in order to develop well-defined skills.

Behavioral Health Intervention Services (BHIS)

- Refer to HHS Informational Letter 2431-MC-FFS for coding and further details. Providers may also reference the **Behavioral Health Intervention Services**

(BHIS) provider manual for additional details. These services apply to members in the Iowa Health Link program only.

- Iowa Total Care covers services for Members with a psychological disorder, and who have a need for intervention services related to their disorder. These services are supportive, directive, and teach interventions. They are provided in a community-based or residential group care environment, and are designed to improve the individual's level of functioning as it relates to a mental health diagnosis. The primary goal is to assist the member and their family to learn age-appropriate skills to manage their behavior.

B-3 and Substance Abuse Services

Refer to Iowa HHS Informational Letter [2348-MC] for coding and further details. B-3 Mental Health and Substance Abuse Services.

- Iowa Total Care covers the following B-3 services for Mental Health and Substance Abuse disorders:
  - Intensive Psychiatric Rehabilitation.
  - Community Support.
  - Peer Support.
  - Residential Substance Abuse Treatment.
  - Integrated Services and Supports (including wrap around services).
  - Respite.
  - Level III.1 Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Abuse.
  - Level III.3 and III.5 Clinically Managed Medium /High Intensity Residential Treatment Substance Abuse.
  - Level III.3 and 5 Clinically Managed Medium /High Intensity Residential Treatment Substance Abuse Hospital Based.
  - Level III.7 Substance Abuse Residential Community-Based.
- For descriptions of services, Provider Type/Qualifications and codes, refer to the B-3 Mental Health and Substance Abuse Services document on the web site at: **https://secureapp.dhs.state.ia.us/IMPA/Information/Bulletins.aspx**

837 COMPANION GUIDE (OCTOBER 2016)

Refers to the Implementation Guides based on the HIPAA Transaction ASC X12N. Standards for Electronic Data Interchange X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). Approved by IDPH.

Overview

The Companion Guide provides Iowa Total Care trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P) and ASC

X12N/005010x223 Health Care Claim: Institutional (837I). The Iowa Total Care Companion Guide documents any assumptions, conventions, or data issues that may be specific to Iowa Total Care business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Iowa Total Care and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Iowa Total Care. This document provides information on Iowa Total Care-specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at **http://store.x12.org**.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Iowa Total Care and its trading partners. Refer to the TPA for guidelines pertaining to Iowa Total Care legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Iowa Total Care business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.

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Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Iowa Total Care.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (TA1,999). A TA1 Acknowledgment is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgment may be used to verify a successful transmission or to indicate various types of errors.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgment

The TA1 Interchange Acknowledgment provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgment

The 999 Functional Acknowledgment reports on all Implementation Guide edits from the Functional Group and transaction Sets.

277CA Health Care Claim Acknowledgment

The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Iowa Total Care also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop.

Note: The STC03 – Action Code will only be a "U" if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Iowa Total Care checks five values within the ISA for redundancy:

- ISA06, ISA08, ISA09, ISA10, ISA13.

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of "025" (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Iowa Total Care checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Note: ISA08 & GS03 could also be the Single Payor ID.

New Trading Partners

New trading partners should access **https://sites.edifecs.com/index.jsp?centene**, to register for access, and perform the steps in the Iowa Total Care trading partner program. The EDI Support Desk (**EDIBA@Centene.com**) will contact you with additional steps necessary upon completing your registration.

Acknowledgments

Senders receive four types of Acknowledgment transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE), the 277CA transaction to acknowledge health care claims, and the Iowa Total Care Audit Report. At the claim level of a transaction, the only Acknowledgment of receipt is the return of the Claim Audit Report and/or a 277CA.

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, Iowa Total Care recommends that providers validate the patient's Membership Number and supplementary or primary carrier information for every claim.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals

The 837 defines what values submitters must use to signal payors that the Inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3.

Data Format/Content

Iowa Total Care accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for "CC" (century) within birthdates are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use Military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010, at 9:15 p.m.
- No spaces or character delimiters should be used in presenting dates or times.

- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after the patient's service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values

Iowa Total Care accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by Iowa Total Care are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation.

Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Iowa Total Care requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Iowa Total Care will not accept more than 97 service lines per UB-04 claim.
- Iowa Total Care will not accept more than 50 service lines per CMS 1500 claim.
- Iowa Total Care will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300- REF02) is limited to 30 characters.

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Iowa Total Care sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Iowa Total Care expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Iowa Total Care will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Iowa Total Care EDI.

Payor Identifier

Single Payor IDs are used for all Health Plans. Please verify directly with the Health Plan and/or Clearinghouse the Payor ID that should be used or contact the EDI Support Desk at 1-800-2252573, x6075525 or **EDIBA@centene.com**.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing Provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than Loop 2310B/NM1*82.

Referring Provider

Iowa Total Care has no specific requirements for Referring Provider information.

Atypical Provider

Atypical providers are not always assigned an NPI number, however, if an Atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical

provider. An Atypical provider which provides non-medical services is not required to have an NPI number (i.e. carpenters, transportation, etc.). Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop.
Note: *If an NPI is billed in any part of the claim, it will not follow the Atypical Provider Logic.*

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber's card in the 2010BA element.

Claim Identifiers

Iowa Total Care issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. Iowa Total Care returns the submitter's Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Iowa Total Care encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Iowa Total Care offers two options for connectivity via FTP.

- Method A – the trading partner will push transactions to the Iowa Total Care FTP server and Iowa Total Care will push outbound transactions to the Iowa Total Care FTP server.
- Method B – The Trading partner will push transactions to the Iowa Total Care FTP server and Iowa Total Care will push outbound transactions to the trading partner's FTP server.

Encryption

Iowa Total Care offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS.

Note: this method only applies with connecting to Iowa Total Care's Secure FTP. Iowa Total Care does not support retrieve files automatically via HTTPS from an external source at this time.

If PGP or SSH keys are used they will shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.

Direct Submission
Iowa Total Care also offers posting an 837 batch file directly on the Provider Portal website for processing.

APPENDIX

APPENDIX I: COMMON HIPAA COMPLIANT EDI REJECTION CODES

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

ERROR_ID	ERROR_DESC
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS;Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS;Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date.
37	Invalid or future date.
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag

39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006
75	Invalid Unit
76	Original claim number required
77	INVALID CLAIM TYPE
81	Invalid Unit;Invalid Prv
83	Invalid Unit;Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
92	Missing or Invalid Provider NPI at any Level.
95	Operating/Purchasing provider information invalid or missing
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
A7	Invalid or Missing Ambulance Point of Pick Up Zip Code
AX	Invalid/missing/duplicate occurrence code
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim

B3	RENDERING OR BILLING NPI/TIN ON DOS NOT ENROLLED WITH STATE
B5	Missing/incomplete/invalid CLIA certification number
C4	Invalid COBA Member
C9	Attending Provider Required
CA	Dates of service cannot span two calendar months, please resubmit
CE	Invalid Billing Provider NPI
CF	Invalid Billing Provider Taxonomy Code
CG	Invalid Billing Provider Zip
CH	Rendering NPI/TIN on DOS not enrolled with state
CI	NPI IS REQUIRED FOR THIS PAYOR
CJ	ACK/REJECT Info Entitys Medicaid Provider Id
D2	BILLING PROVIDER NOT REGISTERED PROMISe PROVIDER
D3	RENDERING PROVIDER NOT REGISTERED PROMISe PROVIDER
D4	ATTENDING PROVIDER NOT REGISTERED PROMISe PROVIDER
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
NE	Missing or Invalid Provider NPI at any Level.
R2	Payor ID Number Invalid for DOS
ZZ	Claim not processed

APPENDIX II: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

CMS-1500 (2/12) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (2/12) form field 24A-G:

- Narrative description of unspecified/miscellaneous/unlisted codes.
- National Drug Codes (NDC) for drugs.
- Contract Rate.

The following qualifiers are to be used when reporting these services.

- ZZ Narrative description of unspecified/miscellaneous/unlisted codes
- N4 National Drug Codes (NDC)
- CTR Contract Rate

The following qualifiers are to be used when reporting NDC units:

- F2 International Unit
- GR Gram
- ML Milliliter
- UN Unit

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (ex. 1000.00; 123.45).

APPENDIX III: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION

Unspecified/Miscellaneous/Unlisted Codes

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached									
								NPI	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker							N	G2	12345678901
10 01 05 10 01 05	11		E1399	12	165 00	1	N	NPI	0123456789

NDC Codes

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1							N	G2	12345678901
10 01 05 10 01 05	11		J0400	1	250 00	40	N	NPI	0123456789

Instructions for Entering the NDC

(Use the guidelines noted below for all claim types including WebPortal submission)

CMS requires the 11-digit National Drug Code (NDC), therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which can be found on the vial of medication. The NDC must include the NDC Unit of Measure and NDC quantity/units.

When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug.

837I/837P		
Data Element	**Loop**	**Segment/Element**
NDC	2410	LIN03
Unit of Measure	2410	CTP05-01
Unit Price	2410	CTP03
Quantity	2410	CTP04

For Electronic submissions, this is highly recommended and will enhance claim reporting/adjudication processes, report in the LIN segment of Loop ID-2410.

Paper Claim Type	**Field**
CMS 1500 (02/12)	24 A (shaded claim line)
UB04	43

Facility

Paper, use Form Locator 43 of the CMS1450 and UB04 (with the corresponding HCPCS code in Locator 44) for Outpatient and Facility Dialysis Revenue Codes 250 – 259 and 634 -636.

Physician

Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size.

If you are given an NDC that is less than 11 digits, add the missing digits as follows:

- For a 4-4-2 digit number, add a 0 to the beginning.
- For a 5-3-2 digit number, add a 0 as the sixth digit.
- For a 5-4-1 digit number, add a 0 as the tenth digit.

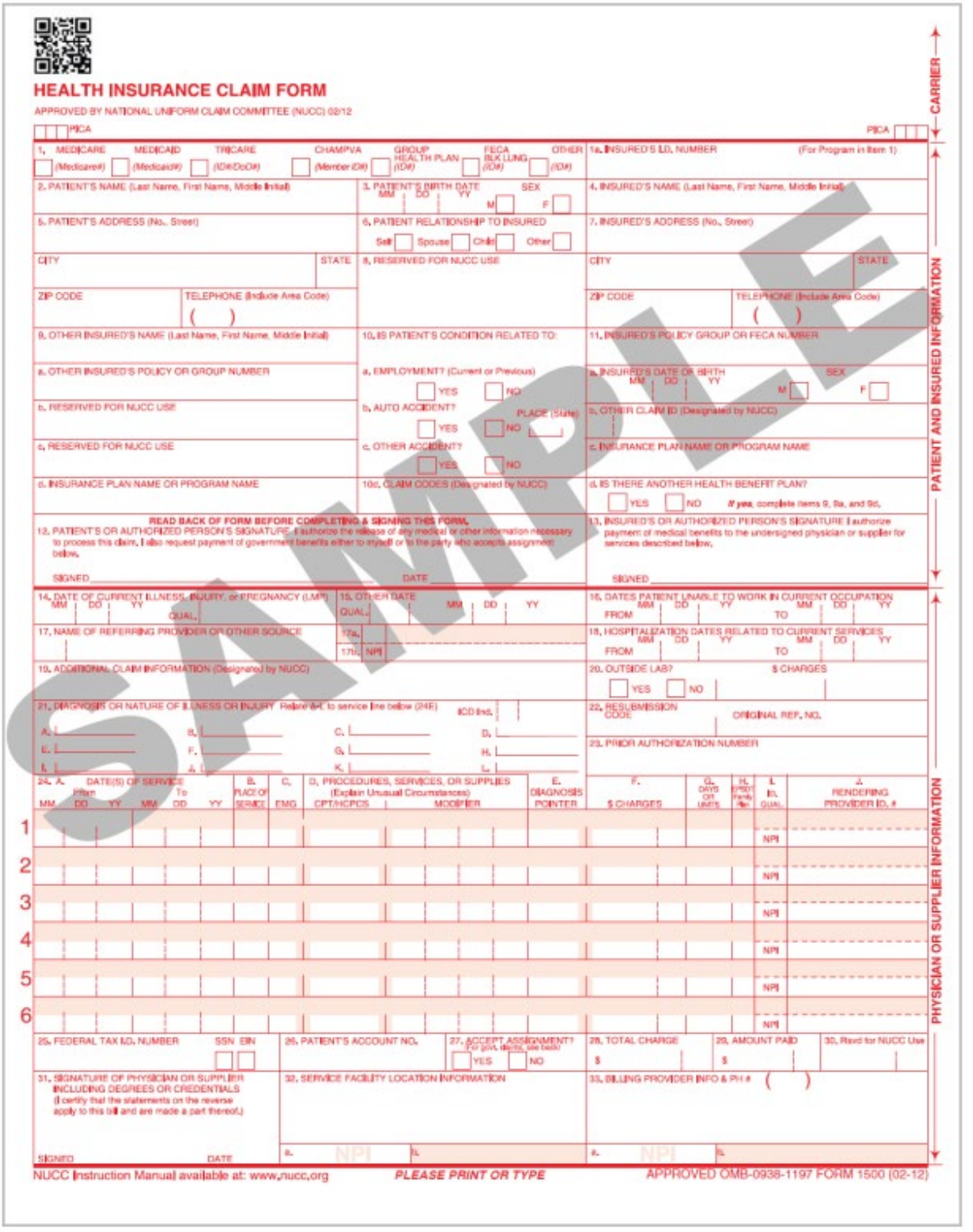
Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:

- F2 - International Unit.
- GR -Gram.
- ML – Milliliter.
- ME – Milligram.
- UN – Unit.

NDC billing information shall comply with Medicaid FFS billing requirements including, but not limited to, inclusion of the NDC for rebate and 340B purposes. The 340B billing guidelines and other guidelines can be found in Informational Letters posted on the Iowa HHS website.

APPENDIX IV: CLAIMS FORM INSTRUCTIONS CMS 1500

CMS 1500 (2/12) Claim Form Instructions



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

Note: Claims with missing or invalid Required (R) field information will be rejected or denied.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATIO N	Check only the type of health coverage applicable to the claim. This field indicated the payor to whom the claim is being field. Enter “X” in the box noted “Other.”	R
1a	INSURED’S I.D. NUMBER	The 9-digit identification number on the member’s Health Plan I.D. Card.	R
2	PATIENTS NAME (Last Name, First Name, Middle Initial)	Enter the patient’s name as it appears on the member’s Health Plan I.D. card. Do not use nicknames.	R
3	PATIENT’S BIRTH DATE/SEX	Enter the patient’s 8 digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient’s sex/gender. M= Male F= Female	R
4	INSURED’S NAME	Enter the patient’s name as it appears on the member’s Health Plan I.D. Card.	C
5	PATIENT’S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		telephone number (i.e. (803)5551414). ***Note:*** Does not exist in the electronic 837P.	
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). ***Note:*** Does not exist in the electronic 837P.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the	C

Field #	Field Description	Instruction or Comments	Required or Conditional
	FECA NUMBER	other insurance. If Item Number 10abc is marked Y, this field should be populated.	
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM DD YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payor.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY	Enter the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual	C

Field #	Field Description	Instruction or Comments	Required or Conditional
	(Accident) OR Pregnancy (LMP)	period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness. 484 Last Menstrual Period.	
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C

Field #	Field Description	Instruction or Comments	Required or Conditional
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Services requiring a diagnosis for payment (example: Emergent Diagnosis, DRG and IHAWP sleep apnea claims), the diagnosis must be in the primary diagnosis position. ***Note:*** Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim (Corrected Claim)8 – Void/Cancel Prior Claim.	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)

Field #	Field Description	Instruction or Comments	Required or Conditional
24a-j General Information	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a-g is for line item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. If you are a FQHC/RHC/Indian Health Center, Chapter 24 provider or have an atypical NPI, leave box 24J blank or use your billing NPI in this box. The un-shaded area of a claim line is for the entry of claim line item detail.		
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC. Narrative description of unspecified codes. Contract Rate. For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM□DD□YYYY). If there is only one date, enter that date in the “From” field. The “To” field may be left blank or populated with the “From” date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R
24B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24 F Unshaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24 G	DAYS OR	Enter quantity (days, visits, units). If only one	R

Field #	Field Description	Instruction or Comments	Required or Conditional
Unshaded	UNITS	service provided, enter a numeric value of one.	
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy. Use 1D qualifier for ID, if an Atypical Provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	<u>Typical Providers:</u> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. <u>Atypical Providers:</u> Enter the Provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider’s 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN.	R
26	PATIENT’S ACCOUNT NO.	Enter the provider’s billing account number.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
27	ACCEPT ASSIGNMENT?	Enter a X in the YES box. Submission of a claim for reimbursement of services provided to a Health Plan Member using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payor. Enter the payment received from the primary payor prior to invoicing the Health Plan. Medicaid programs are always the payors of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payor). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. ***Note:*** Does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	c

Field #	Field Description	Instruction or Comments	Required or Conditional
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D (no spaces).	C
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). ***Note:*** The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	R
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

APPENDIX V – CLAIMS FORM INSTRUCTIONS – UB

UB-04/CMS 1450 (2/12) Claim Form Instructions

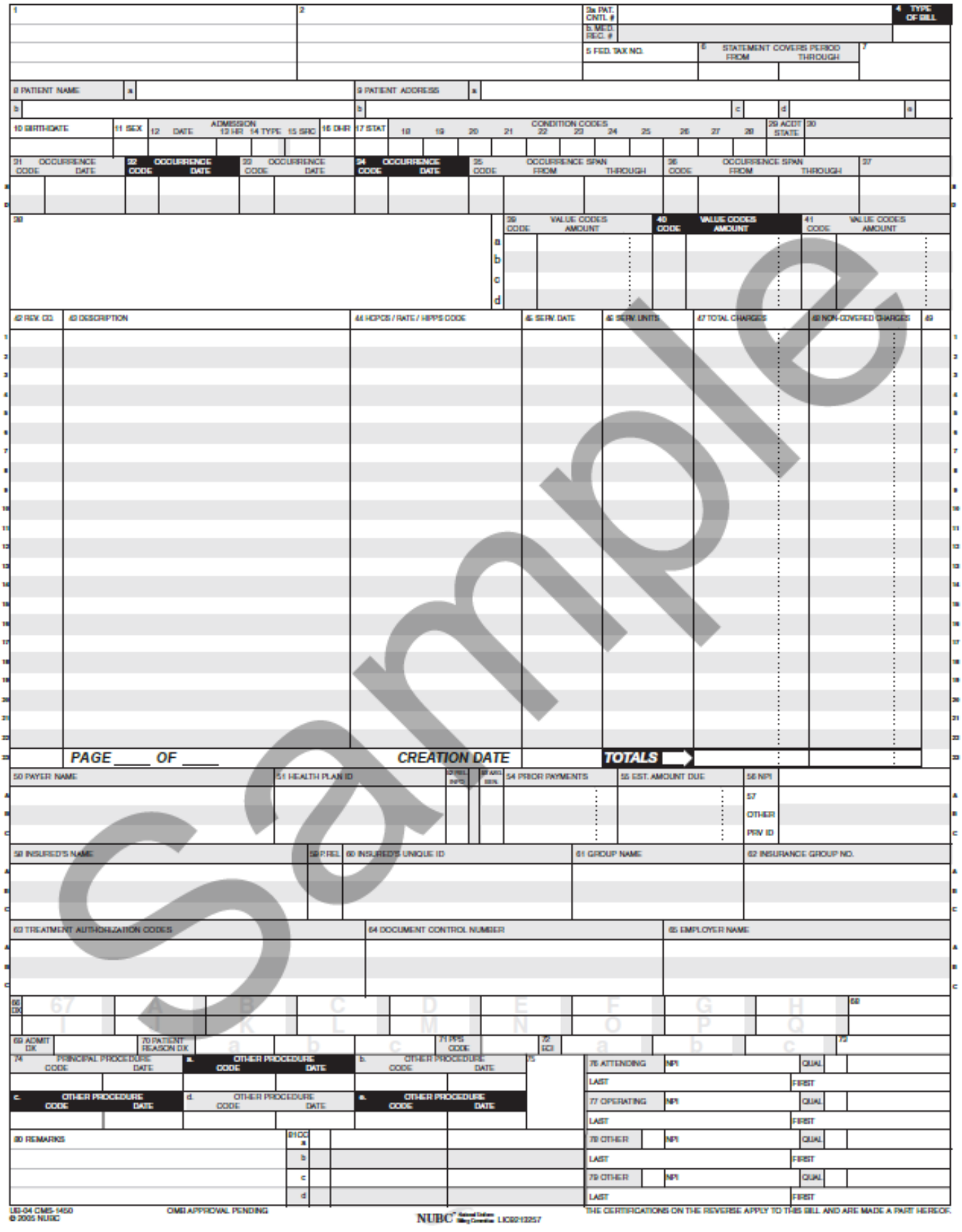
Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Iowa Total Care. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.
- Please refer to your provider contract with Iowa Total Care or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
ADMISSION 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX
a b c
71 PPS CODE
72 ECI
a b c
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC
a
b
c
d
UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC0213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Required Fields

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	UNLABELED FIELD	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). Note: The 9 digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	UNLABELED FIELD	Enter the Pay- to Name and Address.	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code). 7 = Corrected Claims Submission, 8= Void	R
5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not used.	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
8a-8b	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the enrollee's Health Plan I.D. card.	Not Required
		8b – Enter the patient's last name, first name, and middle initial as it appears on the Health Plan ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g. McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address of the patient.	R
9	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY).	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
13	ADMISSION HOUR	0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02- 02:00 to 02:59 14-02:00 to 02:59 03- 03:00 to 03:39 15-03:00 to 03:59 04- 04:00 to 04:59 16-04:00 to 04:59 05- 05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R
14	ADMISSION TYPE	Require for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: Physician Referral 1 Clinic Referral 2 Health Maintenance Referral (HMO) 3 Transfer from a hospital 4 Transfer from Skilled Nursing Facility 5 Transfer from another health care facility 6 Emergency Room	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		7 Court/Law Enforcement 8 Information not available For Type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	
16	DISCHARGE HOUR	Enter the time using 2 digit military times (00-23) for the time of the inpatient or outpatient discharge. 0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 -03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	C
17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2 digit disposition of the patient as of the “through” date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payor processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
30	UNLABELED FIELD	NOT USED	Not required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payor processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payor processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
37	(UNLABELED FIELD)	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payor processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: **REQUIRED** when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of	C

Field #	Field Description	Instruction or Comments	Required or Conditional
Line 23		pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e. PAGE “1” OF “1”). (Limited to 4 pages per claim)	
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims.	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least “1” must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used.	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
50 A-C	PAYOR	Enter the name of each Payor from which reimbursement is being sought in the order of the Payor liability. Line A refers to the primary payor; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN IDENTIFCATI O N NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payor directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payor on the appropriate line when Medicaid is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHI P		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATI ON CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting the Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of “7” (Replacement of Prior Claim) or Type of Bill. Frequency of “8” (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Services requiring a diagnosis for payment (example: Emergent Diagnosis, IHAWP sleep apnea claims), the diagnosis must be in the principal diagnosis position.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" and most “V” codes are **NOT** acceptable as a primary diagnosis. ***Note:*** Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" codes	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		and most “V” are **NOT** acceptable as a primary diagnosis. ***Note:*** Claims with missing or invalid diagnosis codes will be denied.	
70	PATIENT REASON CODE	Enter the ICD-9/10-CM Code that reflects the patient’s reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or“5”. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis. ***Note:*** Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	UNLABLED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-9/ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	UNLABLED		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Hospice Providers billing for room and board (revenue code 658) can use box 77 for the nursing facility NPI (required). Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider. ZZ – Other Operating MD. 82 – Rendering Provider. NPI: Enter the other physician 10-character NPI ID.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		QUAL: Enter one of the following qualifier and ID number: 0B - State license number. 1G - Provider UPIN number. G2 - Provider commercial number.	
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R

APPENDIX VI – ORIGIN AND DESTINATION MODIFIERS FOR TRANSPORTATION

Origin and Destination Modifiers for Ambulance Transportation

Origin and Destination Modifiers	
The first place alpha code is the origin; the second place alpha code is the destination.	
Mod	Description.
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes.
E	Residential, domiciliary, custodial facility (other than 1819 facility).
G	Hospital-based dialysis facility (hospital or hospital related).
H	Hospital.
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport.
J	Non-hospital based dialysis facility.
N	Skilled nursing facility (SNF) (1819 facility).
P	Physician's office (includes HMO non-hospital facility, clinic, etc.).
R	Residence.
S	Scene of accident or acute event.

Based on the modifiers noted above:

The following are all of the valid combinations for the first modifier fields:

DN	RD	IH	EN	SI	ND	HE
EH	RN	JN	GN	DH	NN	HN
GE	DD	NH	HI	EE	RH	JE
HG	DR	RE	IN	ER	I I	NE
HR	EJ	SH	JR	GR	DJ	NR
JH	GH	DG	NJ	HJ	EG	RJ
NG	HH	ED	RG	JD	GD	

For a repeat trip - Modifier 59 (Follow up Service) is used in the second modifier position to indicate a repeat trip for the same member on the same day.