



Medicaid Enterprise
Department of Human Services

For Human Services use only:
General Letter No. 8-AP-298
Employees' Manual, Title 8
Medicaid Appendix

May 1, 2009

ALL PROVIDERS MANUAL TRANSMITTAL NO. 09-1

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: **ALL PROVIDERS MANUAL**,
Chapter I, **General Program Policies**, page 40, revised, and form
470-3744, *Provider Inquiry*, revised;
Chapter II, **Member Eligibility**, page 4, revised, and form 470-2629,
Presumptive Medicaid Income Calculation, revised.

Summary

This manual is revised to:

- ◆ Transmit an updated sample of the *Provider Inquiry*, which has been revised to clarify that it can be used to request policy interpretation as well as to inquire about claim issues.
- ◆ Correct the phone numbers for the Eligibility Verification System (ELVS). In the Des Moines area or from outside Iowa, call 515-323-9639; from inside Iowa, use the Iowa WATTS number, 1-800-338-7752.
- ◆ Update the *Presumptive Medicaid Income Calculation* with income guidelines based on the federal poverty level guidelines for 2009.

Date Effective

April 1, 2009

Material Superseded

Remove the following form and pages from the **ALL PROVIDERS MANUAL**, Chapter I and Chapter II, and destroy them:

<u>Page</u>	<u>Date</u>
Chapter I	
40	March 1, 2008
470-3744 (before p. 41)	5/07
Chapter II	
4	April 1, 2007
470-2629 (after p. 24)	4/08

Additional Information

The updated provider manual containing the revised pages can be found at:
www.ime.state.ia.us/

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your provider identifier, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise.



- ◆ Any service provided to pregnant women. Members have been advised that if they wish to be exempt from copayment, they are responsible to inform the providers or their income maintenance worker if they are pregnant.
- ◆ Services provided by an HMO.
- ◆ Emergency services. Emergency services are those services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate attention could reasonable be expected to result in:
 - Placing the member's health in serious jeopardy,
 - Serious impairment to bodily functions, or
 - Serious dysfunction to any bodily organ or part.

Diagnosis codes are used indicate the emergency service exemption from copayment. To view RC-0113 for the list of emergency diagnosis codes that meet the copayment exemption, click [here](#).

4. Problems With Submitted Claims

After you have submitted a Medicaid claim, you will receive a *Remittance Advice* indicating whether the claim was paid, denied, or suspended. A sample of the *Remittance Advice* for your particular provider type is included in Chapter III of your provider manual.

You should review each *Remittance Advice* promptly to determine whether there were any problems with your claims. If so, note the "transaction control number" for that claim and contact the IME Provider Services Unit.

a. Provider Inquiry, Form 470-3744

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. You may also use this form to submit questions regarding policy interpretation.

You can obtain this form by printing or copying the sample in the manual or contacting the IME Provider Services Unit. To view a sample of this form on line, click [here](#).

PROVIDER INQUIRY

Please check the type of inquiry below:

- Inquiry about payment or medical determination of a **specific claim** (TCN below)
- General Issue** regarding Medicaid policy (an example TCN may be reference below)

Attach supporting documentation. Check applicable boxes:

- Claim form Remittance copy Other pertinent information for possible claim reprocessing

INQUIRY	1. 17-DIGIT TCN * Required if about a specific claim	
	2. NATURE OF INQUIRY:	
Date	MAIL TO: IME Provider Services P. O. BOX 36450 DES MOINES IA 50315	Date
Provider Signature:		IME Signature:
Provider Please Complete:		(FOR IME USE ONLY)
Provider NPI#	Member ID#	PR Inquiry Log #
Phone Number		Received Date Stamp:
Name		
Address		
City	State	Zip Code



- ◆ If the member is enrolled in managed care, including a health maintenance organization, a prepaid health plan, or the Medicaid patient access to service system
- ◆ If the member is locked in to specific providers
- ◆ If the member has third party liability

Only providers enrolled in Medicaid can obtain this information. You will need to use your Medicaid provider number to access these systems.

The address of the web portal is <http://ime-ediss.noridan.com/lowaxchange/>. To get authorization to use the web portal, you must submit an *Additional Access Request Form for Iowa Medicaid Real-Time Transactions* to EDI Support Services. This form is available on the IME provider web page, <http://www.ime.state.ia.us/Providers/>.

ELVS is an automated response system that uses a touch-tone telephone to report:

- ◆ A member's eligibility status as of specific dates of service.
- ◆ Whether other third-party resources exist.
- ◆ The name of the third-party payors, if known.
- ◆ Medicaid HMO or MediPASS coverage (and telephone number).
- ◆ Services not covered by the member's managed health care plan.
- ◆ Any lock-in restrictions for the member.
- ◆ The amount of the member's Medically Needy spenddown balance for the certification period (including the date of service), if any.

The system can also give the date and amount of a provider's last payment. ELVS can process up to five inquires per call.

You should access ELVS:

- ◆ At the time service is provided or requested.
- ◆ When a woman presents a *Presumptive Medical Eligibility Notice of Decision*, form 470-2580.
- ◆ You want to find out the remaining spenddown amount to be met by a member on Medically Needy.

To use ELVS:

1. Dial either phone number with a touch-tone phone.

Des Moines area or out-of-state: 515-323-9639

Iowa WATTS: 1-800-338-7752

PRESUMPTIVE MEDICAID INCOME CALCULATION

If pregnant woman (1) is age 18 or older; or (2) is married, divorced, or widowed; or (3) does not reside with her parents, go directly to Section II. If the pregnant woman is under age 18, resides with her parents, and is unmarried (or her marriage has been annulled), consider parental income in the eligibility determination as follows in section I:

SECTION I. PARENTAL INCOME

	<u>Parent 1</u>	<u>Parent 2</u>
A. Enter total gross earned income	\$ _____	\$ _____
B. Enter 20% of Line A (work expense deduction)	- \$ _____	- \$ _____
C. Enter child care expenses: For employees, allow <u>up to</u> \$175/mo per child over age 2 \$200/mo per child under age 2 (allow for month child turns 2)		
D. Subtotal (Subtract Lines B and C from Line A)	- \$ _____	- \$ _____
E. If more than one household member has earnings, add together their earned income from Line D.		= \$ _____
F. Using the table below, enter income to meet needs of parents and their dependents in the home. (DO NOT count the pregnant woman when determining the amount of income to subtract.)		- \$ _____

<u>Number of Persons</u>	<u>Amount of Income to Enter on Line F</u>
1	\$ 365
2	\$ 719
3	\$ 849
4	\$ 986
5	\$ 1,092
6	\$ 1,216
7	\$ 1,335
8	\$ 1,457
For each additional person add \$173	\$ 173

G. Subtotal (Line E minus Line F)	= \$ _____
H. Enter any unearned income of parents	+ \$ _____
I. COUNTABLE MONTHLY PARENTAL INCOME TO CONSIDER TOWARD THE PREGNANT WOMAN'S ELIGIBILITY (Line G plus Line H)	= \$ _____

SECTION II. INCOME OF THE PREGNANT WOMAN

Household Size* _____	<u>Pregnant Woman</u>	<u>Unborn's Father</u>
A. Enter total gross earned income**	\$ _____	\$ _____
B. Enter 20% of Line A (work expense deduction)	- \$ _____	- \$ _____
C. Enter child care expenses: For employees, allow <u>up to</u> \$175/mo per child over age 2 \$200/mo per child under age 2 (allow for month child turns 2)		
D. Subtotal (Line A minus Lines B and C)	- \$ _____	- \$ _____
E. Add the earnings of the pregnant woman, the unborn's father, and the unborn's siblings who are under age 19, if they are in the home.		= \$ _____
F. Enter any court-ordered child support payment made to persons outside the home by the pregnant woman or the father of the unborn child (if he is residing with the pregnant woman). (Allow the amount that is actually paid.)		- \$ _____
G. Subtotal (Line E minus Line F)		= \$ _____
H. Enter total monthly unearned income**		+ \$ _____
I. Enter countable parental income if applicable (See Line I in SECTION I.)		+ \$ _____
J. TOTAL COUNTABLE NET MONTHLY INCOME (Lines G plus H plus I)		= \$ _____

If the total countable income (Line J) does not exceed the income limit on the chart below for the household size, the pregnant woman is presumptively eligible.

Household Size	Income Limit
1	\$ 1,805
2	\$ 2,429
3	\$ 3,052
4	\$ 3,675
5	\$ 4,299
6	\$ 4,922
7	\$ 5,545
8	\$ 6,169
For each additional person, add	\$ 624

* To determine household size, count the pregnant woman, the unborn child(ren), the father of the unborn child and any siblings of the unborn child when in the home.

** Count the income of the pregnant woman, the father of the unborn child and siblings of the unborn child when in the home.