

ALL PROVIDERS

I. GENERAL PROGRAM POLICIES





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CHAPTER I. GENERAL PROGRAM POLICIES

A. ORGANIZATION AND ADMINISTRATION OF MEDICAID

Medicaid is a public assistance medical care program administered by states and financed jointly through federal and state funds. The purpose of the Medicaid program is to help ensure that people of low income have available to them medical and health care of good quality. The legal basis for the program is Title XIX of the Social Security Act.

At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS) in the U. S. Department of Health and Human Services. In order to participate in Medicaid, the state legislature must appropriate funds and designate a state agency to administer the program. Iowa's Medicaid program is administered by the Division of Medical Services in the Iowa Department of Human Services.

To obtain federal funds, the state's program must meet federal requirements. These requirements are designed to ensure that states are administering Medicaid programs of good quality, both in terms of the people covered under the program and the medical and health services for which the program makes payment.

States must submit a plan declaring how they meet these requirements. If CMS approves a state's Medicaid plan, then federal matching funds for program expenditures are available at a rate based on a formula for each state that takes into account the per capita income for the state.

1. Eligibility

The Department's Bureau of Financial, Health, and Work Supports is responsible for formulating Medicaid eligibility policy and procedure within the framework of state and federal law and regulations.

The Department has local offices in each county in Iowa. These offices are organized into five geographical service areas and a service area for centralized functions. Each service area is led by a service area manager. (See the [Appendix](#) to this manual for a directory of Department offices and Social Security offices.)



Eligibility determination is generally done by staff in the Department's service areas. For certain groups, eligibility is determined by staff of the Social Security Administration or by qualified providers.

Department income maintenance workers are responsible for maintaining the Medicaid eligibility records for all members by entering eligibility information into a centralized automated system with an electronic case file.

Eligibility for Medicaid is based primarily on a person's financial situation. The federal government requires states that participate in the Medicaid program to provide coverage for:

- ◆ People who are eligible for federal Supplemental Security Income (SSI) benefits (low-income people who are aged, blind, or disabled).
- ◆ People who would be eligible for the Family Investment Program as in effect on July 16, 1996 (low-income families with children).
- ◆ Children who are eligible for benefits under the federal Foster Care and Adoption Assistance program.

States have the option of covering members of state-funded public assistance programs and various groups of people whose situations are similar in some respects to recipients of public assistance, but who do not meet all the requirements. The Iowa Legislature specifies in Iowa Code Chapter 249A what groups can be covered for medical assistance.

A more detailed description of the groups covered by the Iowa Medicaid program is found in Chapter II, [Member Eligibility](#).

2. Benefits

The Division of Medical Services is responsible for formulating Medicaid policy and procedure within the framework of state and federal law and regulations. Together with other units of the Department, the Division also oversees the operation of the program to ensure that it is effectively and efficiently administered throughout the state.

The Department has contracted with several private firms to handle administrative duties for the program. These contractors, together with staff of the Division of Medical Services and the Department's Bureau of Medical Systems and Data Warehousing, collectively form the "Iowa Medicaid Enterprise" (IME). The IME office is located at 100 Army Post Road in Des Moines, Iowa.



- ◆ The Division's Bureau of Long-Term Care is responsible for development of policies about coverage and payment for nursing facilities, facilities for persons with mental retardation or mental illness, home- and community-based services waivers, hospice, home health and habilitation services.
- ◆ The Division's Bureau of Adult and Children's Medical Programs is responsible for the development of policies about coverage and payment for all other services, including IowaCare, *hawk-i*, and the health insurance premium payment programs.
- ◆ The Division's Operations Team is responsible for the Iowa Plan for Behavioral Health and other managed care contracts, pharmacy benefits, and quality assurance operations.
- ◆ The IME Core Unit is responsible for operating the Medicaid Management Information System (MMIS) and the automated eligibility reporting system, known as ELVS. The core unit is also responsible for processing and payment of claims, mail handling, and reporting.
- ◆ The IME Medical Service Unit houses the medical review staff and affiliated staff that provide medical opinions on specific areas, such as coverage and benefits, as well as assisting with opinions on exceptions to policy and appeals.
- ◆ The IME Member Services Unit is a call center that assists Medicaid members in accessing services or explains how services can be provided, including help in enrolling in managed care, when applicable.
- ◆ The IME Pharmacy Medical Services Unit is responsible for pharmacy prior authorization (PA), drug utilization review (DUR), and the preferred drug list (PDL).
- ◆ The IME Pharmacy Point of Sale Unit is responsible for maintaining a real-time system for pharmacies to submit prescription drug claims for Iowa Medicaid members and receive a timely determination regarding payment.
- ◆ The IME Provider Cost Audit and Rate Setting Unit is responsible for helping policy staff to develop payment rates that are consistent and appropriate for services being provided to members.
- ◆ The IME Provider Services Unit is responsible for provider training, provider enrollment, and the provider call center.
- ◆ The IME Revenue Collection Unit is responsible for capture of payments that are to be made to the Medicaid program through other third-party insurance, estate recovery, and liens.
- ◆ The IME Program Integrity Unit is responsible for routine inspection of claims submitted to the IME to assure that Medicaid is paying appropriately for covered services.



3. Iowa Medicaid Enterprise Addresses and Telephone Numbers

Direct inquiries by telephone or in writing to the following sources:

Unit Address

Telephone Numbers

IME Medicaid Claims

P.O. Box 150001
Des Moines, Iowa 50315

ELVS (Eligibility Verification System)

24 hours a day, 7 days a week

800-338-7752
515-323-9639 (Local)

EDI Support Services

10:00 AM – 4:00 PM

800-967-7902

IME Medical Prior Authorization

P.O. Box 36478
Des Moines, Iowa 50315

8:00 AM – 4:30 PM

888-424-2070
515-256-4624 (Local)
515-725-1356 (Fax)

IME Medical Services

8:00 AM – 4:30 PM

800-383-1173
515-256-4623 (Local)

IME Member Services

P.O. Box 36510
Des Moines, Iowa 50315

8:00 AM – 5:00 PM

800-338-8366
515-256-4606 (Local)

IME Pharmacy Point of Sale

8:00 AM – 6:00 PM
(after hours on-call available)
877-463-7671
515-256-4608 (Local)

**IME Pharmacy Prior
Authorization**

800-574-2515 - Fax Only

Provider PA Hotline

8:00 AM – 6:00 PM
(after hours on-call available)
877-776-1567
515-256-4607 (Local)

Provider Authorization Requests

800-574-2515 - Fax Only

IME Program Integrity Unit

8:00 AM – 5:00 PM
877-446-3787
515-256-4615 (Local)



Unit Address

Telephone Numbers

IME Provider Correspondence:

Iowa Medicaid Enterprise
P.O. Box 36450
Des Moines, Iowa 50315

Provider Services

7:30 AM – 4:30 PM
800-338-7909
515-256-4609 (Local)
515-725-1155 (Fax)

**IME Provider Cost Audits and
Rate Setting**

8:00 AM – 5:00 PM
866-863-8610
515-256-4610 (Local)

State MAC Help Line

800-591-1183

IME Drug Rebate (including
supplemental)

P.O. Box 310195
Des Moines, Iowa 50315-0195

IME Revenue Collection:

Estate Recovery and Miller Trust

P.O. Box 36445
Des Moines, Iowa 50315

7:30 AM – 5:30 PM
877-463-7887
515-256-4618 (Local)

IME Lien Recovery

P.O. Box 36446
Des Moines, Iowa 50315

8:30 AM – 5:00 PM
888-543-6742
515-256-4620 (Local)

**IME Third Party Liability and
Refunds**

P.O. Box 310202
Des Moines, Iowa 50331-0202

8:30 AM – 5:00 PM
866-810-1206
515-256-4619 (Local)


IME Refund Checks

P.O. BOX 310202
Des Moines, Iowa 50331-0202

4. Provider Services

a. Provider Manuals

The Iowa Medicaid Provider Manual contains basic information concerning Iowa's Medical Assistance Program (Medicaid). It is intended for use by all providers of medical and health services participating in the program.

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We urge you and your office staff to familiarize yourself with the contents of this Manual and to refer to it when questions arise. Use of the Manual will do much to eliminate misunderstandings concerning the coverage status of services, member eligibility, and proper billing procedures, which can result in delays in payment, incorrect payment, or denial of payment.

However, when the medical claims are to be submitted to a managed care organization for payment of a covered service, the instructions for billing are established by the managed care organization. The claim must adhere to the managed care organization's guidelines and not the ones in this manual. If you have questions, contact the managed care organization for assistance.

The Manual contains sections dealing with:


- ◆ The organization, administration, and financing of the Medicaid program, including program policies and procedures applicable to all providers (Chapter I)
- ◆ Member eligibility (Chapter II)
- ◆ Coverage policies and billing instructions procedures applicable to your particular provider group (Chapter III)
- ◆ Directories of offices involved in administering the program (Appendix)

The heading of each provider manual page indicates the chapter subject, the chapter number, the page number, and the effective date of that page.

The provider manuals are available on the Internet at: www.ime.state.ia.us/. To access the manual, choose the links to "Reports and Publications" and "Provider Manuals."

You can also access provider manuals from <http://www.dhs.iowa.gov/policyanalysis>. This web site contains all of the published policy manuals for the Iowa Department of Human Services as well as all of the administrative rules adopted by the Department.

Chapters I and II and the Appendix are published as separate documents in the category "all providers." Chapter III for each provider type is published as a separate document.

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You will need Adobe Reader software to view these documents. A link to download the software is available on the web site. Additional instructions on how to use the web site are available in the “help” section.

As chapters or individual pages of the Manual are revised, they are issued through a manual transmittal letter. You will receive a printed copy of the transmittal letter to notify you of changes.

The transmittal letter identifies and locates the changes being made and provides instructions for filing the revised material. These transmittal letters are numbered consecutively for each provider type, with a separate series for changes to the chapters that are identical for all providers.

The transmittal letters and their revised pages are also published as separate documents on the Internet. You can access them through the table labeled “General Letters.” When the revised pages are issued in advance of their effective date, they will be available only through the “General Letters” file. The chapter files are not updated until the week of the effective date.

If you do not have access to the Internet, you may request IME Provider Services Unit to issue printed pages.

Occasionally, information may be released to providers through “informational letters.” These do not update manual pages.

b. Change of Provider Enrollment Status

You must keep the IME Provider Services Unit informed concerning:

- ◆ Any change in your licensure status (if subject to state licensure); or
- ◆ Any changes in your certification status as a provider of service under Part A or Part B of Medicare.

You may amend your provider file by submitting a revised copy of your provider enrollment form or a letter to the Provider Services Unit. Submit a revised copy to add a Medicaid service that requires special certification or approval to provide the service or to receive additional reimbursement for the service. Submit additional information that shows that you meet the criteria for the service or additional payment.



The Provider Services Unit will review the documents and advise you within 30 days of receipt if the criteria for approval are met. Approval of an amendment is retroactive to the date you requested or the date you meet all applicable criteria, whichever is later, not to exceed 30 days before the IME receives the amendment.

You may appeal denial of an amendment using the same procedures as for appealing the denial of a claim. (See [Appeals](#).)

No payment shall be made for care or services provided before the effective date of the approval of your application, unless you were enrolled and participating in the Iowa Medicaid program for the care and services as of April 1, 1993.

c. Form Orders

Copy the *Iowa Medicaid Provider Form Request*, form 470-4166, to request supplies of Iowa Medicaid forms by mail.

To view a sample of this form on line, click [here](#).

B. COVERAGE OF MEDICAL AND HEALTH SERVICES

Following is a list of providers that can enroll to provide the medical and health services within the scope of the Medicaid program and the principal conditions and restrictions that apply to each.

This information is included so all providers may be aware of the medical benefits to which Medicaid members are entitled. A detailed statement of coverage policies for your particular provider group is found in Chapter III of your provider manual.

1. Acute Hospitals

Medicaid covers both inpatient and outpatient hospital care. All inpatient care is covered for the length of stay needed. Hospital admissions and certain surgical procedures are subject to prior approval by the IME Medical Services Unit. Outpatient services are limited to specific outpatient programs. Limits are placed on certain outpatient programs.



2. Advanced Registered Nurse Practitioners

Medicaid covers services provided by advanced registered nurse practitioners who are duly licensed and registered as advanced registered nurse practitioners with certification pursuant to Board of Nursing rules at 655 Iowa Administrative Code Chapter 7. This includes nurse-midwives, certified registered nurse anesthetists, and other specialties recognized by the Board of Nursing.

Payment will be approved for services provided within the nurse practitioner's scope of practice and the limitations of state law, including advanced nursing and physician-delegated functions under a protocol with a collaborating physician.

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

3. Ambulance Services

For ambulance services to be covered, the member's condition must be such that the member can be transported only by ambulance, and the transportation must be to the nearest hospital with appropriate facilities, from one hospital to another, or to a nursing facility.

4. Ambulatory Surgical Centers

Medicaid covers services furnished by ambulatory surgical centers in connection with a covered surgical procedure. Covered surgical procedures are those medically necessary procedures that are eligible for payment under the same circumstances as physician services.

5. Area Education Agencies

Medicaid covers services provided by area education agencies in connection with physical therapy, occupational therapy, speech-language therapy, psychological services, nursing social work, vision services, and audiological services. Screening, assessment, and direct services are covered.



6. Audiologists and Hearing Aid Dealers

Payment is made for testing services to establish the need for a hearing aid. When needed, payment is made for hearing aids, repairs of hearing aids, and maintenance items. Some types of aids require prior approval by the IME Medical Services Unit.

7. Behavioral Health Intervention Services

Behavioral health intervention services (formerly remedial services) are supportive, directive and teaching interventions provided in a community-based or residential group care environment.

Services are designed to improve the member's level of functioning (child and adult) as it relates to the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control.

8. Behavioral Health Services

Covered behavioral health services include mental health examinations, evaluation, individual therapy, family therapy, and group therapy.

9. Birth Center Services

Medicaid covers prenatal care, delivery, and postpartum care provided in a birth center that is enrolled as a Medicaid provider.

10. Case Management

Case management services are covered when provided by case management provider organizations certified eligible to participate in the Medicaid program. To be eligible for case management services, a member must have a primary diagnosis of mental retardation, developmental disability, or chronic mental illness. Case management services are not available to members residing in an ICF/MR.

11. Chiropractic Services

The Medicaid program covers services of a chiropractor performed in the office or home. The only covered service is manual manipulation of the spine for treatment of a subluxation demonstrated to exist by an X-ray.



12. Community Mental Health Centers

Medicaid pays for the services of a psychiatrist, psychologist, social worker, or psychiatric nurse on the staff of a mental health center.

13. Dental Services

Payment is made for dental services, including cleaning of teeth, fillings, extractions, dental surgery, dentures, and orthodontia. Some dental services require prior approval by the IME Medical Services Unit.

14. Family Planning Clinics

Covered family planning services include counseling, medical examination, laboratory tests, drugs, and supplies that are furnished by a clinic in connection with family planning.

15. Federally Qualified Health Centers

Medicaid covers services provided by federally qualified health centers that are within the scope of practice of the health professional rendering the service and are within the exclusions and coverage limitations under the Medicaid program.

16. Habilitation Services

Habilitation services are designed to assist members who have functional deficits typically seen in persons with a chronic mental illness. These home- and community based services assist in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Services available through the program include:

- ◆ Case management
- ◆ Home-based habilitation
- ◆ Day habilitation
- ◆ Prevocational services
- ◆ Supported employment



17. Health Maintenance Organizations

The Department may contract with a health maintenance organization (HMO) that is licensed to operate in the state of Iowa to provide medical and health services to enrolled members.

When a member is enrolled in an HMO, the services that are not available through the HMO's contract with the Department are payable through regular fee-for-service. Services paid by the IME are:

- ◆ Dental care
- ◆ Prescribed drugs
- ◆ Skilled care
- ◆ ICF
- ◆ ICF-MR
- ◆ HCBS waiver
- ◆ Remedial services
- ◆ Habilitation services
- ◆ Family planning
- ◆ Lead investigation
- ◆ Infant and toddler program
- ◆ Area and local education agency

Mental health services and substance abuse services will be paid through the Iowa Plan for Behavioral Health.

18. Home- and Community-Based Waiver Services

Under the home- and community-based services waiver programs, Medicaid provides services to keep eligible people out of medical institutions. The state must be able to show that these services do not cost the Medicaid program more than providing care in an institution.

If the state demonstrates this for a specified population, the federal government may agree to waive some federal requirements for eligibility and for amount, duration, and scope of services. Thus, these programs are referred to as "Medicaid waivers."

To be eligible for home- and community-based waiver services, a member must choose to receive services at home. The member must meet various requirements, including requiring the level of care otherwise provided in an institution and requiring and receiving at least one waiver service quarterly. Enrolled members are also eligible to receive regular Medicaid services.



Iowa currently has the following home- and community-based services waivers:

a. AIDS/HIV Waiver

The AIDS/HIV waiver serves members who have been diagnosed with AIDS or HIV. Members must also require the level of care available in a hospital or nursing facility. The services offered under the AIDS/HIV waiver are: adult day care, consumer choices option, consumer-directed attendant care, counseling, home-delivered meals, home health aide, homemaker, nursing, and respite.

b. Brain Injury Waiver

The brain injury waiver serves members who are under 65 years of age and have a diagnosis of brain injury. To be eligible, a member must require the level of care provided in a nursing facility or an intermediate care facility for the mentally retarded.

The services available under the brain injury waiver are: adult day care, behavioral programming, case management, consumer choices option, consumer-directed attendant care, family counseling and training, home and vehicle modifications, interim medical monitoring and treatment, personal emergency response system, prevocational services, respite, specialized medical equipment, supported community living, supported employment, and transportation.

c. Children's Mental Health Waiver

The children's mental health waiver provides funding and individualized supports that allow eligible children and youth up to the age of 18 to live in their own homes. This waiver is limited to 752 children and youth.

Eligible children and youth must have a current diagnosis of "serious emotional disorder" as determined by a mental health professional. "Serious emotional disorder" does not include developmental disorders or substance-related disorders. All eligible children and youth must be assessed to meet hospital level of care.

The services available under the children's mental health waiver are: family and community support services, environmental modifications and adaptive devices, in-home family therapy, and respite. Upon approval for the waiver, all children and youth receive service coordination and monitoring from Medicaid targeted case management.



d. Elderly Waiver

Members who are at least 65 years old may qualify for the elderly waiver program if they need care at the intermediate or skilled nursing level.

The services available under the elderly waiver are: adult day care, assistive devices, case management, chore service, consumer choices option, consumer-directed attendant care, home and vehicle modification, home-delivered meals, home health aide, homemaker, mental health outreach, nursing, nutritional counseling, personal emergency response, respite, senior companion, and transportation.

e. Ill and Handicapped Waiver

To be eligible for the ill and handicapped waiver, a member must be under age 65 and must be determined to need a nursing facility or intermediate care facility for the mentally retarded level of care.

The services available under the ill and handicapped waiver are: adult day care, consumer choices option, consumer-directed attendant care, counseling, home and vehicle modification, home-delivered meals, home health aide, homemaker, interim medical monitoring and treatment, nursing care, nutritional counseling, personal emergency response, and respite.

f. Intellectual Disability Waiver

The intellectual disability waiver provides services for members with a primary diagnosis of mental retardation who require the level of care available in an intermediate care facility for the mentally retarded. Members can choose to live at home or in assisted living arrangements. This program encourages total community integration.

Services provided under the intellectual disability waiver are: adult day care, consumer choices option, consumer-directed attendant care, day habilitation, home and vehicle modifications, home health aide, interim medical monitoring and treatment, nursing, personal emergency response, prevocational service, respite, supported community living, residential-based supported community living, supported employment, and transportation.



g. Physical Disability Waiver

The physical disability waiver serves members ages 18 through 64 who have a physical disability, determined according to the criteria used for Supplemental Security Income (SSI). Members must require the skilled nursing or intermediate level of care. Members with mental retardation are **not** eligible for this waiver.

The services available under the physical disability waiver are: consumer choices option, consumer-directed attendant care, home and vehicle modification, personal emergency response system, specialized medical equipment, and transportation.

19. Home Health Agency Services

Services provided by home health agencies are covered if the agency is certified to participate in the Medicare program. To be covered, services must be medically necessary in the treatment of an illness or an injury.

Covered services can include part-time skilled nursing care, physical therapy, occupational therapy, speech therapy, part-time services of a home health aide, medical social services, limited medical supplies, and equipment provided by the home health agency. Personal care and private duty nursing are available for children aged 20 and under with prior authorization.

20. Hospice Services

Medicaid hospice provides care to members who are terminally ill and elect hospice rather than active treatment for the illness. Services are aimed at controlling pain and providing support to the member to continue life with as little disruption as possible.

The four core services are: nursing care, medical social services, physician services, and counseling. Supplemental services include short inpatient care, medical appliances, supplies and medication, home health, homemaker services, physical therapy, occupational therapy, and speech-language pathology. Members eligible for Medicare hospice must use that benefit.

21. Independent Laboratory Services

Medicaid can pay for diagnostic tests provided by independent laboratories. The laboratory must be certified by Medicare and Medicaid for all of the services for which it requests payment.



22. Infant and Toddler Services

Medicaid covers services provided by the Early Access program in connection with physical therapy, occupational therapy, speech-language therapy, psychological services, developmental, health and nursing, medical transportation, nutritional counseling, social work, vision, and audiological services. Assessment and direct services are covered.

23. Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Medicaid covers care and services in an ICF/MR if prescribed and certified by the attending physician and supported by an interdisciplinary evaluation. The member served must be mentally retarded or otherwise developmentally disabled, be substantially handicapped, and be able to benefit from an active treatment program.

24. Lead Investigation Services

Payment will be made for medically necessary lead inspection services in order to identify the sources of lead poisoning. The provider must be certified as an elevated blood level (EBL) agency by the Iowa Department of Public Health.

25. Local Education Agency Services

Medicaid covers services provided by local education agencies in connection with audiological services, physical therapy, occupational therapy, speech therapy, psychological services, behavior services, consultation services, medical supplies, medical transportation and escort service, nursing, nutrition counseling, personal health services, social work and counseling, vision, and primary and preventive care services.

26. Maternal Health Centers

Payment is made to maternal health centers for prenatal and postpartum care, including nutritional counseling and social services, provided by bachelor-degree nutritionists, bachelor-degree social workers, physicians, and nurse practitioners employed or under contract with the center.



27. Medical Equipment and Supply Dealers

Medicaid covers durable medical equipment, prosthetics, orthotics, and supplies prescribed by a physician, physician assistant, or advanced registered nurse practitioner. Only equipment whose use is primarily medical in nature is payable under the program. Items that have only an incidental medical use in individual cases are not covered.

28. Nursing Facilities

Medicaid covers care and services in nursing facilities if prescribed by the attending physician, and if the physician certifies that nursing care above the level of board and room is required, but not to the degree of hospital or skilled nursing care.

Medicaid pays for skilled care if the facility has been certified for participation in the Medicare program. In order to be medically eligible for such care, the member must require nursing care under the 24-hour supervision of licensed nursing personnel.

29. Occupational Therapy Services

Occupational therapy services are covered in accordance with Medicare criteria when provided by an occupational therapist employed by a hospital, home health agency, rural health clinic, nursing home, rehabilitation agency, or physician or by an independently practicing occupational therapist.

Services are limited to the annual Medicare dollar amount per member in a rolling 12-month period, except for services provided by hospitals, which are excluded from this provision.

30. Optometrist and Optician Services

Covered services include the examination determining the need for glasses, the glasses, necessary repairs for them, and visual aids for subnormal vision and certain other optical appliances, if medically necessary. No payment is made for photogray or gradient-tinted cosmetic lenses. Payment for contact lenses is made following cataract surgery only.



31. Orthopedic Shoes

Orthopedic shoes are covered only if prescribed in writing by a physician, podiatrist, physician assistant, or advanced registered nurse practitioner.

32. Patient Management

Certain Medicaid members are required to enroll in the managed health care option known as MediPASS (Medicaid Patient Access to Service System). These members select or are assigned to a primary care physician, advanced registered nurse practitioner, rural health center, or federally qualified health center that serves as their patient manager.

The patient manager is responsible for providing all primary care, for referring the member to other levels of care, and for coordinating and monitoring necessary medical care. An agreement in addition to the regular Medicaid agreement is required.

For services that require authorization, designate the service authorization on the claim form, as specified in Chapter III. Services that are not authorized by the patient manager are **not** payable.

Services paid by IME without need for an authorization from the MediPASS provider are:

- ◆ Ambulance services
- ◆ Area or local education services
- ◆ Chiropractic services
- ◆ Dental services
- ◆ Family planning screening
- ◆ HCBS waiver services
- ◆ Nursing facility care
- ◆ ICF-MR care
- ◆ Infant and toddler program
- ◆ Lead investigation
- ◆ Mental health services
- ◆ Ophthalmology
- ◆ Optometric services
- ◆ Prescribed drugs
- ◆ Skilled care
- ◆ Substance abuse services

33. Pharmacy Services

Medicaid covers drugs that by law can be dispensed only by a pharmacy on a physician's prescription. Insulin is covered, although not a prescription drug. Also covered are medical and sickroom supplies. A limited number of nonprescription drugs are covered. Some types of drugs are covered only if approved in advance by the IME Pharmacy Medical Services Unit.



34. Physical Therapy Services

Physical therapy services are covered in accordance with Medicare criteria when provided by a physical therapist employed by a hospital, home health agency, rural health clinic, nursing home, rehabilitation agency, physician, or by an independently practicing physical therapist.

Services are limited to the annual Medicare dollar amount per member in a rolling 12-month period, except for services provided by hospitals, which are excluded from this provision.

35. Physician Services

Medicaid covers medical and surgical services performed in the office, clinic, hospital, home, or other location by a doctor of medicine or osteopathy. The following exclusions from coverage apply: routine physical examinations, cosmetic surgery, routine foot care, and experimental or nonproven medical and surgical procedures.

Abortion and sterilization are covered only under certain conditions. Hospital admissions and certain surgical procedures, including surgery for obesity, are subject to prior approval by the IME Medical Services Unit.

36. Podiatry Services

Covered services primarily include surgery of the foot and certain orthotic appliances for the foot. Services that are not covered include treatment for flat feet or routine foot care.

37. Psychiatric Medical Institutions for Children (PMICs)

Medicaid coverage is available for PMIC services when certain conditions of service to the child are met and the child is determined to meet specific level of care criteria.

38. Psychologist Services

Covered services include psychological examinations, evaluation, and individual and group psychotherapy in the psychologist's office, a hospital, or a nursing or residential care facility.



39. Rehabilitation Agency Services

Services of a rehabilitation agency are covered if the agency has been certified eligible to participate in the Medicare and Medicaid programs. Services of physical therapists and speech therapists can be covered.

40. Rural Health Clinics

Services of rural health clinics are covered if the clinic has been certified eligible to participate in the Medicare and Medicaid programs. Covered services include those of a physician, nurse, physician assistant, and other ambulatory services.

41. Screening Centers

Screening services are quick, simple procedures to sort out apparently well persons who have a disease or abnormality and to identify those in need of more definitive study. These services are available for members under age 21.

42. Speech Therapists

Speech therapy services are covered in accordance with Medicare criteria when provided by a speech therapist employed by a hospital, home health agency, rural health clinic, nursing home, rehabilitation agency or physician.

Services are limited to the annual Medicare dollar amount per member in a rolling 12-month period, except for services provided by hospitals, which are excluded from this provision.

43. Transportation to Receive Medical Care

Medicaid covers transportation to receive necessary medical care that is not available in the member's community. Transportation cost is covered if the member needs the services of a physician, practitioner, or institution, and there is none available in the member's community.

Payment is made only for transportation to the nearest institution or practitioner having appropriate facilities for the treatment of the patient. For members who are under age 21 or pregnant women, transportation within the community is covered.



C. GENERAL REQUIREMENTS FOR SERVICES

1. Service Delivery

The policies in this section apply to all providers of Medicaid services.

The services covered by Medicaid shall:

- ◆ Be consistent with the diagnosis and treatment of the patient's condition.
- ◆ Be in accordance with standards of good medical practice.
- ◆ Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- ◆ Be the least costly type of service that would reasonably meet the medical need of the patient.
- ◆ Be eligible for federal financial participation, unless specifically covered by state law or rule.
- ◆ Be within the scope of the provider's licensure.
- ◆ Be provided with the full knowledge and consent of the patient or someone acting in the patient's behalf, unless otherwise required by law or court order, or in emergencies.
- ◆ Be supplied by a provider who is eligible to participate in the Medicaid program.

Medicare definitions and policies shall apply to services provided by Medicaid, unless terms or policies are specifically defined differently in this manual.

In an effort to ensure quality care and to contain costs under the Medicaid program, certain restrictions have been placed on Medicaid payments to providers of service. The following list of medical and health care services that are not covered is presented as a general reference. See Chapter III for restrictions and limitations applicable to your provider group.



Payment will not be made for medical care and services:

- ◆ That are medically unnecessary or unreasonable.
- ◆ That fail to meet existing standards of professional practice, are currently professionally unacceptable, or are investigational or experimental in nature.
- ◆ That are rendered during a period when the patient was ineligible for Medicaid.
- ◆ That require prior approval but for which approval was not obtained or was denied.
- ◆ For which third parties, such as Medicare or private health insurance, are liable. (See [Third-Party Liability](#).)
- ◆ That are fraudulently claimed.
- ◆ That represent abuse or overuse.
- ◆ That are for cosmetic purposes and are provided only because of the member's personal preference.
- ◆ That have already been rejected or disallowed by Medicare, when the rejection was based upon findings for any of the reasons set forth above.
- ◆ That are provided to a person while the person is an inmate of a non-medical public institution. A non-medical public institution includes, but is not limited to, jails, prisons, and juvenile detention centers.

If a noncovered service is provided, you must inform the member before providing the service that the member will be responsible for the bill.

You are expected to supply all the same services to the Medicaid members you serve as you offered to your other clients.

As a condition of receiving Medicaid payments, you must comply with Title VI of the Civil Rights Act of 1964, as amended, and federal regulations 45 CFR Part 80. No person in the United States shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, or national origin, under any program or activity receiving federal financial assistance from the U.S. Department of Health and Human Services.



As a condition of receiving Medicaid payments, you must comply with the Section 504 of the Rehabilitation Act of 1973, as amended, and federal regulations 45 CFR Part 84 as amended to December 19, 1990. Discrimination on the basis of handicap is prohibited in all programs or activities that receive or benefit from federal financial assistance provided by the U.S. Department of Health and Human Services.

As a condition of receiving Medicaid payments, you must comply with the Age Discrimination Act of 1975, as amended, and federal regulations 45 CFR Part 91. Discrimination on the basis of age is prohibited in all programs or activities that receive or benefit from federal financial assistance provided by the U.S. Department of Health and Human Services.

2. Determination of Coverage

Services are covered only for Medicaid members. See [Chapter II, Section A](#), for a discussion of the ways members can demonstrate eligibility and methods for providers to verify eligibility.

Presentation of a *Medical Assistance Eligibility Card* does not guarantee that a person continues to be eligible for Medicaid. Verify the person's eligibility and check for any restrictions on payment at each visit (or monthly for persons in a facility or hospital).

Possession of Medicaid eligibility does not guarantee that all services will be paid.

- ◆ Bills not used to meet a spenddown for Medically Needy eligibility will be paid.
- ◆ Certain services must be authorized or must have prior approval before they are covered. For example:
 - Nursing facilities and ICFs/MR should check with the local Department office to verify that payment for medical institutional care will be made for a person who is Medicaid eligible.
 - Home- and community-based waiver services require specific authorization.

See Chapter III, *Provider-Specific Policies*, for details.



- ◆ There may be restrictions on what providers can be paid for services to a specific member.
 - Members with a patient manager require the manager's authorization for most services.
 - Managed care plans may limit the provision of certain services. For example, not all mental health services are covered under the fee-for-service reimbursement. Preauthorization is necessary for people to enroll in the Iowa Plan.
 - Members may be "locked in" to service by certain providers because of overuse of service.

a. Determining Member Status

Use the Iowa Eligibility Verification System (ELVS) or the IME web portal to get the information you need concerning eligibility and restrictions on payment. See Chapter II, [Eligibility Verification](#), for instructions. For pharmacies, this information is available in the point-of-sale system.

The verification system will indicate whether the member:

- ◆ Has full or limited Medicaid benefits.
- ◆ Has a patient manager.
- ◆ Is enrolled in the lock-in program.
- ◆ Is enrolled in a managed care organization.
- ◆ Is enrolled in the Iowa Plan for Behavioral Health services.
- ◆ Has health insurance (third-party liability).

If the member has limited Medicaid benefits, the verification system will say what benefits the member has. Only those benefits will be paid.

If the member has a patient manager, the verification system will give the name of the patient manager and that provider's phone number. The patient manager should be called for prior authorization. See [Patient Management](#) for the list of services where the patient manager is not involved.

If the member is enrolled in the lock-in program, only the designated provider listed for the service shall be paid for that type of service. See [Lock-In Program](#) for more information.



If the member is enrolled in the managed care plan, the plan is named on the verification system with the telephone number for more information. See [Health Maintenance Organizations](#) for the list of services that the plan does not cover.

If the member is enrolled in the Iowa Plan for Behavioral Health, the Iowa Plan contractor is named with the telephone number for more information.

If the member has health insurance, the policy number and the type of coverage are given. Most times the insurance company name is given. However, for the less common companies, a code is given in place of the name. You may contact the IME Provider Services Unit for the name and address of the health insurance company.

b. Iowa Plan for Behavioral Health

Medicaid enrolls most members in the Iowa Plan for Behavioral Health, which is administered by Magellan Behavioral Care of Iowa (Magellan). Members who are **not** enrolled in the Iowa Plan include:

- ◆ Members whose eligibility is Medically Needy with spenddown,
- ◆ Members with limited benefits such as IowaCare or family planning services, and
- ◆ Members living in Glenwood and Woodward Resource Centers.

Members enrolled in the Iowa Plan receive mental health and substance abuse services from providers enrolled with Magellan. **EXCEPTION:** Certain behavioral health services are paid by IME. They include remedial services, habitation services, PMICs for mental health, the children's mental health waiver, and prescribed drugs.

In order to allow flexibility, a member may receive mental health visits from the member's regular physician 12 times a year, paid by the IME. To determine if this limit has been met, call the IME Provider Services Unit.

Providers who are enrolled only with Magellan should call the provider number at Magellan for eligibility information for each visit or entrance to a facility. Also if the stays exceed a month, the eligibility should be verified monthly.



c. Lock-In Program

Members who use Medicaid services or items at a frequency or in an amount that is considered overuse of services may be restricted (“locked in”) to receive services from designated providers. The purpose of the lock-in program is to promote high quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions.

“Overuse of services” is defined as receipt of treatments, drugs, medical supplies, or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

Determination of overuse of services is based on utilization data generated by the Medicaid Management Information System. This utilization review does not apply to children under 21, members enrolled in the MediPASS program, members enrolled with an HMO contracting with the Department, or residents of a nursing facility. The system reports cases in which:

- ◆ The utilization exceeds the statistical average.
- ◆ The member has more than 24 physician visits in any 12-month period. A “physician” visit is considered to have occurred for the following providers:
 - Physicians,
 - Family and pediatric nurse practitioners,
 - Federally qualified health centers,
 - Rural health centers,
 - Other clinics, and
 - Emergency rooms.

For the purposes of this provision, a “physician” does not include a psychiatrist.

The IME Medical Services Unit investigates the members identified to determine if actual overuse exists. The Unit verifies that the information reported is valid and is unusual based on professional medical judgment. Physicians, pharmacists, nurses, and other professionals who are employed by, under contract to, or consultants for the Department make medical judgments.



If the review determines inappropriate use, member health education and, possibly, lock-in will follow. Lock-in is applied to an individual member. A member can be restricted for overuse in most provider types, such as physician, pharmacy, hospital, dentist, psychologist, and chiropractor. The lock-in period is for a minimum of 24 months.

The member has the choice of designated providers. If the member does not designate a provider, the Department assigns a provider from those seen by the member in the past. The primary care provider selected is contacted before the restriction is imposed to determine if the provider is willing to treat the patient. "Locked-in" providers are notified of the member's selection.

Changes in providers can be made at the provider's request by a letter to the Department. Members may add additional or referred providers to the original designation with the approval of the Department's Division of Medical Services. Members may change designated providers when a member has moved or when the provider has moved, no longer participates, or refuses to see the member.

You are strongly urged to call ELVS or check the web portal before each visit for a possible lock-in message. If the member is in the lock-in program, you will be told to call Provider Services for the name of the designated provider. When a member the lock-in program, services from another provider of that type **will not** be reimbursed, except when:

- ◆ Emergency care is required and the designated provider is not available.
- ◆ The designated provider requires consultation with or requests referral to another provider.

When one of the designated providers is a physician, that doctor is the primary care physician and is responsible for providing or directing the member's medical care and making necessary referrals to other providers.

Prescriptions will be reimbursed only if written or approved by the primary physician.



When there is restriction on a provider type that uses the CMS-1500 claim form, the referring provider's number must be identified in block 17a. The referring provider must be a designated lock-in primary physician.

When there is restriction on a provider type that uses the UB-04 claim form, the referring or attending physician's Medicaid number must be identified in form locator 82. The referring or attending physician must be a designated lock-in primary physician.

3. Prior Approval

Following is a list of medical services and equipment requiring prior approval, preprocedure review, or preadmission review. Refer to Chapter III of your provider manual for information regarding specific criteria that must be met for approval.

- ◆ Services, procedures, and medications prescribed by a physician (M.D. or D.O.):
 - Certain drugs as indicated on the Iowa Medicaid Preferred Drug List (PDL) available at www.iowamedicaidpdl.com.
 - Certain frequently performed surgical procedures. (See Chapter III of the [Physician Services Provider Manual](#).)
 - Cochlear implants.
 - Gastrointestinal surgery for treatment of obesity.
 - Prescription or nonprescription nutritional supplements.
- ◆ Hospital services (see the [Acute Hospital Services Provider Manual](#) Chapter III, [Certification of Inpatient Care](#), for details):
 - All physical rehabilitation admissions and continued stays.
 - All swing-bed and lower-level-of-care admissions and continued stays.
 - Certain diagnoses and procedures.
 - Certain inpatient and outpatient surgical procedures.
 - Medical or surgical procedures, as set forth above.



- ◆ Dental services:
 - Endodontic services
 - Fixed and removal protheses
 - Implants
 - More than two porcelain crowns in a 12-month period
 - Orthodontic services
 - Periodontal services
 - Root resection
 - Surgical endodontic treatment
- ◆ Ambulatory surgical centers:
 - Certain surgical procedures require preprocedure review by the IFMC.
 - Medical or surgical procedures require prior approval, as set forth above.
- ◆ Home health agency EPSDT private-duty nursing and personal care services.
- ◆ Durable medical equipment and supplies:
 - Augmentative communication system
 - Enclosed beds
 - Enteral products, enteral feeding pumps, and supplies
 - External insulin infusion pumps
 - Vest airway clearance systems
- ◆ Hearing aids:
 - A hearing aid costing more than \$650.
 - Replacement of a hearing aid less than four years old for patients 21 years of age and older.
- ◆ Optometric services and eyeglasses:
 - A second lens correction within a 24-month period for members eight years of age and older.
 - Subnormal visual aids, including hand magnifiers, loupes, telescopic spectacles, and reverse Galilean telescope systems where near visual acuity is better than 20/100 at 16 inches, 2m print.
 - Visual therapy warranted by case history or diagnosis, (i.e., convergence insufficiency and amblyopia).



If you are unsure whether an item or service is covered because it is rare or unusual, you may submit a request for prior approval. When you have provided medical services or equipment and you later determine prior approval was necessary, you can submit a retroactive approval request.

a. Requests for Prior Approval

If your provider type furnishes services that require prior approval, the request form and instructions for its use are included in Chapter III of your provider manual.

Your request should address the criteria applicable to the particular service, medication, or equipment for which you are seeking prior approval, according to the standards in Chapter III. You may attach copies of pertinent information rather than incorporate them on the prior authorization form.

- ◆ **Medical Prior Authorization.** Make requests for prior approval on form 470-0829, *Request for Prior Authorization*. Send requests to: IME Medical Prior Authorization, P.O. Box 36478, Des Moines, Iowa 50315, or fax prior authorization requests to 515-256-4624.

Pharmacies requesting prior authorization for medical equipment or medical supply items shall make requests using this process.

- ◆ **Drug Prior Authorization.** Requests can be submitted by faxing to 800-574-2515. Form can be downloaded at www.iowamedicaidpdl.com.

b. Review of Request

The IME reviews requests for prior approval according to the policies in this chapter and the conditions for payment as established in Chapter III. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval are reviewed according to the following criteria, in order of priority:

- ◆ The conditions for payment outlined in the provider manual with reference to coverage and duration.
- ◆ The determinations made by the Medicare program, unless specifically stated differently in state law or rule.
- ◆ The recommendation to the Department from the appropriate advisory committee.



- ◆ Whether there are other less expensive procedures that are covered and which would be as effective.
- ◆ The advice of an appropriate professional consultant.

c. Denial of Request

If the IME denies a request for prior approval, you may resubmit the request for reconsideration with additional justification.

In the event of the denial of a drug prior authorization request, the IME will fax a copy of form 470-2962, *Medicaid Notification of Drug Prior Authorization*, to the prescriber and the provider pharmacy.

The Department issues a notice to members upon a denial of a request for prior approval. The notice of decision to the member, form 470-0390, is mailed within five working days of the date the prior approval form is returned to the provider.

The aggrieved party (the member) may file an appeal within 30 days of the date of the notice of decision. (See [Appeals](#) for appeal procedures.)

4. Records

Your contract with the Iowa Medicaid program requires you to maintain clinical and fiscal records necessary to fully disclose the extent of services, care, and supplies furnished to Medicaid members. Records may be either typewritten or handwritten. Clinical and fiscal records shall be retained for a minimum of five years from the date service was rendered.

Fiscal records shall support and document services provided for which a charge is made to the Medicaid program. A fiscal record does not constitute a clinical record.

Clinical records shall support charges made to the Medicaid program by documenting:

- ◆ Medical necessity of the services.
- ◆ The services provided are consistent with the diagnosis of the patient's condition.
- ◆ The services are consistent with professionally recognized standards of care.



Documentation shall be complete and legible.

The clinical record shall document each patient encounter, and include the following when appropriate:

- ◆ Complaint and symptoms, history, examination findings, diagnostic test results, assessment, clinical impression or diagnosis, plan for care, date, and identity of observer.
- ◆ Specific procedures or treatments performed.
- ◆ Medications or other supplies.
- ◆ Patient's progress, response to treatment, changes in treatment, and revision of diagnosis.
- ◆ Information necessary to support each item of service provided on Medicaid claim form.

Both types of records must support claims submitted to the Iowa Medicaid Enterprise. Records must be currently maintained. A claim form or billing statement does not constitute a clinical or fiscal record. Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment.

The legal reference for Medicaid policy on maintenance of clinical and fiscal records is [441 IAC 79.3\(249A\)](#).

Upon proper identification, authorized representatives of the Department shall have the right to review your clinical and fiscal records using generally accepted auditing procedures to determine whether:

- ◆ The Department has accurately paid claims for goods or services.
- ◆ You have furnished the services to Medicaid members.
- ◆ You have retained clinical and fiscal records that substantiate claims you submitted for payment during the audit period.

Federal regulations allow for access to any member's medical records by authorized Department of Health and Human Services personnel and Department of Human Services personnel.

Medical records (exclusive of billings) may be released to other people according to applicable HIPAA guidelines.



Whenever a member or the representative of a member, including the member's attorney, requests duplicates of claims billed to or paid by Medicaid:

- ◆ Release copies of the billing or medical records to the member or representative; then
- ◆ Notify the IME Revenue Collection Unit if there was an accident or trauma claim and provide information that is available concerning the incident. Provide this information by mail or by calling the Revenue Collection Unit at 1-866-810-1206 or 515-256-4619 (local).

If you receive a subpoena for medical bills, release the bills. At the same time, send a copy of the subpoena and any additional information to:

IME Revenue Collection Unit
P.O. Box 36446
Des Moines, Iowa 50315

D. REIMBURSEMENT FOR SERVICES

As a condition of participation in the Medicaid program, you must agree to accept the payment made by the Medicaid program as payment in full and make no additional charges to the member or others.

No Medicaid payment can be made directly to a member or to anyone other than the provider of service. A Medicaid claim may be submitted when a patient becomes eligible after service is provided and has already paid for the service. To do this, refund the payment to the patient before submitting the Medicaid claim.

Provider reimbursement may be changed each July 1, following the direction of the Legislature. Provider reimbursement changes are announced in an informational release to all providers. If you have any questions about reimbursement rates, you may call the IME Provider Services Unit.



1. Claims

Obtain CMS-1500, UB-04, pharmacy, and dental claim forms from any wholesale vendor. Order the *Claim for Targeted Medical Care* from the IME Provider Services Unit. (See [Form Orders](#) for instructions on ordering forms.)

The Iowa Medicaid Enterprise supports the electronic submission of claims. Through electronic submission, you are able to submit claims more accurately. You also receive your Medicaid payments more quickly than if you submitted paper claims.

If you are not currently submitting claims electronically but would like to do so, IME offers a free software program called PC-ACE Pro32. To use PC-ACE Pro32, you need an IBM-compatible personal computer running Windows-95 or newer, as well as a local modem and analog phone line access. For information about electronic claims, please call 1-800-967-7902.

For information specific to your office, contact the EDISS coordinator at 1-800-967-7902. Or visit the IME web site at www.ime.state.ia.us. Follow the links for electronic data interchange. You will find the required EDI forms as well as the PC-ACE Pro32 software for downloading. The EDI staff can assist you in installing PC-ACE Pro32 if you need help.

a. Procedure Coding

The Health Care Financing Administration Common Procedure Coding System (HCPCS) includes specially designed codes and modifiers for reporting medical services and procedures that are copyrighted by the American Medical Association.

Iowa Medicaid has adopted a coding scheme based on the Current Procedure Terminology, Fourth Edition, copyright 1985, by the American Medical Association (CPT-4). The CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures.

HCPCS codes are divided into three levels. Level 1 is the current CPT-4 codes. Levels 2 and 3 are specially designed five-position codes consisting of a letter followed by four numbers. Level 2 (regional codes) begin with letters from A-V. Level 3 (local codes) begin with letters from W-Z.



b. Claim Submission

Submit claims any time during the month. Payment will be made for covered services when the IME receives the initial claim within one year from the date of service.

Claims submitted beyond the one-year limit may be paid when they are delayed due to delays in receiving third-party payments or retroactive certification for eligibility. State on the claim form the reason the claim is late, or attach it.

When you resubmit claims to correct a problem on the claim form, clearly mark them as a resubmission of a previous claim.

2. Third-Party Liability

The Medicaid Program is the payer of **last resort** for services covered by the program. Federal and state rules require that providers make a reasonable effort to pursue third-party resources.

Call ELVS or access the web portal to determine if other third-party resources are available to pay for the services being provided.

In addition, question the member to determine if any other resources are available for payment. If you note a discrepancy between the member's statement and the verification system, please notify the IME Revenue Collection Unit, either:

- ◆ Verbally at 1-866-810-1206 or 515-256-4619 (local); or
- ◆ In writing to Iowa Medicaid Enterprise, Revenue Collection Unit, PO Box 36450, Des Moines, Iowa 50315; or
- ◆ By electronic mail to REVCOL@dhs.state.ia.us.

If a third-party resource is identified, you must pursue payment from the other source. If you do not accept assignment from an available third-party resource, it is your responsibility to collect the other insurance payment from the patient before billing Medicaid.



“Pay and chase” means that you bill Medicaid even though the member has health insurance and Medicaid bills the insurance company. Medicaid requires “pay and chase” for certain situations, including when services are provided to:

- ◆ Pregnant women. The Medicaid system is programmed to recognize pregnant women when the diagnosis is entered on the claim.
- ◆ Children whose medical is provided from an absent parent, as identified by statements of the parent concerning who provides the insurance.
- ◆ Children under the age of 21 for preventative pediatric services, which include all drugs; home health services with procedure codes S9122, S9123, S9124; and the following V codes:

V01.0-9	V20.0-C20.2	V77.0
V02.0-V02.9	V70.0	V77.7
V03.0-V02.9	V72.0-V72.3	V78.2-V78.3
V07.0-V07.9	V73.0-V75.9	V79.2-V79.3

List on the claim form any payments made by the other insurance, whether made to you or to the patient. If the other source denies payment, indicate this on the Medicaid claim form. (See Chapter III for claim form instructions.)

- ◆ If the insurance makes a payment, you may submit a claim to Medicaid for consideration, unless you received payment in full.
- ◆ On the claim, show the amount that was paid by the insurance. You are not required to show the contractual write-off as payment from a third-party payer. Indicate only the actual payment you received from the third-party payer.
- ◆ Medicaid will make payment only according to the Medicaid allowance. The third-party payment plus any Medicaid payment cannot exceed the Medicaid allowance.
- ◆ If the third-party payment equals or exceeds the Medicaid allowance, Medicaid will pay the claim at \$0.00. Medicaid now considers the claim paid and you cannot bill the Medicaid member.



a. Eligibility Under Both Medicare and Medicaid

Medicare is a federally administered program of health insurance for people who are over age or are permanently disabled. The program is financed in the same manner as Social Security.

- ◆ Medicare Part A (hospital insurance) helps pay the expenses of a patient in a hospital, in a skilled nursing facility, or at home receiving services from a home health agency.
- ◆ Medicare Part B (medical insurance) helps pay for physician services, outpatient hospital services, medical services and supplies, home health services, outpatient physical therapy, and other health care services.

When Medicare benefits are available for services also provided under the Medicaid program, the only charges payable by the Medicaid program are the deductibles and coinsurance amounts, beginning with services rendered on or after the first day of the patient's eligibility for Medicaid. (This includes for hospitalization (Part A), practitioner services (Part B), or any other covered services.)

Part B providers must in all instances accept assignment of the claim if Medicaid is to make payment for deductibles or coinsurance. There is no provision in Medicaid for reimbursement of the member for any payments the member may make to a provider of service.

It is not necessary to secure the member's signature on the Medicare claim form, because there is on file in the Department's local office a one-time statement from all Medicare beneficiaries agreeing to a permanent assignment of all Part B claims.

b. Services Provided to Medicare Beneficiaries

To obtain Medicaid reimbursement for services provided to Medicare beneficiaries, observe the following special conditions:

- ◆ Always bill the Part A or Part B Medicare intermediary first for any Medicare-covered services. Use the Medicare billing form.

Following payment of Medicare-covered services, the Medicare intermediary transfers the claim to the Iowa Medicaid Enterprise for payment of deductibles, coinsurance, and any Medicaid-covered services beyond the scope of Medicare (if there is Medicaid coverage **at that time**).



(There may be a delay in determining Medicaid eligibility, and a resultant delay in Medicaid payment of the Medicare Part B premium.)

- ◆ If the member has been denied benefits through Medicare on the basis that the benefits were not medically necessary, the member is not eligible to receive these benefits under the Medicaid program for the same reason.
- ◆ Medicaid payment for Medicare deductibles and coinsurance amounts is limited to the maximum allowable charge under the Medicare program for that particular service.
- ◆ When parts of the services are covered by Medicare Part A or Part B and others are covered only by Medicaid, submit **separate** billings to the Medicare intermediary and to the Iowa Medicaid Enterprise.

The Medicaid program pays in its usual manner for services that Medicaid covers but Medicare does not. Submit claims for these services separately to the Iowa Medicaid Enterprise on the regular Medicaid billing form.

c. **Medicare With Other Insurance**

If a patient has Medicare coverage and insurance, bill the other sources before submitting a bill to Medicaid. If you receive a payment, but the other resource has not paid your full charge, the central Medicare contractor will send your claim to the IME.

You may submit the bill to Medicaid for consideration if the payment is not made within 60 days of the Explanation of Medicare Benefits (EOMB). If the payment you received is less than the allowable Medicaid payment, Medicaid will pay the difference, up to the Medicaid allowed amount.

d. **Medicare Crossover Invoice**

All providers enrolled with Iowa Medicaid Enterprise are **required** to use a *Medicare Crossover Invoice* and **attach** a copy of the Medicare Explanation of Benefits (EOMB) when it is necessary to send a paper crossover billing to the IME. This requirement is pursuant to 441 Iowa Administrative Code (IAC) 80.2(2)"h."



There are two different crossover invoice forms depending on which provider and claim types you use to bill Medicare:

- ◆ The *Medicare Crossover Invoice (Professional)*, form 470-4708. To view a sample of this form, click [here](#).
- ◆ The *Medicare Crossover Invoice (Institutional)*, form 470-4707. To view a sample of this form, click [here](#).

Submit these forms only after Medicare has paid and established a coinsurance or deductible. These forms are not for submission of a claim where Medicare has denied the charges. Continue to attach the denied EOMB from Medicare to the CMS-1500 and UB04 claim forms when submitting for denied or noncovered charges.

(1) Medicare Crossover Invoice (Professional), Form 470-4708

To bill professional services to Iowa Medicaid that were originally billed to Medicare on a CMS-1500 claim form that did not electronically cross over from Medicare, submit **both**:

- Form 470-4708, *Medicare Crossover Invoice (Professional)*, and
- A **copy** of the *Explanation of Medicare Benefits (EOMB)*.

If you have access to a computer you **must** use the printable version of the invoice, which is available on the IME website at: <http://www.ime.state.ia.us/docs/CrossOverProfessional.pdf>

If you do **not** have access to a computer to type in the needed fields, contact Provider Services at 1-800-338-7909 or locally (in the Des Moines area) at 515-256-4609 to order blank forms. Please print legibly and use only blue or black ink.

Mail the crossover invoice along with the EOMB to:

Medicaid Claims
PO Box 150001
Des Moines, Iowa 50315

If you have questions, please contact IME Provider Services at 1-800-338-7909, locally in Des Moines at 515-256-4609 or via email to imeproviderservices@dhs.state.ia.us



The following table contains information that will aid in the completion of the invoice.

FIELD NO.	FIELD NAME	INSTRUCTIONS
Medicare Information		
1	MEDICARE'S ICN	SITUATIONAL If available, enter the ICN number from the <i>Explanation of Medicare Benefits</i> .
2	MEDICARE PAYMENT DATE	REQUIRED Enter in a MM/DD/YY format the date that Medicare paid for the services (from the <i>Explanation of Medicare Benefits</i>).
Member's Information		
3	MEMBER'S NAME	REQUIRED Enter the last name, first name, and middle initial of the member.
4	MEMBER'S MEDICAID ID #	REQUIRED Enter the member's Medicaid identification number, found on the <i>Medical Assistance Eligibility Card</i> . The number consists of seven digits followed by a letter, such as 1234567A
5	PATIENT ACCOUNT NUMBER	OPTIONAL Enter the account number you have assigned to the patient. This field is limited to 10 characters.
Provider's Information		
6	PROVIDER'S NAME, ADDRESS, CITY, STATE	REQUIRED Enter the name, address, city, and state of the billing provider.
7	ZIP	REQUIRED Enter the zip code for the billing provider's address.
8	NPI	REQUIRED Enter the national provider identifier of the billing provider.
9	TAXONOMY CODE	REQUIRED Enter the taxonomy code for the billing provider.



FIELD NO.	FIELD NAME	INSTRUCTIONS
Other Health Insurance Information		
10	IS THERE ANOTHER INSURANCE/ TPL	SITUATIONAL REQUIRED if the member has insurance other than Medicare and Medicaid. (Example: commercial insurance) Check if the member has other insurance. If not, leave blank.
11	DID THE OTHER INSURANCE/ TPL DENY COVERAGE	SITUATIONAL REQUIRED if the member's insurance other than Medicare and Medicaid has denied payment. Check if the member's other insurance has denied payment. If not, leave blank.
12	OTHER INSURANCE/ TPL AMOUNT PAID	SITUATIONAL REQUIRED if the member has insurance other than Medicare and Medicaid that has made a payment. Enter only the total amount paid by a third party. If none, leave blank. Do not list member copayments, contractual write-offs, Medicare payments, or previous Medicaid payments in this field.
Diagnosis or Nature of Injury or Illness		
13	PRIM. DIAG. CODE	REQUIRED Indicate the applicable primary ICD-9-CM diagnosis code.
14 & 15	OTHER DIAG. CODE	SITUATIONAL REQUIRED if there is an additional diagnosis code. Enter the ICD-9-CM codes for additional diagnoses other than primary, in order of importance.
Service Information Transferred From Medicare Explanation of Benefits (EOB)		
16	DATE(S) OF SERVICE FROM/TO	REQUIRED Enter in a MM/DD/YY format the month, day, and year under both the "From" and "To" categories for the period listed on the <i>Explanation of Medicare Benefits</i> .



FIELD NO.	FIELD NAME	INSTRUCTIONS
17	POS	<p>REQUIRED Enter the two-digit place of service code from the <i>Explanation of Medicare Benefits</i>. Convert the code to one of the following codes if the code from the <i>Explanation of Medicare Benefits</i> is not on the list below:</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility for persons with mental retardation 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility
18	NOS/UNITS	<p>REQUIRED Enter the number of times this procedure was performed or number of supply items dispensed (from the <i>Explanation of Medicare Benefits</i>).</p>



FIELD NO.	FIELD NAME	INSTRUCTIONS
19	PROCEDURE CODE & MODIFIER(S)	REQUIRED Enter the applicable five-digit procedure code and any necessary modifier (up to two modifiers allowed) for each of the dates of service from the <i>Explanation of Medicare Benefits</i> . Do not list services that Medicare did not cover.
20	NDC	SITUATIONAL REQUIRED if the procedure code is a 'J' code. Enter the eleven-digit national drug code associated with the procedure code, without dashes or spaces.
21	BILLED AMOUNT	REQUIRED Enter the billed amount for each procedure code from the <i>Explanation of Medicare Benefits</i> .
22	ALLOWED AMOUNT	REQUIRED Enter the amount allowed by Medicare for each procedure code from the <i>Explanation of Medicare Benefits</i> .
23	DEDUCTIBLE	SITUATIONAL REQUIRED if there is a deductible amount indicated on the <i>Explanation of Medicare Benefits</i> . Enter the deductible amount for each procedure code from the <i>Explanation of Medicare Benefits</i> .
24	COINSURANCE	SITUATIONAL REQUIRED if there is a coinsurance amount indicated on the <i>Explanation of Medicare Benefits</i> . Enter the coinsurance amount for each procedure code from the <i>Explanation of Medicare Benefits</i> .
25	COPAY	SITUATIONAL REQUIRED if there is a copayment amount indicated on the <i>Explanation of Medicare Benefits</i> . Enter the copayment amount for each procedure code from the <i>Explanation of Medicare Benefits</i> .
26	PSYCH REDUCTION	SITUATIONAL REQUIRED if there is a psychiatric reduction amount (PR-122) indicated on the <i>Explanation of Medicare Benefits</i> . Enter the PR-122 amount for each procedure code from the <i>Explanation of Medicare Benefits</i> .



FIELD NO.	FIELD NAME	INSTRUCTIONS
27	PROVIDER PAID	SITUATIONAL REQUIRED if there is a Medicare payment indicated on the <i>Explanation of Medicare Benefits</i> . Enter the amount paid by Medicare for each procedure code from the <i>Explanation of Medicare Benefits</i> .
28	TOTAL BILLED AMOUNT	REQUIRED Enter the total of the line item charges on the LAST page of the claim. If more than one claim form is used to bill services performed, give the claim Total Charge only on the last page of the claim. The pages before the last page should have "continued" or "page 1 of ___" in Box 27.
Signature of Physician or Supplier		
29	PROVIDER SIGNATURE	REQUIRED The provider or an authorized representative must sign the claim.
30	SIGNATURE DATE	REQUIRED The provider or authorized representative must indicate the original filing date.

(2) Medicare Crossover Invoice (Institutional), Form 470-4707

To bill institutional services to Iowa Medicaid that were originally billed to Medicare on a UB04 claim form that did not electronically crossover from Medicare, submit both:

- Form 470-4707, *Medicare Crossover Invoice (Institutional)*, and
- A **copy** of the *Explanation Medicare of Benefits* (EOMB).

if you have access to a computer, you must use the printable version, which is available on the IME website at:
<http://www.ime.state.ia.us/docs/CrossOverInstitutional1192010.pdf>

If you do **not** have access to a computer to type in the needed fields, contact Provider Services at 1-800-338-7909 or locally (in the Des Moines area) at 515-256-4609 to order blank forms. Please print legibly and use only blue or black ink.



Mail the crossover invoice along with the EOMB to:

Medicaid Claims
PO Box 150001
Des Moines, Iowa 50315

If you have questions, please contact IME Provider Services at 1-800-338-7909, locally in Des Moines at 515-256-4609 or via email to imeproviderservices@dhs.state.ia.us

The following table contains information that will aid in the completion of the invoice.

FIELD NO.	FIELD NAME	INSTRUCTIONS
Medicare Information		
1	MEDICARE'S ICN	SITUATIONAL If available, enter the ICN number from the <i>Explanation of Medicare Benefits</i> . For Medicare HMO crossovers, please enter the HMO claim transaction number. If the ICN number is not available, leave blank.
2	MEDICARE PAYMENT DATE	REQUIRED Enter in an MM/DD/YY format the date that Medicare paid for the services (from the <i>Explanation of Medicare Benefits</i>).
Member's Information		
3	MEMBER'S NAME	REQUIRED Enter the last name, first name, and middle initial of the member.
4	MEMBER'S MEDICAID ID #	REQUIRED Enter the member's Medicaid identification number, found on the <i>Medical Assistance Eligibility Card</i> . The number consists of seven digits followed by a letter, such as 1234567A
5	PATIENT ACCOUNT NUMBER	OPTIONAL Enter the account number assigned to the member by the provider of service. This field is limited to 10 characters.



FIELD NO.	FIELD NAME	INSTRUCTIONS
Provider's Information		
6	PROVIDER'S NAME, ADDRESS, CITY, STATE	REQUIRED Enter the name, address, city, and state of the billing provider.
7	ZIP	REQUIRED Enter the zip code associated with the billing provider's address.
8	NPI	REQUIRED Enter the national provider identifier for the billing provider.
9	TAXONOMY CODE	REQUIRED Enter the taxonomy code associated with the billing provider.
Other Health Insurance Information		
10	IS THERE ANOTHER INSURANCE/ TPL	SITUATIONAL REQUIRED if the member has insurance other than Medicare and Medicaid. (Example: commercial insurance) Check if the member has other insurance. If not, leave blank.
11	DID THE OTHER INSURANCE/ TPL DENY COVERAGE	SITUATIONAL REQUIRED if the member has insurance other than Medicare and Medicaid that has denied payment. Check if the member's other insurance has denied payment. If not, leave blank.
12	OTHER INSURANCE/ TPL AMOUNT PAID	SITUATIONAL REQUIRED if the member has insurance other than Medicare and Medicaid that has made a payment. Enter only the total amount paid by a third party. If none, leave blank. Do not list member copayments, contractual write-offs, Medicare payments or previous Medicaid payments in this field.



FIELD NO.	FIELD NAME	INSTRUCTIONS
Diagnosis or Nature of Injury or Illness		
13	PRIM. DIAG. CODE	REQUIRED Indicate the applicable primary ICD-9-CM diagnosis code.
14 - 18	OTHER DIAG. CODE	SITUATIONAL REQUIRED if there is an additional diagnosis code. Enter the ICD-9-CM codes (without a decimal point), other than primary, for additional diagnoses in order of importance.
Service Information Transferred From Medicare Explanation of Benefits (EOB)		
19	TYPE OF BILL	<p>REQUIRED Enter a three-digit number consisting of one digit from each of the following categories in this sequence:</p> <p>First digit Type of facility Second digit Bill classification Third digit Frequency</p> <p><u>Type of Facility</u></p> <p>1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice</p> <p><u>Bill Classification</u></p> <p>1 Inpatient hospital, inpatient skilled nursing care or hospice (nonhospital-based) 2 Hospice (hospital based) 3 Outpatient hospital, outpatient skilled nursing care or hospice (hospital-based) 4 Hospital-referenced laboratory services, home health agency, rehabilitation agency</p> <p><u>Frequency</u></p> <p>1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim</p>



FIELD NO.	FIELD NAME	INSTRUCTIONS
20	DATE(S) OF SERVICE FROM/TO	REQUIRED Enter in a MM/DD/YY format the month, day, and year under both the 'From' and 'To' categories for the period from the <i>Explanation of Medicare Benefits</i> .
21	COVERED DAYS	SITUATIONAL REQUIRED FOR NURSING FACILITIES Enter the number of covered days. Do not use the day of discharge in your calculations.
22	TOTAL COVERED CHARGES	REQUIRED Enter the total covered charges from the <i>Explanation of Medicare Benefits</i> .
23	TOTAL NON-COVERED CHARGES	SITUATIONAL REQUIRED if there are total non-covered charges indicated on the <i>Explanation of Medicare Benefits</i> . Enter the total non-covered charges.
24	DEDUCTIBLE	SITUATIONAL REQUIRED if there is a deductible amount indicated on the <i>Explanation of Medicare Benefits</i> . Enter the total deductible amount.
25	BLOOD DEDUCTIBLE	SITUATIONAL REQUIRED if there is a blood deductible amount indicated on the <i>Explanation of Medicare Benefits</i> . Enter the total blood deductible amount.
26	COINSURANCE	SITUATIONAL REQUIRED if there is a coinsurance amount indicated on the <i>Explanation of Medicare Benefits</i> . Enter the total coinsurance amount.
27	COPAY	SITUATIONAL REQUIRED if there is a copayment amount indicated on the <i>Explanation of Medicare Benefits</i> . Enter the total copayment amount.
28	PROVIDER PAID	SITUATIONAL REQUIRED if there is a Medicare payment indicated on the <i>Explanation of Medicare Benefits</i> . Enter the total amount paid by Medicare



FIELD NO.	FIELD NAME	INSTRUCTIONS
Signature of Physician or Supplier		
29	PROVIDER SIGNATURE	REQUIRED The provider or an authorized representative must sign the claim.
30	SIGNATURE DATE	REQUIRED The provider or authorized representative must indicate the original filing date.

3. Copayment

A copayment is a charge that the member must pay to the provider of service when the service is covered under Medicaid.

As a condition of participating in the Medicaid program, you may **not** deny care or services to a member because of the member's inability to pay a copayment. An assertion that the person is unable to pay establishes inability to pay. However, this does not remove the member's liability for these charges, and it does not preclude you from attempting to collect the copayment.

a. Drugs

The member must pay a copayment for new and refill prescription drugs as follows:

- ◆ **\$1.00** for generic drugs and preferred brand-name drugs.
- ◆ **\$2.00** for non-preferred brand-name drugs for which the cost to the state is \$25.01 to \$50.00.
- ◆ **\$3.00** for non-preferred brand-name drugs for which the cost to the state is \$50.01 or more.

b. Other Services

The member must pay a **\$1.00** copayment for the total services rendered on a given date for the following types of services:

- ◆ Chiropractor services
- ◆ Physical therapists
- ◆ Podiatrist services



The member must pay a copayment of **\$2.00** for the total services rendered on a given date for the following types of service:

- ◆ Ambulance services
- ◆ Audiologist services
- ◆ Hearing aid dealer services
- ◆ Medical equipment and appliances
- ◆ Optician services
- ◆ Optometrist services
- ◆ Orthopedic shoes
- ◆ Prosthetic devices and sickroom supplies
- ◆ Psychologist services
- ◆ Rehabilitation agency services

The member must make a copayment of **\$3.00** for the total covered service rendered on a given date for:

- ◆ Dental treatment
- ◆ Hearing aids
- ◆ Services rendered in a physician (MD/DO) office visit
- ◆ Nonemergency services rendered in a hospital emergency room (unless the visit results in a hospital admission)

Dually eligible Medicare and Medicaid members must make a copayment of **\$1.00** for Medicare Part B (crossover) claims submitted to Medicaid for services in which Medicaid collects a copayment.

c. Exemptions

Copayment is **not** applicable to the following services:

- ◆ Services provided to members under age 21. The member's age is indicated on the member's *Medical Assistance Eligibility Card*.
- ◆ Family planning services (oral contraceptives, contraceptive devices).
- ◆ Services provided to members in nursing facilities, intermediate care facilities for persons with mental retardation, or psychiatric institutions. EXCEPTIONS: Copayment is required for:
 - Residents in a noncertified facility or noncertified bed,
 - Nursing facility residents who have transferred resources, or
 - Medically Needy members who reside in a nursing facility.

Medicaid cannot make payment for nursing care for these residents; therefore they are not exempt from copayments.



- ◆ 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 a health maintenance organization.
- ◆ 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](#).



Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records.

Send these forms to:

IME Provider Services Unit
PO Box 36450
Des Moines, Iowa 50315

b. Credit/Adjustment Request, Form 470-0040

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. 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](#).

Use the *Credit/Adjustment Request* to notify the IME to take an action against a paid claim, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *Remittance Advice* should be canceled.

Do **not** use the *Credit/Adjustment Request* when a claim has been denied. Denied claims must be resubmitted.

NOTE: Requests for adjustments on paid claims will not be processed if more than one year has elapsed between the date of payment of the claim in question and the date the IME receives the request for adjustment.

Send these forms to:

IME Provider Services Unit
PO Box 36450
Des Moines, Iowa 50315



5. Appeals

You have the right to appeal a denied claim for services only after you have exhausted all administrative procedures with the IME. At that point, the IME issues an official notice that the service is not covered by Medicaid and notifies you of the right to an appeal.

Administrative procedures include, but are not limited to:

- ◆ Resubmitting the claim due to errors in completing the original claim.
- ◆ Providing all requested documentation.

When you wish to appeal a denied claim, you must submit a written request for a hearing within 30 days from the date of the official notice denying the claim.

To appeal in writing, do one of the following:

- ◆ Complete an appeal electronically at <https://dhssecure.dhs.state.ia.us/forms/appealrequest.htm>, or
- ◆ Write a letter telling us why you think a decision is wrong, or
- ◆ Fill out an *Appeal and Request for Hearing* form. You can get this form at the local DHS office. Specify in the request the nature of the complaint. If possible, include a copy of the official notice of the denial of the claim.

Take or mail the request to:

Appeals Section
Iowa Department of Human Services
1305 E Walnut Street
Des Moines, Iowa 50319-0114

The Department's rules on appeal hearings are found at [441 Iowa Administrative Code Chapter 7](#).

6. Reviews and Audits

You may be audited at any time at the discretion of the Department. The legal reference for Medicaid provider reviews and audits is [441 Iowa Administrative Code 79.4\(249A\)](#).

The Department will select the appropriate method of conducting a review and will protect the confidential nature of the records being reviewed. You may be required to furnish records to the Department. You may select the method of delivering any requested records to the Department.



Review procedures may include, but are not limited to, the following:

- ◆ Comparing clinical and fiscal records with each claim.
- ◆ Interviewing members of services and provider employees.
- ◆ Examining third-party payment records.
- ◆ Comparing Medicaid charges with private client charges to determine that the charge to Medicaid is not more than the customary and prevailing fee. Records of privately paying clients will be requested by subpoena.

The Department's procedures for auditing Medicaid providers may include the use of random sampling and extrapolation. When the Department's audit findings have been generated through sampling and extrapolation, and you disagree with the findings, the burden of proof of compliance rests with you.

7. Overpayments

When an overpayment is found, the Department may proceed with one or more of the following:

- ◆ Request repayment in writing.
- ◆ Impose sanctions provided for in 441 Iowa Administrative Code 79.2(249A), which may include:
 - A term of probation for participation in the Iowa Medicaid program.
 - Termination from participation in the Iowa Medicaid program.
 - Suspension from participation in the Iowa Medicaid program.
 - Suspension or withholding of your payments.
 - Referral to peer review.
 - Prior authorization of services.
 - Review of all of your claims before payment.
 - Referral to the state licensing board for investigation.
- ◆ Investigate and refer to an agency empowered to prosecute under applicable federal or state laws.

If a sanction is imposed and you have a total Medicaid credit balance of more than \$500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance, you will be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that you had a credit balance over \$500.

You must make repayment or reach agreement with the Iowa Medicaid Enterprise. Overpayments and interest charged may be withheld from your future payments.



8. Penalties

Section 1909 of the Social Security Act provides that whoever furnishes items or services to a person for which payment is or may be made in total or in part out of federal Medicaid funds shall be guilty of a misdemeanor when they solicit, offer, or receive any:

- ◆ Kickback or bribe in connection with the furnishings of the items or services or the making or receipt of such payment, or
- ◆ Rebate of any fee or charge for referring any such person to another person for the furnishing of the items or services.

Upon conviction, the penalty is a fine not more than \$10,999, imprisonment for not more than one year, or both.