iowa total care™

Iowa Health Link
Iowa HHS

Hawki
Iowa HHS

Provider Manual

IowaTotalCare.com

Rev. 08/2024
I-SS-OP-P-1992

Iowa Total Care HealthPlan Contacts

Appeals/Grievances/Complaints

Phone: 1-833-404-1061 (TTY: 711)
FAX: 1-833-809-3868
Website: iowatotalcare.com/providers/resources/grievance-process.html
Email: appealsgrievances@iowatotalcare.com
Hours: Mon. – Fri., 8 a.m. to 5 p.m., CT

Care Coordination – Medical/LTSS/Waiver

Phone: 1-833-404-1061 (TTY: 711)
Website: iowatotalcare.com/providers/resources/integrated-care.html
Email: care_management@iowatotalcare.com
Hours: Mon. – Fri., 8 a.m. to 5 p.m., CT

Claim Payments, Disputes, & Refunds

Claim Inquiries

Phone: 1-833-404-1061 (TTY: 711)
1-833-765-8507 (Duals)
1-833-222-4832 (Foster Care)

Claim Disputes

Iowa Total Care
TTN: Claims Dept.
P.O. Box 8030
Farmington, MO 63640-8030

Payments – EFT and ERA Services

Mailing Address: Iowa Total Care
1080 Jordan Creek Pkwy, Suite 400 South
West Des Moines, IA 50266
Website: Provider Portal - Provider.iowatotalcare.com
Hours: Mon. - Fri., 7:30 a.m. to 6 p.m. CT

Provider Claim Refunds to Iowa Total Care

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

Provider Claim Refunds Overnight

US Bank
ATTN: 958092
3180 Rider Trail S.
Earth City, MO 63045

Clinical Quality Consultant

Phone: 1-833-404-1061 (TTY: 711)
FAX: 1-833-338-0240
Website: Quality-improvement/Clinical-Quality-Consultant
Territory Map: Clinical Quality Consultant Territory Map

Contracting

Phone: 1-833-404-1061 (TTY: 711)
FAX: 1-833-208-1397
Website: Contracting and Credentialing
Email: networkmanagement@iowatotalcare.com
Hours: Mon. – Fri., 8 a.m. to 5 p.m. CT

Credentialing and Recredentialing

Phone: 1-833-404-1061 (TTY: 711)
FAX: 1-833-208-1397
Website: Contracting and Credentialing
Email: networkmanagement@iowatotalcare.com
Hours: Mon. – Fri., 8 a.m. to 5 p.m. CT

Electronic Claims Submission

Mailing Address: Iowa Total Care
c/o Centene EDI Department
Payor ID: 68069
Phone: 1-800-225-2573, ext. 6075525
Website: sites.edifecs.com/index.jsp?centene
(New Trading Partner Registration)
Email: EDIBA@Centene.com

Fraud and Abuse for Providers

Mailing Address: Iowa Total Care
ATTN: Special Investigations Unit
1080 Jordan Creek Pkwy, Suite 400 South
West Des Moines, IA 50266
Phone: 1-866-685-8664
Email: Special_Investigations_Unit@centene.com

Hospital/Facility Admissions

Phone: 1-833-404-1061 (TTY: 711)
FAX: 1-833-257-8327
Hours: Mon. – Fri., 8 a.m. to 5 p.m.

Member Eligibility

Phone: 1-833-404-1061 (TTY: 711)
Website: iowatotalcare.com/providers/login.html
Hours: Mon. - Fri., 7:30 a.m. to 6 p.m. CT

Pharmacy – Point-of-Sale Only

Phone: 1-833-404-1061 (TTY: 711)
1-833-750-4405 (Point-of-Sale Billing Issues)
Website: iowatotalcare.com/providers/pharmacy.html
Hours: Mon. – Fri., 8 a.m. to 5 p.m. CT

Emergency 72-Hour Supply

Phone: 1-833-587-2012
Hours: 24 Hours a Day, 7 Days a Week

QUICK REFERENCE GUIDE

Iowa Total Care HealthPlan Contacts (continued)

Prior Authorizations	
Behavioral Health – Outpatient & Concurrent	
Phone:	1-833-404-1061 (TTY: 711)
FAX:	1-844-908-1170
Behavioral Health – Inpatient & Concurrent	
Phone:	1-833-404-1061 (TTY: 711)
FAX:	1-844-908-1169
Behavioral Health - Retroactive Review	
Phone:	1-833-404-1061 (TTY: 711)
FAX:	1-866-714-7991
Medical Prior Authorizations	
Phone:	1-833-404-1061 (TTY: 711)
FAX:	1-833-257-8327
Website:	Preauth Check Tool
Hours:	Mon. - Fri., 7:30 a.m. to 6 p.m. CT
Medical - Concurrent Review	
Phone:	1-833-404-1061 (TTY: 711)
FAX:	1-833-257-8327
Medical - Retroactive Review	
Phone:	1-833-404-1061 (TTY: 711)
FAX:	1-833-257-8327
Pharmacy Services – Providers & Point-of-Sale	
Phone:	1-866-399-0928
FAX:	1-833-404-2392
Website:	Covermymeds Prior Authorization Forms
Hours:	Mon. - Fri., 8 a.m. to 5 p.m. CT
Pharmacy Services for Medical – Buy & Bill	
Phone:	1-833-404-1061 (TTY: 711)
FAX:	1-833-711-0485
Pharmacy Services for Pharmacies (PBM)	
Phone:	Refer to number provided on the claim response or call 1-833-750-4405

Provider Relations/Provider Services	
Phone:	1-833-404-1061 (TTY: 711)
FAX:	1-833-208-1397
Territory Map Link:	Refer to the Territory Map for your Provider Relations Specialists contact information.
Email:	ProviderRelations@iowatotalcare.com
Website:	Provider Portal - Provider.iowatotalcare.com
Hours:	Mon. – Fri., 7:30 a.m. to 6 p.m. CT

Your Life Iowa - 24/7 Behavioral Health Resource	
Phone:	1-855-581-8111
FAX:	1-855-895-8398
Website:	yourlifeiowa.org
Hours:	24 Hours a Day / 7 Days a Week

Vendor Partners

Access2Care – Schedule a Ride

Phone: 1-877-271-4819

CareBridge – Electronic Visit Verification (EVV)

CareBridge Contact Information

Phone: 1-844-343-3653 (CareBridge Health)
Website: carebridgehealth.zendesk.com
Email: iaevv@carebridgehealth.com
Hours: Mon. - Fri., 7 a.m. to 5 p.m. CT

Iowa Total Care EVV Contact Information

Phone: 1-833-404-1061 (Iowa Total Care)
Website: iowatotalcare.com/providers/electronic-visit-verification.html
Email: itc_evv@IowaTotalCare.com
Hours: Hours: Mon. - Fri., 7:30 a.m. to 6 p.m. CT

Envolve Vision

Provider Services

Phone: 1-833-564-1205
FAX: 1-866-614-4951
Website: envolvevision.com
Email: envolvevision.com/contact-us.html
Hours: Mon. - Fri., 7 a.m. to 7 p.m. CT

Utilization Management - Prior Authorization Requests

Phone: 1-800-465-6972
FAX: 1-877-865-1077
Website: visionbenefits.envolvehealth.com/gencontact.html (Refer to Utilization Management Contact Details)
visionbenefits.envolvehealth.com/UM_contact.aspx (web form used to send emails)
Hours: Mon. - Fri., 8 a.m. to 5 p.m. CT

Evolent (Imaging, Cardiac, IPM, PT, OT, & ST)

Phone: 1-866-493-9441 (Prior Authorizations)
1-800-327-0641 (Tech Support & IPM Program)
1-800-450-7281 Ext. 31042 (Education)
FAX: 1-800-784-6864
Website: RadMD.com
Email: RadMDSupport@Evolent.com
Hours: Mon. - Fri., 7 a.m. to 7 p.m. CT

Interpretation Services

Language Access Services

Phone: 1-833-404-1061 (TTY: 711)

Iowa Relay Services (Relay Iowa)

Phone: TTY: 711
1-800-735-2942 (ASCII)
1-800-735-2943 (Voice)
1-800-264-7190 (Spanish)
1-877-735-1007 (Speech-to-Speech - STS)
1-800-855-8440 (Visually Assisted Speech-to-Speech – VA STS)
Website: hamiltonrelay.com/iowa
Email: iarelay@hamiltonrelay.com
Hours: 24 x 7, 365 Days a year

Nurse Advice Line (Available 24 x 7)

Phone: 1-833-404-1061 (TTY: 711)

Payspan

Phone: 1-877-331-7154, option 1 – Providers
Website: Payspan.com
Email: ProviderSupport@payspanhealth.com
Hours: Mon. – Fri., 7 a.m. to 7 p.m. CT

Teladoc (Telehealth Services)

Non-Emergency Issues

Phone: 1-800-835-2362
Website: Teladoc.com
Hours: 24 Hours a Day, 7 Days a Week

Behavioral Health Telehealth Support – 18+

Phone: 1-800-835-2362
Website: Teladoc.com
Hours: 7 Days a Week, 7 a.m. to 9 p.m. CT

State Contacts

Iowa Medicaid Member Services

Phone: 1-800-338-8366 (Toll Free)
1-515-256-4606 (Des Moines Area)
1-800-735-2942 (Relay Iowa TTY: for deaf, hard-of-hearing, deaf-blind, or for those who have difficulty speaking.)
FAX: 1-515-725-1351
Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/member-services
Email: IMEMemberServices@dhs.state.ia.us
Hours: Mon. - Fri., 8 a.m. to 5 p.m. CT
Mailing Address: Iowa Medicaid – Member Services
P.O. Box 36510
Des Moines, IA 50315

Iowa Medicaid Member Services

Phone: 1-800-338-7909 (Toll Free)
1-515-256-4609 (Des Moines Area)
FAX: 1-515-725-1155
Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services
Email: IMEProviderServices@dhs.state.ia.us
Hours: Mon. - Fri., 8 a.m. to 5 p.m. CT
Mailing Address: Iowa Medicaid Enterprise
P.O. Box 36450
Des Moines, IA 50315

Ombudsman

Managed Care Ombudsman

Phone: 1-866-236-1430 (Toll Free)
FAX: 1-515-242-6007 (Des Moines Area)
Email: ManagedCareOmbudsman@iowa.gov

State Ombudsman

Phone: 1-888-426-6283 (Toll Free)
1-515-281-3592 (Des Moines Area)
FAX: 1-515-242-6007
Website: ombudsman.iowa.gov
Hours: ombudsman@legis.iowa.gov

Reporting Suspected Child/Dependent Adult Abuse

Phone: 1-800-362-2178
Hours: 24 Hours a Day, 7 Days a Week

Contents

PURPOSE AND MISSION STATEMENT

Transform the health of the community, one person at a time.

About Us

Iowa Total Care is a Managed Care Organization (MCO) health plan contracted with the Iowa Department of Health and Human Services (Iowa HHS) to serve Medicaid members enrolled in Iowa Health Link, the Iowa Health and Wellness Plan (IHAWP), 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 **Manuals, Forms and Resources page**.

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 Quick Reference section of this manual.

ENROLLMENT AND COVERED BENEFITS

Iowa Total Care serves Medicaid members enrolled in the Hawki, IHAWP, and Iowa Health Link Medicaid programs. While all three are Medicaid, they do have different benefits associated with each type. In the following section, we will outline services available to all Medicaid members and those benefits that are more specifically available only as part of certain Medicaid programs. Please note that these benefits are subject to change based on the guidance of Iowa Medicaid. Always remember to request an authorization, if required.

Enrollment in Medicaid

Iowa Medicaid has the exclusive right to determine an individual's eligibility for Medicaid programs. Members determined eligible for Medicaid programs will be enrolled with Iowa Total Care either by the member's choice or by assignment by Iowa Medicaid. When a member is enrolled with Iowa Total Care, we provide welcome packets, member handbooks, and other educational materials to help members understand their coverage and available services in the language of their choice or in alternate formats such as: large print, braille, and audio. The following section will describe the benefits specific to each Medicaid program.

Most members who get health coverage under Iowa Medicaid are enrolled in the Iowa Health Link managed care program. The IHAWP program provides health coverage at low or no cost to Iowans between the ages of 19 and 64.

The Children's Health Insurance Program (CHIP) is offered through the Hawki program. Hawki 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. 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 Provider Services number at **1-833-404-1061 (TTY: 711)** 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 number at **1-833-404-1061 (TTY: 711)**. 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 body mass index (BMI) assessment. To view this list, log into the Secure Provider Web Portal.
- 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 the most up to date member eligibility available to Iowa Total Care on the date of service.
- 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 (TTY: 711)**.

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 Iowa Medicaid ID card (pictured below) to receive benefits that are not covered by Iowa Total Care.

Iowa Medicaid Card

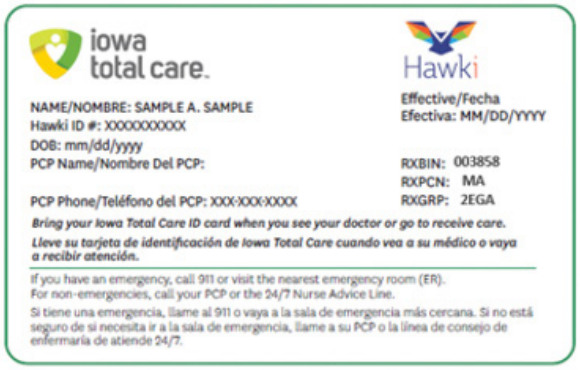
All members receive a *Medical Assistance Eligibility Card* (form 470-1911).

- Members should keep their card until they receive a new one.
- Members should carry their card with them and not let anyone else use it.
- Members should show their card to their provider every time they receive care.
- Members should call Iowa Medicaid Member Services at 1-800-338-8366 (TTY: 711) if they lose their Medicaid Card.

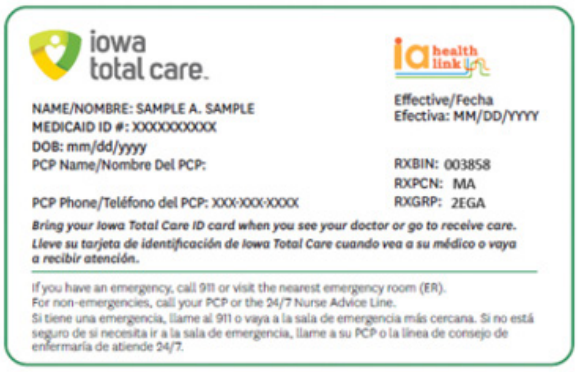
Iowa Medicaid ID Card Example

Iowa Total Care Member ID Card

Hawki ID Front



Iowa Health Link ID Front



Hawki ID Back

Iowa Health Link ID Back

MEMBER BENEFITS

The below benefits are available to Iowa Total Care members. The benefits members receive will depend on the type of Medicaid coverage the members qualify for. Please note these benefits are subject to change based on policy updates made by Iowa HHS and prior authorization may be required. Additional information may be found in the Iowa Administrative Code 441.78 AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL SERVICES.

Hawki

Enrollment Information: Hawki (CHIP) covers children of working families under the age of 19 who exceed income limits to qualify for Medicaid but cannot afford private health insurance and are not enrolled in other health insurance.

Iowa Health and Wellness (IHAWP)

Enrollment Information: The Iowa Health and Wellness Plan covers individuals between the ages of 19 and 64 that are not eligible for other Medicaid coverage groups, pregnant, are not entitled to or enrolled in Medicare and whose countable income does not exceed 133% of the federal poverty level for their household size. Dependent children of IHAWP members are covered by essential health benefits.

Iowa Health and Wellness Medically Exempt (IHAWP Medically Exempt)

Enrollment Information: The Medically Exempt program provides medical coverage to people who are pregnant, under age 21, caretaker relatives, aged, blind, or disabled, and would qualify for Medicaid programs, other than the Iowa Health and Wellness Plan, except they have too much income/resources or they have higher incomes but have unusually high medical expenses.

Iowa Health Link Traditional Medicaid

Enrollment Information: Members who are aged 65 or older, disabled, blind, families with dependent children, pregnant women, children (up to age 21), children formerly in foster care (up to age 26), adults ages 19 to 64 and individuals with breast and/or cervical cancer or precancerous conditions. Eligibility is based on financial and non-financial criteria such as income, assets, citizenship, Iowa residency, immigration status, and disability.

Member Benefit Grid

Service	**HAWKI** Children's Health Insurance Program (CHIP)	**Iowa Health & Wellness Plan- IHAWP**	**Iowa Health & Wellness Plan – IHAWP - Medically Exempt**	**Iowa Health Link** Traditional Medicaid
Behavioral Health Services				
(b)(3) Services (Intensive Psychiatric Rehabilitation, Community Support Services, Peer Support, and Residential Substance Use Treatment		✔	✔	✔
Assertive Community Treatment (ACT)		✔	✔	✔
Behavioral Health Intervention Services (BHIS)		✔	✔	✔
Crisis Response and Subacute Mental Health Services	✔	✔	✔	✔
Inpatient Mental Health and Substance Abuse Treatment	✔	✔	✔	✔

Service	HAWKI Children's Health Insurance Program (CHIP)	Iowa Health & Wellness Plan- IHAWP	Iowa Health & Wellness Plan – IHAWP - Medically Exempt	Iowa Health Link Traditional Medicaid
Behavioral Health Services				
Office Visit	✓	✓	✓	✓
Outpatient Mental Health and Substance Abuse	✓	✓	✓	✓
Psychiatric Medical Institutions for Children (PMIC)	✓	✓	✓	✓
Durable Medical Equipment (DME)				
Breast Pumps	✓	✓	✓	✓
Diabetes Equipment & Supplies	✓	✓	✓	✓
Hearing Aids	✓	✓	✓	✓
Medical Equipment and Supplies	✓	✓	✓	✓
Orthotics	✓	✓	✓	✓
Emergency Care				
Ambulance	✓	✓	✓	✓
Hospital Emergency Room	✓ $25 Copay may exist	✓ $8 Copay may exist	✓ $8 Copay may exist	✓ $3 Copay may exist
Urgent Care Center	✓	✓	✓	✓
Home Health				
Home Health Services · Home Health Aide · Occupational Therapy (OT) · Physical Therapy (PT)	✓	✓	✓	✓
Private Duty Nursing/Personal Care per EPSDT Authority		✓ Up to age 21	✓ Up to age 21	✓ Up to age 21
Hospice				
Daily Categories · Continuous · Facility Respite · Inpatient Hospital · Room & Board · Routine Care	✓	✓	✓	✓

Service	HAWKI Children's Health Insurance Program (CHIP)	Iowa Health & Wellness Plan- IHAWP	Iowa Health & Wellness Plan – IHAWP - Medically Exempt	Iowa Health Link Traditional Medicaid
Hospital Services				
Inpatient Hospital Services				
Bariatric Surgery for Morbid Obesity	✓	✓	✓	✓
Breast construction, following breast cancer and mastectomy	✓	✓	✓	✓
Inpatient Hospital Services: · Physician services (includes anesthesia) · Room and Board · Supplies · Surgery	✓	✓	✓	✓
Organ/Bone Marrow Transplants, limitations apply.	✓	✓	✓	✓
Preapproval of Inpatient Admissions, required for non-emergent admissions.	✓	✓	✓	✓
Outpatient Hospital Services				
Abortions, certain circumstances must apply. Contact Member Services for coverage criteria. *Prior authorization required.*	✓	✓	✓	✓
Ambulatory Surgical Center, including anesthesia.	✓	✓	✓	✓
Chemotherapy	✓	✓	✓	✓
Dental Treatment that cannot be completed in a normal dental setting.	✓	✓	✓	✓
Dialysis	✓	✓	✓	✓
Outpatient Diagnostic Lab, Radiology	✓	✓	✓	✓
Laboratory Services				
Colorectal Cancer Screening	✓	✓	✓	✓
Diagnostic Genetic Testing	✓	✓	✓	✓
Pap Smears	✓	✓	✓	✓
Pathology Tests	✓	✓	✓	✓
Routine Laboratory Screening and Diagnostic Services	✓	✓	✓	✓
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) Testing	✓	✓	✓	✓

Service	HAWKI Children's Health Insurance Program (CHIP)	Iowa Health & Wellness Plan- IHAWP	Iowa Health & Wellness Plan – IHAWP - Medically Exempt	Iowa Health Link Traditional Medicaid
Long-term Services and Support (LTSS)				
Community-Based Services				
Case Management HCBS Waiver and HCBS Habilitation Populations Only				✓
Child Care Medical Services				✓
Integrated Health Homes			✓	✓
Section 1915(i) Habilitation Services			✓	✓
Section 1915(C) Home and Community-Based Services (HCBS)				✓
Institutional Services				
Community-Based Neurobehavioral Rehabilitation Services			✓	✓
ICF/MC (Intermediate Care Facility for Medically Complex)				✓
ICF/ID (Intermediate Care Facility for Individuals with Intellectual Disabilities)				✓
Nursing Facility (NF)			✓	✓
Nursing Facility for the Mentally Ill (NF/MI)			✓	✓
Skilled Nursing Facility (SNF)		✓ Limited to 120 days.	✓ Limited to 120 days.	✓
Skilled Nursing Facility Out of State (Skilled Preapproval)				✓
Outpatient Therapy Services – Prior authorization may be required for these services				
Cardiac Rehabilitation	✓	✓	✓	✓
Occupational Therapy	✓	✓	✓	✓
Oxygen Therapy	✓	✓	✓	✓
Physical Therapy	✓	✓	✓	✓
Pulmonary Therapy	✓	✓	✓	✓
Respiratory Therapy	✓	✓	✓	✓
Speech Therapy	✓	✓	✓	✓
Pharmacy Services				
Medical Pharmacy Benefits – Limitations may apply for these services				
Medical Supplies	✓	✓	✓	✓
Vaccines	✓	✓	✓	✓
Nicotine Cessation	✓	✓	✓	✓

Service	HAWKI Children's Health Insurance Program (CHIP)	Iowa Health & Wellness Plan- IHAWP	Iowa Health & Wellness Plan – IHAWP - Medically Exempt	Iowa Health Link Traditional Medicaid
Medical Pharmacy Benefits – Limitations may apply for these services				
Naloxone	✓	✓	✓	✓
Test & Treat (I.e., Flu, Covid, etc.)	✓	✓	✓	✓
Point-of-Sale (POS) Pharmacy Benefits				
Pharmacy POS Drugs Based on State PDL*	✓	✓	✓	✓
Preventative Services				
Affordable Care Act (ACA) Preventative Services	✓	✓	✓	✓
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)		✓ Up to age 21	✓ Up to age 21	✓
Immunizations	✓	✓	✓	✓
Routine Check-ups	✓	✓	✓	✓
Professional Office Services				
Allergy Serum and Injections	✓	✓	✓	✓
Allergy Testing	✓	✓	✓	✓
Certified Nurse Midwife Services	✓	✓	✓	✓
Chiropractor, limitations may apply.	✓	✓	✓	✓
Contraceptive Devices	✓	✓	✓	✓
Diabetic Self-Management Training	✓	✓	✓	✓
Family Planning and Family Planning Related Services	✓	✓	✓	✓
Gynecological Exam	✓	✓	✓	✓
Injections, limitations may apply.	✓	✓	✓	✓
Laboratory Tests	✓	✓	✓	✓
Newborn Child Office Visits	✓	✓	✓	✓
Podiatry	✓	✓	✓	✓
Routine Eye Exam *One routine vision exam per calendar year.*	✓	✓	✓	✓
Routine Hearing Exam, limit of one routine hearing exam per calendar year.	✓	✓	✓	✓
Specialist Office Visit, PCP referral may be required.	✓	✓	✓	✓

Service	HAWKI Children's Health Insurance Program (CHIP)	Iowa Health & Wellness Plan- IHAWP	Iowa Health & Wellness Plan – IHAWP - Medically Exempt	Iowa Health Link Traditional Medicaid
Radiology Services				
Mammography	✓	✓	✓	✓
Routine Radiology Screening and Diagnostic Services	✓	✓	✓	✓
Sleep Study Testing	✓	✓	✓	✓
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.			✓	✓
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.				✓ When Case Managers write additional transportation benefits into the member's service plan based on need.
Vision Benefits				
Eyewear**	✓	✓	✓	✓
Eyewear Repairs***	✓	✓	✓	✓
Routine Eye Exams****	✓	✓	✓	✓
For coverage questions, please call Envolve Vision at 1-833-564-1205.				

* Point-of-Sale (POS) claims must be submitted to the Pharmacy benefit manager (PBM).

** Eyewear claims must be submitted to Envolve Vision. Limitations may apply.

*** Eyewear repair claims must be submitted to Envolve Vision. Limitations may apply.

**** Routine eye exam claims must be submitted to Envolve Vision, including all Optometrist eye exams.

Ophthalmologists may submit non-routine vision exam claims to Iowa Total Care. More information is available in the Billing section of this manual.

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: Iowa Medicaid Provider Manuals.

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 to develop well-defined skills.
- Claims being billed for ABA therapy must have a primary diagnosis of Autism Spectrum Disorder.

Behavioral Health Intervention Services (BHIS)

- Refer to Iowa 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.

Pharmacy Services

Point of Sale

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. Please visit Iowa Total Care's Pharmacy page for a link to the state's current PDL and prior authorization 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. Medications requiring prior authorization 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 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, some over the counter drugs and to physician-administered drugs. It is expected that providers will follow the guidance on appropriate billing, as given in Iowa HHS 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.

New Food and Drug Administration (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.

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.

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.

Pharmacies supplying compounded prescriptions must be contracted with Iowa Total Care's current PBM.

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 is always the payer of last resort meaning that if a member has other insurance, the other insurance must always be billed as primary. If the primary insurance is a commercial insurer, Medicaid benefits may cover the remaining portion, after the primary insurance has paid, up to the Medicaid allowable. 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, number of 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.

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 do 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 do 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, 7 days a week.

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

Pharmacy 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 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 31-day supply. Some contraceptives can be filled up to a 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.

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 prior authorization review for medically necessary treatments. If the drug has an age limit and is being requested for a member that does not meet those requirements, a prior authorization will be required.

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 Iowa Total Care's Pharmacy page.

Medical Pharmacy

Pharmacies and pharmacists are allowed to bill medical claims for services like vaccines. Some pharmacists are also able to perform point-of-care testing if they are certified per Iowa Medicaid guidelines. These services must be billed directly to Iowa Total Care and not through the PBM. To provide these services to Iowa Total Care members, the pharmacy and/or pharmacist must be enrolled with Iowa Medicaid but do not have to be credentialed with Iowa Total Care unlike pharmacies that supply Medical Supplies.

Pharmacies that provide medical supplies must be enrolled with Iowa Medicaid and credentialed with Iowa Total Care as a Medical Supply Dealer. There may be some medical supplies that Iowa Medicaid considers a medical benefit while other insurances consider them a pharmacy benefit. Even when Iowa Total Care is secondary to a primary payer, these claims must be submitted as a medical claim. Additional information on submitting medical claims can be found in the Billing section of this manual.

MEMBER 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 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.

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 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.
- Race, ethnicity, language, and sexual orientation and gender identity (REL SOGI) information.
    - Iowa Total Care keeps REL SOGI data private. Ways we protect data:
        - Keeping papers in locked areas.
        - Keeping electronic data behind locked doors.
        - Keeping electronic data password protected.
- We may use REL SOGI data for our work. Our work may include:
    - Checking for healthcare unfairness.
    - Planning actions to improve disparities.
    - Creating member materials.
    - Updating providers about member language needs.
- We will never use your REL SOGI data:
    - To gain business.
    - To make decisions about healthcare coverage.
    - Or give REL SOGI data to anyone without approval.
- Checking for healthcare unfairness.
- Planning actions to improve disparities.
- Creating member materials.
- Updating providers about member language needs.

Member Responsibilities

Iowa Total Care members are responsible for ensuring their personal information is accurate and up to date, including contact information such as their telephone number and address. Members are required to contact Iowa Medicaid if their family size changes, they move out of state or they get or have health coverage under another policy, other third party, or there are changes to that coverage. Additional information on member responsibilities can be found in the Iowa Total Care Member Manual located on the Iowa Total Care website.

Client Participation

Client participation is the percentage of income the member must pay before Medicaid reimbursement for services is available. Iowa HHS determines member liability amounts. 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.

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 written Notice of Decision that a member has client participation and amount the provider needs to request from the member for their share of the cost of their services.

Cost Sharing (Copayment)

Some Iowa Total Care members are subject to a copayment for non-emergent emergency department (ED) visits (see Emergency Care Copayments below). Member copayments are capped at 5% of household income and may be collected incrementally at the time of service based on the member's eligibility type. The copayment for each non-emergent emergency department visit is as follows:

- Hawki - $25 per visit.
- IHAWP (including Medically Exempt) - $8 per visit*.
- Traditional Medicaid - $3 per visit*.

Copayment shall not be imposed on Hawki members whose family income is less than 181% of the federal poverty level or Iowa Health and Wellness Plan Enrolled Members whose family income is at or below 50% of the federal poverty level. Before providing non-emergency services and imposing copayments, 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 copayment 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 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 ED, the hospital will assess the copayment. Emergency services rendered for emergent conditions are exempt from any copayment.

*Medicaid members under the age of 21, pregnant women, American Indians, Alaskan Natives, and Family Planning Waiver will not be charged a copay for any services.

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Responsibilities

Iowa Total Care members have the right to privacy of their health information. Iowa Total Care's privacy policy assures that all members are afforded the privacy rights permitted under the Health Insurance Portability and Accountability Act (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 protected health information (PHI), as well as the 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.

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 foregoing treatment, and 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 based on 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.

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 member's 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.
- Accommodating the request would place excessive demands on us or our time and resources and is contrary to HIPAA.

Iowa Total Care Provider Responsibilities:

- Treat members with fairness, dignity, and respect.
- Not discriminate against members based on 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, if they understand 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 Healthcare Effectiveness and Information Set (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.
- Not object to providing relevant or medically necessary services based on 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 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 12 months or more.
    - Have been discharged from an inpatient stay within the last 24 hours since notification.
    - Have a gap-in-care overdue by 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 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 epidemiologists in partnership with the designated county or municipal health department staffs to appropriately communicate reportable conditions.

Health Equity & Cultural Competency in Healthcare

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 and 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. The concepts of cultural competence and patient-centered care intersect in meaningful ways.

Patient-centered care is defined as "providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions". It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to healthcare 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.

"Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare." Persons in racial and ethnic minority groups were found to receive lower-quality healthcare than whites received, even when they were insured to the same degree and when other healthcare access-related factors, such as the ability to pay for care, were the same. Clients in minority groups were also not getting their needs met in mental health treatment.

Patient-centered care has the potential to enhance equity in health care delivery. Indicators of culturally sensitive healthcare identified in focus groups of low-income African American, Latino American, and European American primary care patients included interpersonal skills, individualized treatment, effective communication, and technical competence. The U.S. Office of Minority Health has set national standards for culturally and linguistically appropriate healthcare services. The principal standard is that healthcare must "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Cultural competence, cultural humility, and patient-centered care are all concepts that endeavor to detail essential components of a healthcare system that is sensitive to patient diversity, individual choice, and doctor–patient connection. A culturally competent healthcare workforce highlights five components: cultural awareness, knowledge, skill, desire, and encounters. Cultural humility focuses on identifying one's own implicit biases, self-understanding, and interpersonal sensitivity and cultivating an appreciation for the multifaceted components of each individual (culture, gender, sexual identity, race and ethnicity, religion, lifestyle, etc.), which promotes patient-centered approaches to treatment. The new concept of **competemility** is the synergistic combination of cultural competence with cultural humility. Healthcare professionals need both process (cultural humility) and product (cultural competence) to interact effectively with culturally diverse patients.

Establishing a collaborative mutual partnership with diverse patients requires an open, self-reflective, other-centered approach to understanding and formulating the patients' strengths and difficulties and co-constructing the treatment plan. 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 sensitively to the ways the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care.

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. Services include over the phone, in person, video remote interpretation (VRI) and translation options.

To obtain language services, members and providers must contact the Iowa Total Care Member Services Department at **1-833-404-1061 (TTY: 711)** or complete the interpreter online request form. 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 member Language Services page.
- Visit our provider Language Services page for the following information:
  - The Provider Language Access Services Request Form for additional guidance on how to access interpretation services.
  - The Interpretation Services Poster, a tool created to help identify a member's language and avoid delaying medical attention.
  - Access to best practices when working with an interpreter.
- The member has the right to file a complaint or grievance if linguistic needs are not met.

Health Equity & Cultural Competency Program Provider Requirements

- Inform members of their right to access free, qualified medical interpreters and signers, accessible transportation, and TDD/TTY services.
- Facilitate members' 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 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 healthcare.

- 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).

Cultural Competency Training and Education

Iowa Total Care provides health equity and cultural competency related educational opportunities for providers on our provider Language Services page.

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

- 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.
- Think Cultural Health's website includes classes, guides, and tools to assist you in providing culturally competent care.
- Iowa Total Care has developed a Health Literacy Cultural Competency Flyer found on our Manuals, Forms and Resources page.

Visit our Provider Trainings and Webinars page for instructions on how to create an account for additional trainings offered through Centene Institute for Advanced Health Education including:

- Cultural Humility and Unconscious Bias in Healthcare.
- Health Equity Essentials: Fundamentals for Transforming Health.
- Person-Centered Thinking for Providers-Podcast Series.
- Facilitating Treatment Adherence for Patients and their Families.

Americans with Disabilities Act

The Provider Accessibility Initiative (PAI) is committed to providing equal access to quality healthcare 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 the 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.
    - Non-disabled: a person who does not have a disability.
- 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.

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 annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

Appointment Availability Requirements:

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Primary Care Providers	**Timeframe**
Non-Urgent Sick Visits (w/persistent symptoms)	Within 48 hours.
Routine Appointments	Not to exceed 4 to 6 weeks.
Specialists	**Timeframe**
Specialty Providers – Urgent	Within 24 hours.
Specialty Providers – Routine	Within 30 days.
Hospitals – Emergency	24 hours a day, seven 7 days a week.
Behavioral Health – Emergency	Immediately upon presentation, 24 hours a day, 7 days a week.
Behavioral Health – Mobile Crisis	Within 1 hour of presentation or request.
Behavioral Health – Urgent	Within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or Iowa Total Care.
Behavioral Health – Persistent Symptoms	Within 48 hours of reporting symptoms.
Behavioral Health – Follow-up Appt or Routine	Within 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 48 hours of seeking treatment.
Intravenous Drug Use	Admitted no later than 14 days after making the request for admission, or 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 48 hours after such request.
Labs and X-Ray Services – Non-Urgent	Not to exceed 3 weeks.
Labs and X-Ray Services – Urgent	Within 48 hours.
General Optometry – Routine	Not to exceed 3 weeks.
General Optometry – Urgent	Within 48 hours.

Access Policies:

- 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 guarantee 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:

Providers that serve Iowa Total Care members are required by law to provide disabled persons full and equal access to medical services. The general prohibitions against discrimination described in 28 CFR Part 35 and apply to providers that see Iowa Total Care members. For more information about ADA laws, regulations and standards, refer to these resources available online at https://www.ada.gov.

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 Line at 1-800-362-2178, available 24 hours a day, 7 days a week. For more information, visit Iowa HHS's **Child Protective Services page**.

To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call the Abuse Line at 1-800-362-2178, available 24 hours a day, 7 days a week. For more information, visit Iowa HHS's **Adult Protective Services page**.

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 decisions about their medical care.

Iowa Total Care is committed to ensuring that members are aware of and can obtain 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.

You cannot condition the delivery of care or otherwise discriminate against a member based on whether or not they have 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 supports. 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 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 attempts to contact the member. 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.

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 (PA).

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 at **1-833-404-1061 (TTY: 711)**. 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 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 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 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 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 sees an unassigned PCP and the PCP is within the same TIN as their previously assigned PCP, the member will not be reassigned. Members will be able to see the practitioners within that practice. 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.

Members reassigned in this way will receive a new ID card with the updated PCP name and 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 preventative 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 limited English proficiency (LEP).
- 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 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.
- 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.

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 consultation reports and other appropriate records within 5 business days.
- Be available for or provide on-call coverage through another source 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 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 department services.
- Notify the Iowa Total Care Medical Management department by sending an electronic file of the ER admission within 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 1 business day.
- Notify the Iowa Total Care Medical Management department of all newborn deliveries within 2 business days of the delivery.
- Allow Iowa Total Care direct access (not via vendor) to medical records for data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.

LONG-TERM SERVICES & SUPPORTS (LTSS) PROVIDER ROLE

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 for leading and overseeing 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). As of July 1, 2023, providers must report major incidents by direct entry into Iowa Medicaid Portal Access (IMPA). For additional information, refer to Iowa HHS Informational Letter 2480.

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 written 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 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 addendum 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 based on member needs.

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 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 30 days from the date of the notice.

INCENTIVE PROGRAMS FOR PROVIDERS

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs have emerged as a promising strategy to improve quality care, reduce health risks, and improve cost effectiveness. Iowa Total Care's P4P programs promote efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, National Committee for Quality Assurance (NCQA), and National Quality Forum (NQF).

The provider-member relationship is a key component in fostering good health and satisfaction among your patients, our members. Quality care is at the heart of this relationship and Iowa Total Care is pleased to offer several financial incentive programs to PCPs, OBGYN, specialists (BH, medical and community-based) such as HEDIS measure-based incentive programs that reward the superior care you provide members throughout the year.

Iowa Total Care evaluates opportunities to expand incentive programs on an ongoing basis for the potential to incorporate other elements and which include elements demonstrating performance on continuous quality improvement and health equity goals. More information on our incentive programs can be obtained by contacting your Iowa Total Care Clinical Quality Consultant (CQC) by phone at **1-833-404-1061 (TTY: 711)**, fax 1-833-338-0240, or by referring to the CQC Territory Map.

PROVIDER NETWORK

Providers performing physical health, behavioral health, or pharmacy services can become Iowa Total Care providers by working with our contracting/credentialing teams.

Contracting

Benefits of Contracting with Iowa Total Care

Iowa Total Care accepts claims from all providers registered with Iowa Medicaid regardless of whether the provider has a contract with Iowa Total Care however, contracted providers receive additional benefits not available to those providers that choose not to contract with Iowa Total Care. These benefits include:

- A dedicated contract manager.
- A dedicated provider relations representative.
- Reduced administrative burden (Example: fewer prior authorization requirements).
- Higher contracted rates rather than 80% of Iowa Medicaid for non-participating providers*.
- Access to the online provider portal tool.
- Ability to participate in financial incentive programs for providers.
- Faster turnaround time for claims payments.

*Emergency department services do not require prior authorization and do not have a reduction in payment for not participating with Iowa Total Care.

Contracting Process

Physical and Behavioral Health Contracting

Providers who are seeking to join the Iowa Total Care network should follow the process listed below:

- Visit the Become a Provider webpage.
- Select Complete the online Contract Request Form:
  - Fill in all required fields.
  - Attach your W-9 Form by selecting Choose File and browsing to your electronic copy. A new W-9 Form is available here, if needed: W-9 Form.
  - Complete the form in its entirety and click **Submit**.
- Providers may choose to submit a new Contract Request via email or fax by completing the Contract Request Form.
  - Submit the completed Contract Request Form, W-9, and Roster form, if applicable, to the Iowa Total Care Network Development and Contracting team either by fax at 1-833-208-1397 or via email to: NetworkMangement@IowaTotalCare.com.
- Questions or requests for assistance may be sent to: NetworkManagement@IowaTotalCare.com or call Provider Services at **1-833-404-1061 (TTY: 711)** to be connected to a local representative.
- Providers who are already contracted and need to modify their agreement, add or remove a service location, or have a change in ownership (CHOW) can initiate the change process by:
  - Email: NetworkManagement@IowaTotalCare.com,
  - Phone: Provider Services at **1-833-404-1061 (TTY: 711)**,
  - Online: Complete and submit the Provider Change Form, or
  - Contact your provider relations representative.
- Upon receipt of the request to contract with us, a contract manager will review the request and validate enrollment with the Iowa Medicaid program.
  - The contract manager will reach out to the provider who submitted the request to discuss the additional documents needed for the contracting and credentialing process.
- A provider agreement will be drafted, based on the provider type from the Iowa Medicaid enrollment and sent to the provider for review and electronic signature.
- Once the signed contract is returned, contracting will review and countersign the agreement, assign an effective date, and provide a fully executed copy to the provider.
- The credentialing process begins.
  - Providers and practitioners may have different credentialing requirements.

Pharmacy – Contracting

Pharmacies providing Point of Sale services, pharmacies providing durable medical equipment, vaccines, or other medical supplies, and Pharmacists providing vaccines, nicotine replacement, Naloxone, and test & treat services, must be enrolled with Iowa Medicaid at: Iowa Medicaid Provider Enrollment.

NOTE: There is no separate contract requirement for Pharmacists to dispense drugs from a contracted pharmacy.

Pharmacy - Point of Sale Billing

Point of Sale pharmacies must join the Pharmacy Network with Express Scripts, in addition to enrolling with Iowa Medicaid. Pharmacies should use the self-service enrollment process as listed below:

- Visit the www.esiprovider.com webpage.
  - Select **New Account**,
  - Enter *NCPDP,*
  - Re-enter *NCPDP, and*
  - Complete the CAPTCHA security request.
  - Click 'Continue'.
  - Follow the on-line prompts to complete your enrollment.
- Questions regarding completing this application or modifying an existing contract should be directed to Express-Scripts at NetworkCompliance@express-scripts.com. You must include your pharmacy NCPDP number, failure to do so will result in your email being deleted.
- For Password Reset, or technical assistance, please reach out to the Express-Scripts System Help Desk at **1-877-866-2655**.

Durable Medical Equipment and Medical Billing

Pharmacies providing durable medical equipment, vaccines, or other medical supplies, and Pharmacists providing vaccines, nicotine replacement, Naloxone, and test & treat services must also be enrolled with Iowa Total Care. Pharmacies and Pharmacists are encouraged to submit a new Contract Request application online by following the process listed below:

- Visit the Become a Provider webpage.
- Select Complete the online Contract Request Form.
- Fill in all required fields.
  - Under, **Type of Contract Request**, select *New Contract*.
  - In the **Entity NPI** field, enter the Pharmacy NPI.
  - For **Provider Type**, select *Ancillary or Hospital Based Practitioners*
  - Attach your W-9 Form by selecting Choose File and browsing to your electronic copy. A new W-9 Form is available here, if needed: W-9 Form.
  - Complete the form in its entirety and click **Submit**.
- Questions regarding completing this application or future questions should be directed to NetworkManagement@IowaTotalCare.com, or call Provider Services at **1-833-404-1061 (TTY: 711)** to be connected to a local representative.
- Providers who are already contracted and need to modify their agreement, add, or remove a service or location, or have a change in ownership (CHOW) can initiate the change process by:
  - Email: NetworkManagement@IowaTotalCare.com,
  - Phone: Provider Services at **1-833-404-1061 (TTY: 711)**,
  - Online: Complete and submit the Provider Change Form, or
  - Contact your provider relations representative.
- Upon receipt of the request to contract with us, a contract manager will review the request and validate enrollment with the Iowa Medicaid program.
  - The contract manager will reach out to the provider who submitted the request to discuss the additional documents needed for the contracting and credentialing process, if applicable.
- The pharmacy will receive final confirmation of enrollment via email.

Credentialing/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. Once Iowa Total Care receives all required credentialing documents, the credentialing process will be completed within 30 days. For the required documents, visit our Contracting & Credentialing page.

Iowa Total Care requires re-credentialing every three 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

- Doctor of medicine (MD).
- Chiropractors (DC).
- Doctor of osteopathic medicine (DO).
- Doctor of podiatric medicine (DPM).
- Nurse practitioners (NP).
- Physician assistants (PA).
- 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, federally qualified health centers (FQHC), rural health clinics (RHC), laboratory testing/diagnostic facilities, rehabilitation centers, Durable Medical Equipment (DME) providers, Pharmacies (medical supplies), 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 120 days or
- Authorize Iowa Total Care to access applicant's information on file with the Council for Affordable Quality Health Care (CAQH).
- 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 Centers for Medicare and Medicaid Services (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 CDAC agency only: Completed Iowa Total Care Provider Attestation Statement.
- Copy of certificate and/or licensure, 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: 85% within 30 days; 98% within 45 days and 100% within 60 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 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 80%, 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 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.

The provider must notify Iowa Total Care of any new provider enrollments, changes, and terminations, at least 30 days prior to effective date of the change. Any new providers that bill Iowa Total Care without completing enrollment and credentialing will be paid at the non-participating provider rate of 80% of Iowa Medicaid.

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), System for Award Management (SAM), and Medicare Opt-Out to identify network providers who are newly sanctioned or excluded from participation in federal and state programs.

For all of Iowa Total Care's roster formats visit our Contracting & Credentialing Forms page.

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 additions please submit at least 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 on our Contracting & Credentialing Forms page.

Any questions regarding provider enrollment/credentialing can be directed to your 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 action's effective date.

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 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 Provider Services 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 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 60 days from the receipt of the additional documentation. Iowa Total Care will send a written response to the provider within 2 weeks of the final decision.

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

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

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 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.

PROVIDER RELATIONS AND SERVICES

Provider Relations

Iowa Total Care's provider relations team is committed to supporting providers as they care for our members. We offer provider orientation, ongoing training, and support of daily business operations including side-by-side education with your provider relations representative. Iowa Total Care provider relations can provide an up-to-date snapshot of provider performance with a provider scorecard with information on assigned membership, claims performance, medical services performance, and quality measures. Providers should speak with their provider relations specialist for more information. Upon credentialing approval and contracting, each provider will have a provider relations specialist assigned to them by region to 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.

Provider relations specialists can assist with topics including but not limited to:

- Report any changes to your practice (locations, NPI, TIN numbers).
- Initiate credentialing of a new practitioner.
- Schedule in-service training for new staff.
- Conduct ongoing education for existing staff.
- Obtain clarification of policies and procedures.
- Obtain clarification of a provider contract.
- Assist with finding fee schedule information.
- Assisting in secure provider web portal registration and Payspan.
- Learn to use electronic solutions on web authorizations, claims submissions, and member eligibility.

Provider Services

Iowa Total Care provider services team is available to assist providers at **1-833-404-1061 (TTY: 711)**, Monday - Friday 7:30 a.m. to 6 p.m. CT.

Closed on state holidays.

Provider services can assist with topics including but not limited to:

- Credentialing/network status.
- Claims inquiries that cannot be addressed through the portal or IVR.
- Request for adding/deleting physicians to an existing group.
- Iowa Total Care website review, portal questions, and registration.
- Complimentary interpretation services.

PERSON-CENTERED HOLISTIC CARE COORDINATION

Our Person-Centered Holistic Care Coordination Program has delivered support and interventions which focus on the whole person since 2019. Our care coordination program promotes the goals of Iowa HHS by providing whole-person integrated care that addresses the unique needs of the individuals and families we serve. Our care coordination model is essential to our continuous process of identification, intervention, and evaluation with members at the center of everything we do.

Our Care Coordination Model Supports Whole-Person Health and Wellness

Building Community Capacity

MemberConnections Community Health Services (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 preventative 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.

Start Smart for Your Baby® (Start Smart) community baby showers promote health education and awareness for healthy pregnancies and healthy babies. Iowa Total Care coordinates the Start Smart community baby showers with the Green to Go events. During these events, we identify any pregnant members who live in the same geographic area as our scheduled

Green to Go events and invite them to the baby shower hosted during these events. At these showers, Iowa Total Care provides education for a healthy pregnancy and our Start Smart program. We also provide a variety of free baby supplies pregnant member's will need after delivery. Additional information about the Start Smart program is available in the Maternity Management Pregnancy Program section of this manual.

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

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 member(s) in 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.

Designated Person Coordinating Member's Services

We designate a person or entity to be primarily responsible for coordinating each member's services. The level and intensity of care coordination varies by the member's risk level, changing needs (pregnancy, behavioral health needs), and preferences. We promote ongoing and consistent communication for all providers involved with the member through data sharing, monitoring, and assistance from our care coordination staff. 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.
- Referring and connecting members 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.

Early and Periodic Screening Diagnostic & Treatment

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventative child health program for individuals under the age of 21, provision of which is mandated by state and federal law.

EPSDT services include periodic screening, vision, dental and hearing services. In addition, the need for corrective treatment, disclosed by such child health screenings, must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan.

Iowa Total Care and its providers will provide the full range of EPSDT services as defined in, and in accordance with, Iowa state regulations and American Medical Association (AMA) policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization schedules using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care.

This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein.

The following minimum elements are to be included in the periodic health screening assessment:

- Comprehensive health and development history (including assessment of both physical and mental development),
- Comprehensive unclothed physical examination,
- Immunizations appropriate to age and health history,
- Assessment of nutritional status,
- Laboratory tests (including finger stick hematocrit, urinalysis [dipstick], sickle cell screen, if not previously performed); blood lead levels must be tested pursuant to the EPSDT provider manual,
- Developmental assessment,
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses,
- Dental screening and services,
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids,
- Health education and anticipatory guidance, and
- Annual Well-Child visits for members under age 21.

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member.

Integrated Care Coordination

Iowa Total Care uses a multi-disciplinary integrated care team (ICT) to offer and coordinate care. Our staff coordinates care with 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. We promote ongoing and consistent communication for all providers involved with the member through data sharing, monitoring, and assistance from our care coordination staff.

Our goal is to help every Iowa Total Care member achieve the highest possible level 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 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 utilized because it effectively engages members. It allows staff the ability to address member questions in real time to better meet the member's needs. Participating members also receive preventative care and screening reminders, invitations to community events, and can call any time regarding healthcare and psychosocial questions or needs.

Screenings, Assessments, and Care Planning

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 Iowa HHS 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 90 days of enrollment and may be conducted by phone, electronically, by mail, or in person with Iowa Total Care staff.

Iowa Total Care will conduct a reassessment within 12 months of the initial outreach or completed initial HRS to obtain new, additional, or updated changes in status over the course of the year. The subsequent HRS outreach is achieved by phone, electronically, by mail, or in person with Iowa Total Care staff.

Comprehensive Health Risk Assessment (CHRA)

The Comprehensive Health Risk Assessment (CHRA) will be scheduled within 30 days of identification of potential need for care management. Reassessment will occur at least every 12 months thereafter, unless there is a change in condition, significant health event, or requested by the member/caregiver. This CHRA is approved by Iowa HHS and is used to help identify supports and services the member may need. All support and service 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 members 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 available and accessible through the care management team. If you have an Iowa Total Care member and feel they could benefit from care management, 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.
- Emergency Room Diversion Program.
- Whole-Person Care Coordination.

To contact Care Management, call our 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 pregnant members and their babies. Start Smart is a unique perinatal program that follows pregnant members 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 neonatal intensive care unit (NICU). 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 the Iowa Total Care medical director on obstetrical care standards and use of newer preventative 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 (PDL), at the Iowa Medicaid website or contact the Start Smart for Your Baby team at Iowa Total Care.

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 member's need.

Members can be referred to MemberConnections 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 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.

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.
- Utilizing community health workers to engage members.
- Transition of care from different care settings/levels.

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 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.

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 at **1-833-404-1061 (TTY: 711)** and completing a referral telephonically.

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 preventative healthcare, appropriate use of preventative, 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 Line, 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 healthcare 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.

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 preventative 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 preventative care.
- Implementation of programs that encourage preventative services and chronic condition self-management.
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals.

PRIOR AUTHORIZATION AND NOTIFICATION

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. Providers can verify prior authorization requirements using the Prior Authorization Check Tool located on Iowa Total Care's Medicaid Prior Authorization page.

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 requires prior authorization for certain services; however, it is not required for service authorizations obtained by the primary payor.

Iowa Total Care partners with third party vendors for prior authorization requests and reviews for specific services to ensure evidence based clinical criteria are being used for prior authorization requests. They also ensure the highest technical and professional quality standards are being met.

EVOLENT

EVOLENT is a third-party partner, Iowa Total Care works with on utilization review of physical, occupational and speech therapy, advanced diagnostic imaging, cardiac solutions, and interventional pain management. The Prior Authorization Check Tool on the Iowa Total Care website can be used to determine if a service requires authorization and will also indicate if that service requires that the prior authorization be submitted to Evolent.

Outpatient Physical, Occupational and Speech Therapy

Outpatient physical, occupational and speech therapy prior authorization requests must be submitted to EVOLENT. Peer consultants then review them to determine if 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, in partnership with Evolent, will continue to allow the first four visits, per rolling year, without requiring authorization. This allows providers time for evaluation, formulation of a plan of care, and authorization submission and review. Additional services, for any ongoing care, require authorization through EVOLENT.

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 EVOLENT to provide prior authorization services and utilization of advanced diagnostic imaging. EVOLENT focuses on radiation awareness, which is designed to assist providers in managing imaging services in the safest and most effective way possible.

The ordering provider is responsible for obtaining prior authorization. Rendering providers for advanced imaging should verify that the necessary prior authorization has been obtained. Failure to do so may result in a claim denial.

NOTE: Emergency room, observation, and inpatient imaging procedures do not require prior authorization.

Cardiac Solutions

Under the Cardiac Solutions program (coming Fall 2024), 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.

Managing cardiac studies promotes the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the American College of Cardiology (ACC) and American Medical Association (AMA), this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available. EVOLENT Cardiac Solutions program utilizes the following:

- 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.

NOTE: Inpatient advanced radiology services, observation setting advanced radiology services, and emergency room radiology services do not require prior authorization through EVOLENT.

Interventional Pain Management

EVOLENT manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. The ordering physician is responsible for obtaining prior authorization for all IPM procedures outlined below.

NOTE: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through EVOLENT for services performed in the emergency department, on an inpatient basis, or in conjunction with a surgery.

General Information on Evolent

Providers must submit clinical information at the time of a prior authorization request. EVOLENT will contact the provider via phone and fax if additional clinical information is needed to complete prior authorization requests. 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 EVOLENT, Iowa Total Care, Inc. oversees the EVOLENT Therapy Management program and continues to be responsible for claims adjudication. If EVOLENT determines that the care provided fails to meet the criteria for the service(s) requested, the provider and the patient will receive notice of the coverage decision. Appeals of adverse benefit determinations follow the same appeals process as authorization requests submitted directly to Iowa Total Care.

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

To reach EVOLENT and obtain prior authorization, call our number at **1-833-404-1061 (TTY: 711)** and follow the prompt for the type of prior authorization you are requesting. EVOLENT also provides an interactive website which may be used to obtain online prior authorizations. Visit RadMD.com for more information.

Requesting a Prior Authorization

When requesting prior authorization, be sure to use the universal prior authorization forms that can be found on Iowa HHS's Prior Authorization page. Be sure to use the correct form for each service you will be performing. If you request an outpatient authorization and bill the claim as though the services were performed in an inpatient setting, the claim will deny for no authorization. If you request an inpatient authorization and bill the claims as though services were done in an outpatient setting, the claim will also deny for no authorization.

The prior authorization forms must be filled out completely including the TIN and rendering provider's NPI on the request. Each request must include clinical records submitted at the time of the request for the request to be reviewed as soon as possible.

Request an authorization for the services you plan on performing and billing. Claims billed with codes not requested as part of the authorization request will deny if a prior authorization is required.

Prior Authorization Forms

Inpatient Medicaid Prior Authorization Form – For behavioral health, this form is ONLY used for psychiatric admissions, chemical/substance detoxification (in a hospital setting), psychiatric medical institute for children (PMIC) room and board, and psychiatric intensive care (PIC).

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 room and board) including residential substance use disorder treatment (ASAM 3.7, ASAM 3.5, and ASAM 3.1).

Pharmacy Point of Sale Prior Authorization Form – For pharmacy point of sale drugs that require a prior authorization. The prior authorization forms are drug specific. Please be sure to use the form that correlates with the drug you are requesting authorization for. Pharmacy Prior Authorization Request Forms can be located on Iowa Total Care's Pharmacy page.

Prior Authorization Request Submissions

- For medical and behavioral health authorizations the preferred method for submitting prior authorizations is through our secure provider portal. The provider must be contracted with Iowa Total Care and a registered user on the secure provider 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.
- Pharmacy Prior Authorizations – The preferred method of requesting a pharmacy prior authorization is through covermymeds website.
- Other methods for submitting prior authorization requests are as follows:
    - By fax with the appropriate prior authorization form below*:

Outpatient Prior Authorization Form
Physical Health - Fax #: 1-833-257-8327
Behavioral Health - Fax #: 1-844-908-1170

Inpatient Prior Authorization Form
Physical Health - Fax #: 1-833-257-8327
Behavioral Health - Fax #: 1-844-908-1169

Pharmacy Point of Sale Authorization Form
Fax #: 1-833-404-2392

Medical Pharmacy
Buy & Bill Drug Requests - Fax #: 1-833-711-0485

EVOLENT
Fax #: 1-800-784-6864

*__NOTE__ Faxes are not monitored after hours and will be responded to the next business day.

- **Call 1-833-404-1061 (TTY: 711)** for Medical (including authorizations that must be submitted to EVOLENT) and behavioral health prior authorization requests or call **1-866-399-0928** for pharmacy prior authorization requests. Normal business hours are Monday - Friday, 8 a.m. to 5 p.m. CT. Voicemails left after hours will be responded to on the next business day.
- Prior authorization must be obtained prior to the delivery of certain elective and scheduled services.
- Any prior authorization request that is faxed or sent via the secure provider portal after normal business hours (Monday - Friday, 8 a.m. to 5 p.m., excluding holidays) will be processed the next business day.

Prior Authorization Request Timings

Prior authorization requests must be submitted within the timeframes listed below. Failure to obtain prior authorization may result in claim denials.

Service Type	Timeframe
Scheduled Admissions/Elective Outpatient Services	5 business days prior to service. Behavioral health is up to 30 days in advance for outpatient services.
Emergent Inpatient Admissions	Notification within 24 hours or the next business day following admission.
Observation	No authorization or notification required for in-network providers.
Crisis Intervention	Within 2 business days.
Delivery	Notification within 2 business days of delivery. This is a notification only; prior authorization is not required.
Neonatal Intensive Care Unit (NICU) Admit	Within 24 hours or the next business day of admission.
Psychiatric Intensive Care Unit (PIC)	Notification within 24 hours or next business day

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 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 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 2 business days of delivery with complete information regarding the delivery status and condition of the newborn.

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

Prior authorizations will be reviewed within the timelines listed below.

Type	Timeframe
Pharmacy	Within 24 hours.
Standard Non-Urgent	14 calendar days.
Expedited Preservice/Urgent	Inpatient: 24 hours. Outpatient: 72 hours.
Inpatient/Concurrent review	72 hours.

Medical Necessity

Medical necessity 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. Medical necessity is reviewed when an authorization is requested.

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, considering both the functional capacity of the member, and the functional capacities appropriate for individuals 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, their family/caretaker and the PCP, and any other providers, programs, and agencies that have evaluated the member.

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 HIPAA, Iowa Total Care is entitled to request and receive 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 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 compensation to individuals or entities that conduct UM activities is not structured 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), Iowa HHS, Iowa Code, and the Iowa Administrative Code, to determine medical necessity for healthcare services. InterQual appropriateness criteria is 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 is established and periodically evaluated and updated with appropriate involvement from physicians. All criteria is utilized as screening guides and is 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 current 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 level of care assessment, person-centered service plan and member encounters 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 (CBCM) will collaborate with the Iowa Total Care medical director; as well as, identified members of the care team to determine the services necessary to best support a member's to ensure successful, member-driven, outcomes. When changes are needed, the CBCM will update the members' person-centered service plan and request authorization of the services. Any changes to a member's HCBS services must go through the members' CBCM.

Pharmacy reviews are performed using the prior authorization criteria established by the State of Iowa Drug Utilization Review (DUR) Commission. Once a determination is made, 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.

APPEALING AN ADVERSE BENEFIT DETERMINATION

Peer-to-Peer Review

Providers may obtain the criteria used by Iowa Total Care to make a specific adverse determination, at the time of notification. The practitioner/facility requesting the criteria may request a peer-to-peer review **within 2 business days of a denial notification**. To schedule a peer discussion of any adverse decisions with a physician or other appropriate reviewer, providers should contact Iowa Total Care via email at MCaidP2P@CENTENE.COM or call Provider Services at **1-833-404-1061 (TTY: 711)** and request a peer review. The requesting practitioner must provide the following information via email or phone:

- Requesting provider's name.
- Requesting provider's NPI.
- Contact number.
- Member's name.
- Member's Medicaid ID.
- Member's date of birth.
- Authorization number.

A member's Iowa Total Care case manager may also coordinate a peer-to-peer review between the medical director and requesting provider.

NOTE: This is not an option for behavioral health adverse determinations.

Member Appeal Process for Adverse Benefit Determination

A member 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 related to an adverse benefit determination may be filed by a member (parent or guardian of a minor member), an authorized representative, or a provider with the written consent form of the member to act on their behalf. The Authorized Representative Designation (ARD) form is required to be filled out and signed by the member when a representative is appealing on their behalf. The ARD form can be located on our Member Grievance and Appeals Process page. Appeals may be filed either 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 60 calendar days from the date on the notice.

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

Medical, Pharmacy or LTSS Member Appeal for Adverse Benefit Determination

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

- Call Member Services 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

Behavioral Health Member Appeal for Adverse Determination

Pre-service (member still in care) Appeal:

- Call Member Services 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):

- Follow the Claim Dispute Process for a claim appeal outlined in the Billing section of this manual if the adverse benefit determination results in a claim denial for no authorization.

NOTE: The ARD form must be completed and submitted with the member appeal if a representative of the member's choosing is assisting the member with the appeal process.

Adverse Benefit Determination Review Process

After we receive a member's call, written, or electronic appeal, we will send a letter within 3 business days of receipt acknowledging the appeal has been received. Iowa Total Care will send an appeal resolution letter within 30 calendar days of receipt of the appeal request. If we cannot resolve the member's appeal in 30 calendar days, we may extend the timeframe by up to 14 calendar days to gather more information to assist in our decision. If Iowa Total Care needs more than 30 calendar days to resolve the appeal, Iowa Total Care will give the member prompt oral notice of the delay and give the member written notice of the delay within two (2) days of the reason for the decision to extend the timeframe, informing the member of their right to file a grievance. The appeal will be resolved as quickly as possible, no later than the date the extension expires.

Members may also request an extension. To request an extension, call Member Services at **1-833-404-1061 (TTY: 711)**. The ARD form must be sent in with the appeal and must be received within 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 - Friday, 7:30 a.m. to 6 p.m. CT.

During the member appeal, 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.

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 10 calendar days of the 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 Care's 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 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 ARD form must be sent in with the expedited appeal request. For the ARD form visit Iowa Total Care's Member Grievance and Appeals Process page.

Expedited appeals will be reviewed as soon as the member's condition warrants and no later than within 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 ARD form signed by the member and the appeal clinical documentation to 1-833-809-3868. To request a behavioral health appeal, fax the ARD 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, as well as providing this information in writing. Iowa Total Care will provide written notice and make reasonable attempts at oral notice of the resolution of expedited appeal determinations.

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 120 calendar days from the date on the appeal decision notice to request a state fair hearing. Members may request their services to continue within 10 calendar days from the date of the notice, during the state fair hearing process.

The member or their authorized representative can ask Iowa HHS 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 Iowa HHS's Appeals page.
- To file in writing submit requests to:

Department of Health and 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**.

NOTE: If a member expresses dissatisfaction about any matter other than an adverse benefit determination, the member or someone chosen by the member have the right to file a grievance by phone or in writing following the process outlined in the Iowa Total Care member handbook.

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 30 calendar days following receipt of the request.

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, preventative 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 Management/Quality Improvement Committee (QM/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 are an example of key committees that report directly to the QM/QIC:

- Medical Management Committee (MMC).
- Credentialing Committee (CC).
- Performance Improvement Committee (PIC).
- Joint Operations Committee.
- Health Equity Drivers of Health Committee.
- Peer Review Committee (ad hoc Committee).

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

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 preventative care; primary care; specialty care; acute care; short-term care; ancillary services; and operations. 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 preventative health guidelines and clinical practice guidelines.
- Continuity and coordination of care.
- Delegated entity oversight.
- Department performance and service.
- Employee and provider cultural competency.
- Health Equity.
- Long Term Services and Support.
- Marketing practices.
- Member enrollment and disenrollment.
- Member grievances and appeals.
- Member experience.
- Medical Management, including population health management.
- Patient 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 Board of Directors (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 requires 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, 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 quality improvement 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 QM/QI Program Goals, by contacting the QI Department.

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 preventative health outreach to its members. Provider-specific scores are being used as evidence of preventative 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.

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.

The HEDIS Hybrid Project is typically conducted February through May each year. Iowa Total Care Quality representatives, or a national 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 hybrid samples. Your prompt response 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 vendor signs a HIPAA-compliant Business Associate Agreement with Iowa Total Care which also allows them to collect PHI on our behalf.

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.
- Provider Electronic supplemental data feed to Iowa Total Care through our secure file transfer process (SFTP).

For questions, comments, or concerns related to the annual HEDIS project or the MRRs, contact the Quality Improvement Department toll-free at 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 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 80% of the requirements for medical record keeping. Elements scoring below 80% are considered deficient and in need of improvement. Iowa Total Care will work with any provider who scores less than 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 preventative 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, preventative 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.

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 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 billing on a CMS-1500 claim form 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 30 days before changes in 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 page**. 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.

Claim Forms

Iowa Total Care accepts CMS 1500 and CMS 1450 (UB-04). Paper claims were accepted until October 1, 2019, after which paper claims were no longer accepted. 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 for EVV.

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 **1-833-404-1061 (TTY: 711)**.

Billing Codes

Iowa Total Care requires claims to be submitted using codes from the current version of International Classification of Diseases (ICD-10), American Society of Anesthesiologists (ASA), Diagnosis Related Group (DRG), CPT4, and HealthCare Common Procedure Coding System (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 points to a diagnosis 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 the same date of service.
- An unspecified diagnosis code should not be used when a more descriptive Diagnosis code is available.
- 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.

The utilization of these codes is 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 paid at zero dollars due to the provider being pre-paid or capitated for the service(s) they provided to 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 Health Service Delivery (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.

Providers must submit an encounter or a claim for each service rendered to an Iowa Total Care member. The encounter or claim file structure and content definition requirements shall adhere to those standards defined by Iowa HHS as revised from time-to-time.

Clean Claim Definition

A clean claim is a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

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. Non-clean claims can result in either claim rejections or claim denials and can involve issues regarding medical necessity or claims not submitted within the filing deadlines.

Rejection vs Denial

REJECTION: A list of common upfront rejections can be found in the Claim Rejection Codes on Iowa Total Care's **Manuals, Forms and Resources page**. 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. When a provider gets a letter or rejection report, the provider is responsible for updating the information on the claim and resubmitting the claim to Iowa Total Care.

In some cases, the claim may be rejected by the provider's clearing house. In those cases, the provider will need to work with their clearing house to resubmit those claims.

In rare circumstances, Iowa Total Care will allow paper claims submission for tertiary claims and to submit corrected claims in response to a recovery project (with approval from Iowa Total Care). These paper claims sent to the Iowa Total Care claims shop must pass the same edits as electronic claims submissions in addition to edits specific to paper claims. Paper claims must be submitted on an original claim form (not printed off) and must be type written or they will be rejected up front.

DENIAL: If a claim submission passes all minimum edits and is accepted into the claims system for processing but is not payable, the claim or claim line will receive a denial. A DENIAL is defined as a claim that has processed through the system but was found to be unpayable. There are many reasons a claim might be found unpayable such as an invalid diagnosis code, incorrect modifier, or the claim is a duplicate submission. The EOP will be sent including the denial explanation. In some cases, a corrected claim may be required to resolve the issue. In other cases, it is an appropriate denial that cannot be resolved with additional information or a corrected claim (example: duplicate claims submission).

CLAIMS PAYMENT INFORMATION

Electronic Claims Submission

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.

Instructions on 837P and 837I claim submissions can be found in the 837 Companion Guide on the Iowa Total Care's Manuals, Form and Resources page. This guide has information on the loops and segments and formatting (example: date formatting) for providers to use if they have questions about submitting their electronic claims.

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 is **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

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.

Claims adjustments (claims previously paid or denied) will be adjusted at the following levels:

- Adjustments with configuration required: 60 business days.
- Adjustments with no configuration required: 30 business days.
- Adjustments to claims with Manual Errors: 15 business days.

Contact Information

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

Customer Service:
1-833-404-1061 (TTY: 711)
Duals: 1-833-765-8507
Foster Care: 1-833-222-4832
Monday - Friday from 7:30 a.m. to 6 p.m. CT.

Claim Payment System

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

- Amisys.
- DST Pricer.
- Optum.

Amisys

Amisys is our core claim 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.

Primary Steps of Adjudication

Step 1: **FIELD EDITS:** Field edits are part of the entry process and are broken down into hard or soft errors. Hard errors require system configuration, while soft errors can be overridden by an analyst.

Step 2: **MEMBER ELIGIBILITY:** Member eligibility (i.e., name, address, date of birth, etc.) for the dates of service is verified

Step 3: **PROVIDER ELEGIBILITY:** Provider eligibility and the provider's financial affiliation with the health plan are determined.

Step 4: **AUTHORIZATION REQUIREMENTS:** Authorization, if required, is located, and populated. If an authorization does not match, the claim pends. If an authorization cannot be found, the claim will deny.

Step 5: **BENEFITS:** Benefit eligibility of services rendered is verified under the member's benefit package (i.e., covered vs. non-covered).

Step 6: **PRICING:** Benefit limitations, co-payments and deductibles, provider discounts, risk, and fund allocations are determined and tracked.

Step 7: **ACCOUNTS PAYABLE CYCLE**: Paper and remittance advices, checks, 835s, ACAs/EFT payments, and claim finalization.

DST Pricer

The DST Pricer is a system outside our core system where we have some flexibility in 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 more attention to detail.

Optum

Optum's primary function is to price inpatient and outpatient hospital claims. It can price inpatient by diagnosis-related group (DRG) or outpatient by Ambulatory Payment Calculation (APC) pricing methodology. Inpatient claims are based on the DRG version determined by Iowa Medicaid and the provider specific base rates. Each hospital in the country is assigned a base rate and add-ons by Medicaid and Medicare based on state or federal guidelines. The payment can be affected by discharge status, length of stay, and other allowed charges. The DRG is based on the diagnosis codes on a claim that may or may not match the DRG the provider indicated on the claim submission.

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 like DRGs, but unlike DRGs, more than one APC can be assigned per claim. These claims are subject to Outpatient Code Editor (OCE) edits determined by Iowa Medicaid outlined in Addendum B. Addendum B is updated quarterly and can be located on the Iowa Medicaid website. Valid OCE edits cannot be overturned. They may apply at the claim line level or at the claim level and claims must be corrected to be considered for payment.

Outpatient claims for critical access hospitals are paid on a cost-to-charge ratio basis (CCR). Each Critical access hospital has a provider specific cost-to-charge ratio based on provider cost reporting to Iowa Medicaid. Claims payments are based

on the cost-to-charge ratio multiplied by the charges billed on the claim except for lab codes paid off of the Iowa Medicaid open fee schedules.

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 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 the last date of EOP from 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.

* Out of Network providers have 12 months for initial claim submission.

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 the 21st Century Cures Act, and it is mandatory for all states.

Affected Services

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

CPT* Code	Revenue Code	Description	EVV Required Submittal Date
T1019	N/A	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or institution for mental diseases (IMD), part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant).	1/1/2021
S5125	N/A	Agency CDAC.	1/1/2021
S5130	N/A	Homemaker.	1/1/2021
G0151	421	Services performed by a qualified physical therapist in the home health or hospice setting. Each 15 minutes.	1/1/2024
G0152	431	Services performed by a qualified occupation therapist in the home health or hospice setting. Each 15 minutes.	1/1/2024
G0153	441	Services performed by a qualified speech language pathologist in the home health or hospice setting. Each 15 minutes.	1/1/2024
G0156	571	Services of home health/hospice aide in home health or hospice settings, each 15 minutes.	1/1/2024
G0158	431	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.	1/1/2024

CPT* Code	Revenue Code	Description	EVV Required Submittal Date
G0159	421	Services performed by a qualified physical therapist, in the home health setting, in the establishment, or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.	1/1/2024
G0160	431	Services performed by a qualified occupational therapist, in the home health setting, in the establishment, or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.	1/1/2024
G0161	551	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the member's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).	1/1/2024
G0299	551	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes.	1/1/2024
G0300	551	Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes.	1/1/2024
S9122	N/A	Home Health Aide, when billed without a revenue code.	1/1/2024
S9123	N/A	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used).	1/1/2024
S9124	N/A	Nursing care, in the home; by LPN, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used).	1/1/2024
T1002	N/A	Interim medical monitoring and treatment (IMMT) Home Health agency RN, each 15 minutes.	1/1/2024
T1003	N/A	IMMT Home Health agency LPN, each 15 minutes.	1/1/2024
T1004 & T1004 U3	N/A	IMMT home health aide, each 15 minutes.	1/1/2024
T1021	N/A	Home Health Aide, home.	1/1/2024
T1030	N/A	Nursing care, RN, home.	1/1/2024
T1031	N/A	Nursing care, LPN, home.	1/1/2024

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 (ALF) and Residential Care Facilities (RCF) as those provider types will be required to bill through CareBridge for dates of service on or after July 1, 2021.

Process

Waiver Services

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.

Home Health Services

Providers will utilize a 21st Century Cures Act EVV vendor to check in and out of visits with their members. Home Health providers will need to obtain an authorization for Home Health services after the first three visits; however, these authorizations will not be sent to Iowa Total Care's EVV vendor, CareBridge. This is to ensure seamless processing of claims without waiting for authorizations to be loaded to record a visit. Home Health providers are also able to determine the frequency of billing within the CareBridge portal.

All Providers who submit via EVV

- 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 into claims.
- If there are no prebilling errors or all previous billing errors are now corrected, these visits can now be rolled into claims.
- Claims will be electronically sent to Iowa Total Care for processing. After Iowa Total Care has processed the claim, the CareBridge provider portal will be 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.
- Requesting login credentials page.
- Email: iaevv@carebridgehealth.com.
- Phone: 1-844-343-3653, Monday - Friday, 7 a.m. to 5 p.m. CT.
- Additional resources can be found on the Iowa Total Care's Electronic Visit Verification page.

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. 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 electronic data interchange (EDI) or the secure web portal and must be submitted on a paper claim.

Medical supplies covered as a pharmacy benefit by a member's primary insurance, may not generate an EOB. For Iowa Total Care to reimburse for these supplies, the pharmacy must submit these claims to Medicaid on a medical claim form. The claim must include the total primary insurance paid, the date the primary insurance payment/explanation of benefits was received, reason codes (CARC/RARC Codes), and patient responsibility (deductible, coinsurance, copay).

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, copayments, 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 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 Third-Party Liability (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 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 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 MCO's.

- 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 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 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 a remittance advice (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's 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.

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. A visit that is considered emergent is one where the member being seen had a diagnosis that is present on the emergent diagnosis code list maintained by Iowa Medicaid. 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.

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 the 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 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 50% of the APC/CCR payment for the treatment provided.

Diagnosis codes used to determine emergency room payment are on the Iowa Medicaid website.

Iowa Total Care will cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with us or is registered with Iowa Medicaid. Out-of-network providers will be paid at 100% of Medicaid rates and will not have a reduction in payment in addition to the non-emergent reductions all providers are subject to.

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

- A member has an emergency medical condition, including cases in which the absence of immediate medical attention will not result in:
    - Placing the health of the individual in serious jeopardy; for pregnant women, the health of the women or unborn child.
    - Serious impairment to bodily functions.
    - Serious dysfunction of any bodily organ or part.
- A representative of Iowa Total Care instructs the member to seek emergency care.

Hospital Emergency Department Copayment (Cost Sharing)

Some Iowa Total Care members are subject to a copayment for non-emergency services provided in the hospital emergency department (ED). Copayments differ based on the Medicaid plan type:

- $25 Copayment for Hawki members*.
- $8 Copayment for IHAWP members.
- $3 Copayment for Traditional Medicaid.

Copayments can be applied per visit to the ED for non-emergent conditions up to the member's aggregate share of cost (5% of household income) and may not be collected after members have paid/reached their total share of cost for a given month. Iowa Total Care tracks the copayments from previous claims and updates remaining a member before reaching the maximum. Prior to collecting copayments from any member, and in conjunction with eligibility verification, providers should verify a member's copayment status before collecting any copayments.

Before providing non-emergency services and imposing copayments, 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 copayment 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 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 ED, the hospital will assess the copayment.

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

* Certain Medicaid populations are exempt from paying copayments. American Indian, Alaskan Native, Family Planning Waiver, pregnant members, and Medicaid members under age 21 are exempt from copayments.

Client Participation

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. Iowa HHS determines the client participation amount for each member. Through the Iowa HHS eligibility and enrollment files, the state will notify Iowa Total Care of any applicable client participation 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 from the total payment. 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.

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 usual 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.

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 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.

Lessor of Billed Charges

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 the Iowa HHS Informational Letter 1785. Please see examples of how lessor of billed charges is applied below:

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.

NDC Requirements

- All drug codes must be billed with an NDC from a labeler that is rebate eligible except for claims billed as part of the 340B Program, vaccines, or medical devices, to be considered for payment. Rebate eligible labelers can be found on the Iowa Medicaid website.
- NDCs are required to be billed on vaccines and 340B drugs however, they are payable for drugs where the labeler may not be rebate eligible.
- Drug codes must have an appropriate NDC to HCPCS/CPT combination with appropriate billing units and quantity for procedure code to be paid.
- NDC requirements apply to all outpatient institutional and professional claims including Medicare crossover claims.

Immunization/Vaccines/Injections

- Providers must bill the appropriate administration code with the vaccine on the same claim to be eligible for reimbursement.
- The HCPCS CPT code must align with the NDC, strength, and dosage of the vaccine being administered.

Clinical Laboratory Improvement Amendment (CLIA) Accreditation

The Centers for Medicare and Medicaid (CMS) regulate 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).

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 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 it is different than the information provided in loop 2310C. The 2420C would contain the 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 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.

Date Span Billing

Date span billing is when a claim is billed 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 if the service is only payable once per day.

- 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.
- Do not overlap an authorized date span on any one claim for a given service. For example: the authorization dates are from 1/15/24 to 1/31/24 you cannot bill from 1/1/24 to 1/31/24. To avoid denials, you must bill a separate claim from 1/1/24 to 1/14/24 and then from 1/15/24 to 1/31/24.

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.
- The 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.

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 healthcare professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised, and deleted) annually.

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 describes supplies, products, and services not included in the CPT code descriptions (durable medical equipment, orthotics, and prosthetics, etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated annually.

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. Providers billing miscellaneous codes may be required to submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative reports, pathology reports, and related pricing information. Once received, the records will be reviewed 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.

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. Iowa Total Care does require providers to correctly bill ICD 10 diagnosis codes including making sure that the diagnosis code is billable and that the date of service is within the dates a given diagnosis code is valid. ICD 10 codes have regular updates for new codes and codes determined to no longer be valid.

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, 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 Code Auditing software applies edits that are based on multiple sources including but not limited to CMS Correct Coding Initiatives and AMA resources. References for each policy are listed on the Iowa Total Care's Clinical, Payment & Pharmacy Polices page.

Claims Audit Tool for Code Editing

Iowa Total Care allows providers to see if a claim coding edit may impact their claim(s) in the Iowa Total Care provider portal through the claims audit tool. This tool is 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. Providers need to register for the provider portal to gain access to this tool. You can access this portal tool in the Claims Module by clicking "Claim Auditing Tool".

This tool offers many benefits including being able to prospectively access the appropriate coding and supporting clinical edit clarifications for services prior to claims being submitted. It can also be used to 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 claims auditing tool is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not consider historical claims information which may be used to determine if an edit is appropriate.

NOTE: This tool is used to apply coding logic **ONLY**. It will not consider 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.

Payment Integrity

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 confirms 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.

Payment Integrity Program 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 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 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.

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 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.

PROVIDER SPECIFIC BILLING GUIDELINES

Ambulance

All ambulance base rate codes (excluding Ground Emergency Medical Transportation (GEMT) A0999) require a two-letter modifier code. The first letter of the modifier should identify the location of the pickup and the second letter should identify the destination. You can find a list of modifier codes for ambulance in the Iowa Medicaid Ambulance Provider Manual or can be found in the Ambulance Modifiers on Iowa Total Care's Manuals, Forms and Resources page.

GEMT

A0999 is required to be billed on each claim expecting reimbursement at the GEMT rate and is only appropriate for Emergent transport. The claim must also include appropriate emergency transportation codes including but not limited to A0225, A0427, A0429, A0433, A0434. Modifiers should be placed on the emergency transportation codes not on A0999.

Behavioral Health and Substance Use Services

Behavioral health and substance abuse services may be billed by Community Mental Health Centers and other behavioral health service providers. Behavioral health providers must bill with credentialing modifiers to reflect the rates on the Iowa Medicaid Fee Schedules when applicable.

Applied Behavioral Analysis (ABA)

- Claims being billed for ABA therapy must have a primary diagnosis of autism spectrum disorder.

Behavioral Health Intervention Services (BHIS)

- BHIS services apply to members in the Iowa Health Link program only.
- Modifiers are required for BHIS services.

Community Mental Health Center (CMHC)

Community Mental Health Centers (CMHCs) must bill with their group billing NPI in the rendering NPI field to be paid at the CMHC rates. If claims are billed with a rendering provider NPI that is not a CMHC, claims will be paid off the Fee Schedule associated with the specialty tied to that NPI.

Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT)

- MST and FFT providers must be certified with FFT Partners, FFT, LLC., or MST services to be paid for MST or FFT services.
- MST should bill H2033 without a modifier.
- FFT should be billed with 90846 or 90847 with the appropriate credentialing modifier outlined in Iowa HHS Informational Letter 2451.

Substance Use and B-3 Services

- Substance Use claims need to bill the appropriate procedure code and modifier combination for the services being rendered as determined by Iowa Medicaid.

Chiropractor

Chiropractic manipulative therapy (CMT) which is eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray.

The member must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment. The manual manipulative services rendered must have a direct therapeutic relationship to the member's condition.

Medicaid limits chiropractic manipulative treatment to one code per day per member. The utilization guideline for diagnostic combinations between categories is a maximum of 28 manipulations per 12-month period. Any treatments beyond the annual utilization guidelines listed require a prior authorization request with documentation to support the medical necessity.

It is the provider's responsibility to select the procedure code that best describes the services provided. A claim submitted without a procedure code and corresponding diagnosis codes will be denied.

Covered procedures for chiropractic manipulative treatment are:

- 98940: Spinal, one or two regions (requires a minimum of one spinal region primary diagnosis code).
- 98941: Spinal, three or four regions (requires a minimum of three spinal region primary diagnosis codes).
- 98942: Spinal, five regions (requires five spinal region primary diagnosis codes).
- 98943: Regions other than spine.
- Spinal regions are cervical, thoracic, lumbar, sacral, pelvic. The head (M99.0) and other regions (M99.06, M99.07, M99.08, M99.09) are not spinal regions and should only be billed with 98943.

Please refer to the Iowa Medicaid website for details of chiropractic coverage, Chiropractic Services Primary (current diagnosis code listing), and Chiropractic Diagnosis Category I, II, and III code listings.

Critical Access Hospital

Swing Bed

Claims for members residing in a swing bed must be billed with the swing bed NPI and type of bill 18X for reimbursement at the swing bed rate. 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.

Outpatient Critical Access Hospital

Outpatient critical access hospital claims must be billed with bill type 85X unless providing labs with no patient contact which is required to be billed under bill type 14X.

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–RHC).
- Bill with the Group NPI in box 24J or leave the box blank.
- Bill using HCPC T1015 along with all ancillary services provided.
- All claims should be billed on a CMS-1500 claim form unless Medicare is the primary payer of the claim.

Same Day Billing Standards

- Bill with a behavioral health diagnosis code in the primary position if the claim is behavioral health in nature.
- Bill with a medical diagnosis code in the primary position if the claim is medical in nature.
- Bill with modifier 59 on the encounter code and any repeated ancillary services if billing a second and distinct medical encounter for the same date of service.
- Bill with distinct ancillary services if billing a second and distinct behavioral health encounter for the same date of service.

Home- and Community Based Services (HCBS)

HCBS providers are required to bill only the modifiers listed on the HCBS and Habilitation Billing Code Chart located on the Iowa Medicaid website.

- Services being billed must match the code and modifier combination that is associated with the member's service plan. If changes need to be made to the service plan you must reach out to the case manager to have any changes updated prior to billing. Contact the case manager to update the service plan.

Home Health

Home Health Services are required to be submitted via Electronic Visit Verification (EVV). Please see the EVV section for more details.

Hospice

Hospice services are available to members residing in a facility and in their homes. Each location has its own billing guidelines.

Hospice Room and Board

- Hospice providers billing services for members residing in a skilled nursing facility, nursing facility or intermediate care facility for persons with an intellectual disability 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. Do not put additional information in box 77. Only include the NPI in that box.
- Check with the nursing facility the member resides in to ensure that the nursing facility NPI hasn't changed. NPI's often change when there has been a change of ownership.
- 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.

Hospice Services Provided in the Home

Hospice services provided in the home are paid using Low Utilization Payment Adjustment (LUPA) rates and must be billed with revenue codes listed in the LUPA rates located on the Iowa Medicaid website.

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.

Hospital Billing

For all hospitals, outpatient procedures (including, but not limited to, surgery, X- rays, and EKGs) provided within 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 for the service dates on the claim form to match those 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.

Inpatient Claims

Psychiatric Intensive Care (PIC)

PIC claims are required to be billed with revenue code 204 and HCPCS code 90899. The days the member resided in the PIC unit will be reimbursed in addition to the DRG or certified psychiatric stay.

POA Indicator

All claims involving inpatient admissions to general acute care hospitals will require present on admission (POA) indicator(s). POA is defined as a condition present or incubating when the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as a Hospital Acquired Condition (HAC). The POA indicator is required on any codes on the CMS HAC list. 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 submit a corrected claim.

Definitions:

- Yes (Y): present at the time of inpatient admission.
- No (N): not present at the time of inpatient admission.
- Unknown (U): the documentation is insufficient to determine if the condition was present at the time of inpatient admission.
- Clinically undermined (W): the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.
- Exempt from POA reporting: when 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 exempt from POA reporting.

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 to receive payment.

NICU

NICU claims must bill per Iowa Medicaid guidelines including the correct revenue code for the level of care being billed by a certified NICU. If the level of care changes from the level of care requested in the authorization, please notify the authorization team to review. Failure to do so could result in a reduction in payment based on the authorized level of care.

Interim Billing

Interim hospital encounters are allowed if the length of stay is greater than 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.

When interim billing, be sure to enter the appropriate Type of Bill code (e.g., 112, 113, 114) with a discharge status of 30 indicating the member is still receiving care.

30 Day Readmissions

When an Iowa Medicaid member is discharged prematurely and subsequently readmitted within 30 days with the same DRG and at the same hospital only the first stay will be reimbursed. The DRG is determined by the DRG grouper based on the diagnosis codes billed on the claim.

Outpatient Claims

Observation Room

Observation Room Claims must be submitted in accordance with the following guidance:

- Code G0378 should be used to bill for outpatient services.
- 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.
- Do not bill for an observation room when billing for Esketamine (Spravato). An E/M code is required when billing for this reason.

Independent Laboratory

Independent laboratories are required to bill their CLIA number at the header any claim that contains labs. Failure to bill the CLIA number at the header of the claim may result in a claim denial.

Medical Supply Dealer

Medical Supply Dealers are required to use modifiers on certain medical supplies to indicate if the supply is a rental (RR modifier) or purchase (NU modifier), partial month rental (KR), and used equipment (UE). Failure to bill with appropriate modifier will result in claim denial.

Medical Supplies cannot be billed with a future date of service. Rentals that require a date range should be billed for the preceding month. The "from" date on DME claims should equal the date of anticipated need and not the delivery date.

Physical (PT), Occupational (OT) and Speech (ST) Therapy

- GN, GO, GP Modifiers – therapy modifiers required for speech, occupational and physical therapy. Failing to bill these modifiers will result in a claim denial.
- PT, OT, ST claims are subject to multiple therapy reduction. On codes where the reduction applies, only the first unit of the highest value code will be paid at 100% of the Medicaid Fee Schedule. All other units and codes will be paid at 90%.

Nursing Facility (NF) and Intermediate Care Facilities (ICF)

- 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 when billing for room and board or bed holds (not payable in a nursing facility).
- Date Span Billing – When billing room and board services, bill consecutive days on one claim line. If there is a gap in the room and board days, bed hold days should be billed on line 2, with the next room and board days billed on line 3 of the claim with a date span if applicable. Do not overlap months when date span billing.
- 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.

Obstetrical Billing Guidelines

- The global obstetric (OB) code should be billed whenever one practitioner, or practitioners of the same group provide all components of a patient's obstetrical care including four or more antepartum visits, delivery, and postpartum care.
- If global OB care (more than three 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.

Psychiatric Mental Health Institution for Children (PMIC)

- PMIC provider should bill with bill type 11X.
- Revenue Code 124 and HCPCS code T2048 should be billed on the claim unless otherwise specified by a provider contract, authorization, or single case agreement.

PAYMENTS

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:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported.
- 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 (TTY: 711)

CLAIM DISPUTE/CLAIM APPEAL 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 Form on Iowa Total Care's Manual, Forms and Resources page.

Disputes/reconsideration/appeals can be submitted via the portal (for in network providers) or via the mail to the following address:

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

NOTE: All disputes/appeals in writing ***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.

A claim payment dispute/reconsideration 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 outcome.
- 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).
- A claim where updates to the information billed on the claim needs to be updated – if any information needs to be updated by the provider, a corrected claim is required.

Claim dispute determinations 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 may submit a second level claim appeal within the 30 days of the date of the EOP indicating the decision was upheld with information as to why the decision should be overturned. Clinical denials will require medical documentation for review as part of the appeal.

Claim second level appeal may be submitted by the 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 or via the provider portal within 30 calendar days from the date of EOP/PRA stating the decision was upheld.
- Any appeal submitted after the 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 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 the final decision results in a claim adjustment, payment and EOP will be sent separately.

If you need more assistance with your dispute or appeal, you may contact provider services or your provider relations representative.

NOTE: Claims disputes/appeals resulting from claim-editing must be disputed/appealed with medical documentation (medical records) related to the dispute. If medical documentation is not received, the original code audit or edit will be upheld.

Corrected Claims

Corrected claims are required when the provider needs to correct an error or omission on a claim. A corrected claim is considered a replacement of a previously submitted corrected claim and should include all services provided for the member during the dates of service indicated on the claim.

Corrected claims must contain a 7 in the resubmission code box (CMS-1500) or 7 as the frequency code (UB-04) with the claim number of the original claim submission in the appropriate box.

Corrected claims can be submitted electronically using HIPAA transaction 837I or 837P or in the provider portal under “Dispute”, then “Correct the Claim”.

Overpayment Refund Checks

To ensure the payment is applied to the appropriate claim, please fill out the Provider Claim Refund Form located on Iowa Total Care’s Manuals, Forms and Resources page. Claim information ***must be*** sent with the refund check in or attached to the form noted above. Overpayment refund checks should be submitted to:

Refund Checks sent to Iowa Total Care via Standard USPS:

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

Refund Checks sent to Iowa Total Care via overnight or certified mail:

U.S. Bank
ATTN: 958092
3180 Rider Trail S.
Earth City, MO 63045

NOTE: Do not return Iowa Total Care issued checks to the above addresses. If a provider wants to return an Iowa Total Care issued check, please contact your provider relations specialist for more guidance.

Overpayment Claims Projects

Iowa Total Care regularly does audits on claims for under and overpayments. If Iowa Total Care determines an overpayment was made on claims, we initiate projects to recover those overpayments if an overpayment refund check has not been received. These recoveries may lead to negative balances that are offset by future claims.

Overpayments can also be initiated by providers in the dispute/reconsideration/appeal process. If the provider initiates an overpayment recovery via this process, a negative balance will be applied in the amount of the overpayment.

Negative Balances

If Iowa Total Care overpays a claim, we may choose not to recoup the overpayment, but to reduce future claim payments to the provider until the overpayment is satisfied. The recoupments are reflected as a negative balance on the provider's EOP and will be carried over to subsequent EOPs until overpayment is satisfied. For example, member's claim with a provider was overpaid by $100. The next claim processed for the provider (for any member) will reduce the payment amount until the $100 is satisfied. This could be processed on one claim or over multiple claims, depending upon the total dollar amount of the recoupment and the claims processed.

Example:

- Member A – DOS 1/1/16, overpaid claim by $100.
- Member B – DOS 1/15/16, provider should be paid $60; EOB will reflect -$60.
- Member C – DOS 1/18/16, provider should be paid $40; EOB will reflect – $40. (Negative balance is satisfied at this point).

The initial EOP will show the claim(s) that will be recouped. It will list the claim number along with the service line or lines that caused the take back. The provider will also receive an EX-code to indicate why we are recouping along with the payment amount to be recouped. Please retain the initial negative balance EOP until the negative balance is $0, as overpaid claims information will not be repeated on future EOPs.

Please request a negative balance report from your provider relations specialist if you need additional information on your negative balance.