iowa total care™

ia health link

Hawki

Annual Provider Training

2022

Your Partner in Community Health Transformation

Iowa Total Care

About Us

About Us

Centene:

- Iowa Total Care is a subsidiary of Centene Corporation
- Over 30 years of experience:
  - Medicare
  - Medicaid
  - Specialty Services

Iowa Total Care:

- NCQA accredited
- Medicaid
- Headquartered in West Des Moines
- Over 700 Iowa Total Care employees
  - Locally-based health plan staff:
    - Call Center
    - Provider Relations Specialists
    - Clinical Quality Consultants
    - Community-Based Case Managers

Why we're in business

OUR PURPOSE

Transforming the health of the community, one person at a time

What we do

OUR MISSION

Better health outcomes at lower costs

What we represent

OUR PILLARS

Focus on the Individual

+

Whole Health

+

Active Local Involvement

What drives our activity

OUR BELIEFS

We believe healthier individuals create more vibrant families and communities.

We believe treating people with kindness, respect and dignity empowers healthy decisions.

We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well

We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful, accessible healthcare.

Commitment to our Partners

Our goal is to help each and every Iowa Total Care member achieve the highest possible levels of wellness and quality of life, while demonstrating positive clinical results.

- Integrated Care
- Coordination of Care
- Continuity of Care

Member Services & Eligibility

Member Population & Benefits

Iowa Total Care provides health care coverage for enrollees of:

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

Core Medicaid benefits are covered, and all services are subject to benefit coverage, limitations, and exclusions, as described in the provider manual.

- **Link to Member Handbook:**
  https://www.iowatotalcare.com/members/medicaid/resources/handbooks-forms.html

- **Link to Provider Manual:**
  https://www.iowatotalcare.com/providers/resources/forms-resources.html

Find A Provider

Find an Iowa Total Care Medicaid Provider

Online Tool	Provider Directory	Member Services
Quick and easy	Updated weekly	1-833-404-1061 (TTY: 711)

providersearch.iowatotalcare.com

Iowa Total Care Member Resources

Start Smart for Your Baby®

Start Smart for Your Baby® is designed to customize the support and care you need for a healthy pregnancy and baby. Call Iowa Total Care at **1-833-404-1061** (TTY: 711)**.**

24/7 Nurse Advice Line

Staffed with registered nurses. Assistance in English and Spanish is available. If you speak a different language, you can ask for an interpreter. To access the **24/7 Nurse Advice** Line, call Iowa Total Care at **1-833-404-1061** (TTY: 711).

Video Appointments with a Doctor

We have partnered with Babylon Health to give 24/7 access to medical care at no cost to Iowa Total Care members. Members can schedule through the Babylon App or call **Babylon Health** directly at **1-800-475-6168** (TTY: 711).

Language Access Services

Access to interpreters over the phone, face-to-face, or via video remote interpretation. You can get interpreters for American sign language, too. Just call Iowa Total Care at **1-833-404-1061** (TTY: 711) for help.

Free Smartphone from SafeLink Wireless

Iowa Total Care is proud to be working with SafeLink Wireless. This program is offered at no cost to you. Members who qualify get a free smartphone and up to 350 minutes per month. Unlimited texting is included too. To apply for this program, visit **SafeLink.com** and use promo code IATOTALCARE or call **1-877-631-2550**.

FindHelp.org

Online tool that connects people in need to the programs that serve them. You can search for places that can help with food, housing, transportation, jobs and more! To find resources near you, log on to **IowaTotalCare.com,** under the Helpful Links section. Then enter your ZIP code to find help near you.

Questions? Call 1-833-404-1061 (TTY: 711)

Access2Care (A2C)

Non-Emergent Medical Transportation (NEMT)

- Eligible Medicaid members, or providers on the members' behalf, may request a ride for a Medically Necessary appointment.
- For non-urgent medical needs or routine appointments, members ages 16 or older may ride alone. To schedule a ride:
  - Call at least 2 business days in advance of the member appointment.
  - Reservations can be made up to 30 days in advance.
  - If a member needs a ride to dialysis, chemotherapy or radiation treatments, you can schedule a ride up to 90 days in advance.

To schedule a ride, please call Access2Care at 1-833-404-1061 (TTY: 711), press 2 for Iowa Total Care Member Services, then press 1 for Transportation.

For member return rides, please call 1-844-521-9948.

Member Eligibility Verification

Eligibility can be validated 1 of 3 ways:

Using the Provider Portal:
https://www.iowatotalcare.com/providers.html

Calling the Member Eligibility IVR Self-Service System:
1-833-404-1061 (TTY: 711)

Calling Iowa Total Care Provider Services:
1-833-404-1061 (TTY: 711)

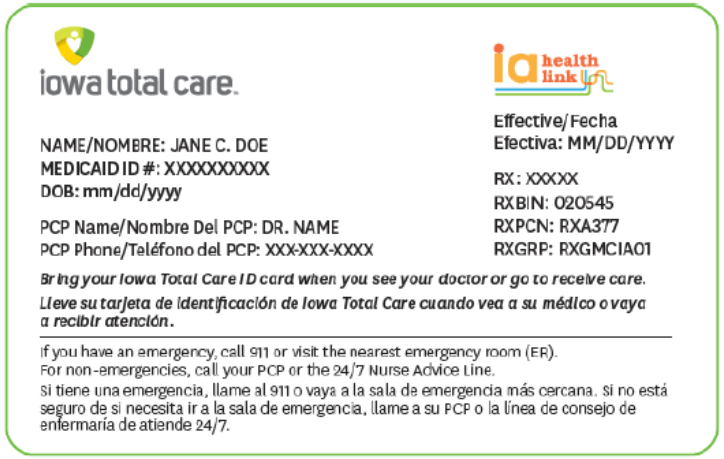
To verify eligibility, be sure to have the following information available:

- Member Name
- Medicaid ID Number
- DOB

The Portal and IVR provide 24/7 self-service convenience.

Member ID Cards

The following are sample Iowa Total Care member ID cards: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NAME/NOMBRE: JANE C. DOE
MEDICAID ID #: XXXXXXXXXX
DOB: mm/dd/yyyy

PCP Name/Nombre Del PCP: DR. NAME
PCP Phone/Teléfono del PCP: XXX-XXX-XXXX

Effective/Fecha Efectiva: MM/DD/YYYY

RX: XXXXX
RXBIN: 020545
RXPCN: RXA377
RXGRP: RXGMCIA01

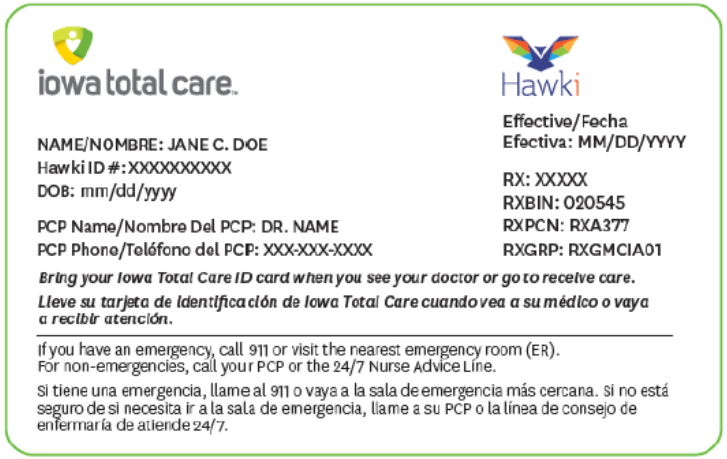
Bring your Iowa Total Care ID card when you see your doctor or go to receive care.
Lleve su tarjeta de identificación de Iowa Total Care cuando vea a su médico o vaya a recibir atención.

If you have an emergency, call 911 or visit the nearest emergency room (ER).
For non-emergencies, call your PCP or the 24/7 Nurse Advice Line.
Si tiene una emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Si no está seguro de si necesita ir a la sala de emergencia, llame a su PCP o la línea de consejo de enfermería de atiende 24/7.


IMPORTANT CONTACT INFORMATION/
INFORMACIÓN IMPORTANTE DE CONTACTO

MEMBERS/MIEMBROS: **1-833-404-1061** (TTY: 711)
Member Services/Servicios para los miembros
24/7 Nurse Advice Line/Línea de consejo de enfermería 24/7

PROVIDERS/PROVEEDORES:
Eligibility: **1-833-404-1061 (TTY: 711)** • Prior Authorization: **1-833-404-1061**
Medical Claims: **PO Box 8030, Farmington, MO 63640**
Provider/claims information via the web: **IowaTotalCare.com**
Pharmacy Help Desk: **1-877-281-9627**


iowa total care.

Hawki

NAME/NOMBRE: JANE C. DOE
Hawki ID #: XXXXXXXXXX
DOB: mm/dd/yyyy

PCP Name/Nombre Del PCP: DR. NAME
PCP Phone/Teléfono del PCP: XXX-XXX-XXXX

Effective/Fecha Efectiva: MM/DD/YYYY

RX: XXXXX
RXBIN: 020545
RXPCN: RXA377
RXGRP: RXGMCIA01

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Member Grievances and Appeals

With the written consent of the member, a provider or an authorized representative may request an appeal or file a grievance on behalf of the member.

For appeals: use the **Authorized Representative Designation form**.
For grievances: use the **Release of Information form**.
Forms may be located on our website:
https://www.iowatotalcare.com/members/medicaid/resources/handbooks-forms.html.

Refer to the **Provider Manual** at
https://www.iowatotalcare.com/providers/resources/forms-resources.html
for information on how to file a member grievance, appeal, and State Fair Hearing, along with details on timely filing deadlines.

Provider Responsibilities, Access and Availability

Provider Responsibilities

Some provider responsibilities include, and are not limited to:

- Initial credentialing and re-credentialing every 36 months.
- ADA compliance (including parking and entry pathways).
- Encourage members to execute an Advance Directive and remain in compliance with Advance Directive requirements.
- Billing primary insurance prior to Iowa Total Care.
- Communicate provider change of address, addition and termination of practitioners, and other important notifications.

Provider Responsibilities, *continued*

- Maintain accurate and complete medical records.
  - See Provider Manual, subsection Required Information or Medical Record Review Policy CC.QI.13.
- Render medically necessary and appropriate levels of care to members.
- Ensure PCP and Specialty access 24 hours a day, 7 days a week.
- Specialist coordination and communication with PCPs.
- Member non-discrimination based on race, color, national origin, disability, age, sex, religion, mental or physical disability, or limited English proficiency.

Provider Access & Availability

Appointment Access & Availability Standards

Network providers must comply with all access standards.

For a complete list of standards, refer to the Provider Manual.

Hospital Emergency Availability

- 24 hours/7 days a week

Primary Care Physician Availability

- **Urgent:** Within 24 hours
- **Routine Appointment:** Four (4) to six (6) weeks from the date of patient's request

Behavioral Health Availability

- **Urgent:** Within one (1) hour of presentation at service site or within 24 hours of phone contact with provider or Iowa Total Care
- **Routine Appointment:** Within three (3) weeks of request for an appointment

Specialty Provider Availability

- **Urgent:** Within 24 hours
- **Routine Care:** Within 30 days

Fraud, Waste, and Abuse

Identification and reporting most common issues:

- Use of incorrect billing code
- Not following the service authorization
- Inaccurate procedure codes for the provided service
- Excessive use of units not authorized by the care coordinator
- Lending of insurance card

Reporting	Iowa Medicaid Program Integrity Unit: **1-877-446-3787** Iowa Total Care Fraud and Abuse Line: **1-866-685-8664**

Critical Incidents

Critical incidents related to one of the following require notification to Iowa Total Care by the end of the next calendar day:

- Physical injury to or by a member that requires a physician's treatment or admission to the hospital
- Results in death
- Requires emergency mental health treatment for a member
- Requires intervention of law enforcement
- Requires a report of child abuse or dependent adult abuse
- A prescription medication error or a patterns of medication errors that leads to outcome(s) 1, 2 or 3
- Member location unknown

Reporting	**Email:** QOCCIR@IowaTotalCare.com **Fax: 1-833-205-1251** To submit the incident, providers must use the Critical Incident Report form located on the Iowa Total Care website: https://www.iowatotalcare.com/providers/resources/forms-resources.html

Contracting & Credentialing

Contracting for Providers

Where does a provider go if they want to contract with Iowa Total Care?

1. Visit IowaTotalCare.com
2. Hover over ‘For Providers’
3. Select ‘Become a Provider’
4. Click on ‘Contract Request Form’

As a reminder, Provider Network generally does not contract for Transportation (A2C), Vision (OD/Hardware), Network (Envolve), Retail Pharmacy (CVS).

Questions? NetworkManagement@IowaTotalCare.com

Provider Enrollment/Credentialing

For all forms and templates:

1. Visit IowaTotalCare.com
2. Hover over ‘For Providers’
3. Select ‘Contracting & Credentialing’
4. Click on ‘Contracting & Credentialing Forms’

Submit to NetworkManagement@IowaTotalCare.com:

- For all Credentialing and Enrollment submissions
  - Once enrolled, keep enrollments up-to-date promptly by submitting the following:
    - Rosters
      - » All Delegated providers should submit quarterly (full) roster
    - New provider adds
    - Terminations
    - Updates and changes
- For questions

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV)

Who can answer questions?

Case Managers can answer questions regarding:

- Authorizations, service plans, member eligibility, etc.

Provider Services team can answer questions regarding:

- Claim issues, payment issues, etc.

CareBridge team can answer questions regarding:

- Issues with using the application/IVR, logging in to the app, trainings, etc.

CareBridge
1-844-343-3653
iaevv@carebridgehealth.com

Iowa Total Care Provider Services
1-833-404-1061 (TTY: 711)
itc_evv@IowaTotalCare.com

For additional EVV information, visit:
https://www.iowatotalcare.com/providers/electronic-visit-verification.html

Claims

Claims Processing: Claim Submissions

Electronic Visit Verification (EVV)

Effective January 1, 2021, EVV is required for CDAC and Homemaker services.

CareBridge
1-844-343-3653
7 a.m. to 5 p.m.
IAEVV@CareBridgeHealth.com

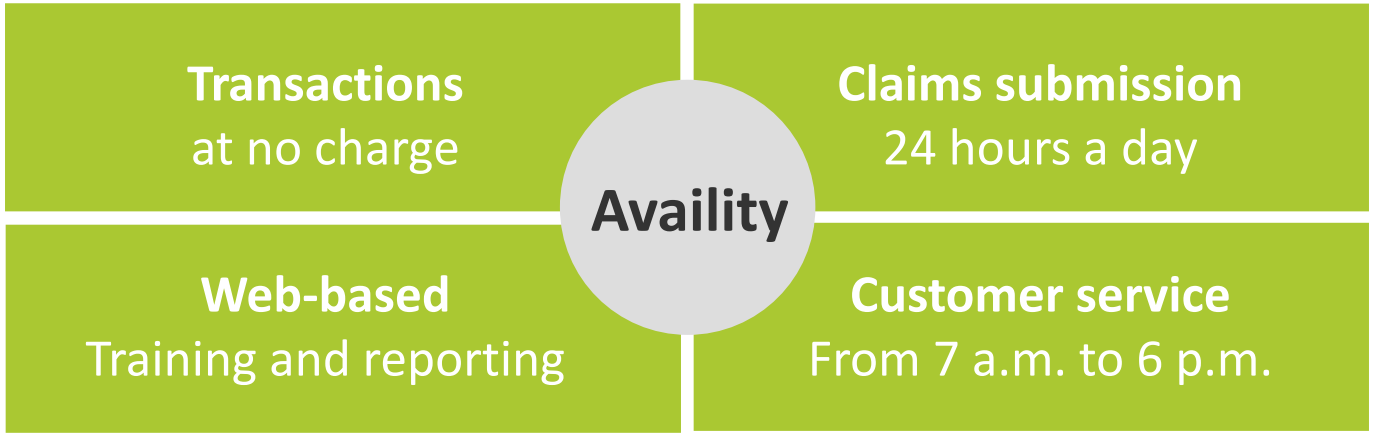
All Other In-Network Providers

All claims must be submitted electronically to Iowa Total Care utilizing the
Provider Portal:
https://provider.iowatotalcare.com/

Or using the
Provider's Clearinghouse:
Iowa Total Care
c/o Centene EDI Dept.
Email: ediba@centene.com
Payor ID: 68069
1-800-225-2573 (x 25525)

Claims Processing: Clearinghouse

Availity is the preferred clearinghouse, offering the following value services:



Iowa Total Care also accepts transmissions from Change Healthcare and Ability.

Other clearinghouses not listed above will need to be reviewed on an individual request basis.

Claims Processing: Submission and Payment Timings

Claim Type	Submission Timing
New clean claim	180 calendar days from date of service
Retroactive eligibility claims	365 calendar days from the notice date
Secondary payer	365 calendar days from final determination of the primary payer
Third-party submission and no reply	After 30 calendar days of no reply, claims accepted for 12 months from date of service
Claim Type	**Payment Timing**
New clean claim	90% within 30 calendar days of receipt
	95% within 45 calendar days of receipt
	99% within 90 calendar days of receipt
Claim Type	**Payment Timing**
Claim reconsiderations	180 days from the date of on the EOP or PRA

Claims: Electronic Payment

Contact Information:
1-877-331-7154 x1 *(available Monday-Friday, from 7 a.m. to 7 p.m.)*
ProviderSupport@PayspanHealth.com
www.payspan.com

Improve cash flow
by getting payments faster.

Settle claims electronically
through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs).

Maintain control over bank accounts
by routing EFTs to the bank account(s) of your choice.

Match payments to advices quickly
and easily re-associate payments with claims.

Manage multiple payers
including any payers that are using Payspan to settle claims.

Eliminate re-keying of remittance data
by choosing how you want to receive remittance details.

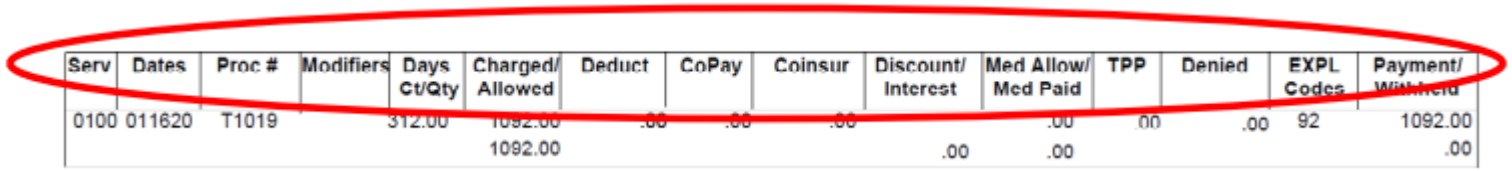
Create custom reports
including ACH summary reports, monthly summary reports, and payment reports sorted by date.

Top 10 Claim Denial Reasons

- Duplicate claim service
- CDR credit balance recovery
- Bill primary insurer 1st resubmit with EOB
- Ace claim level return to provider
- The time frame for filing a claim reconsideration
- No authorization on file that matches service(s)
- Billing NPI not registered with Iowa Department of Health & Human Services/ Iowa Medicaid
- Diagnosis code incorrectly coded per ICD10 Manual
- Payment per State methodology
- Ancillary charges not separately payable

Remittance Advice/Explanation of Payment (EOP) Guide

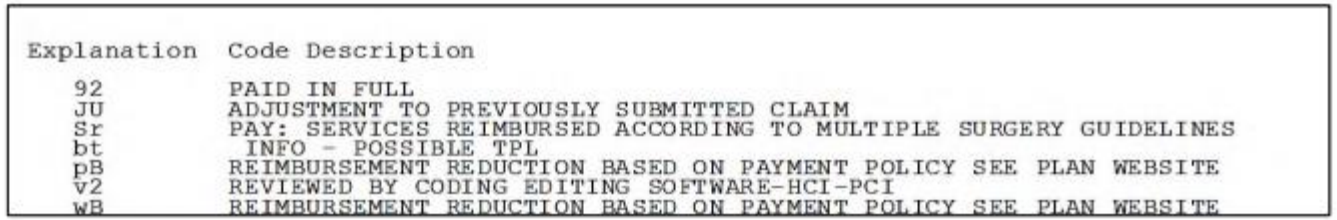
Definitions of Service Detail Columns



Serv	Dates	Proc #	Modifiers	Days Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	EXPL Codes	Payment/ Withheld
0100	011620	T1019		312.00	1092.00	.00	.00	.00		.00	.00	.00	92	1092.00
					1092.00				.00	.00				.00

ITC EOP Term	Definition
Serv	The service line/s on the claim.
Dates	Date/s of service.
Diag #/Drug #	The diagnosis code or drug code submitted on the claim
Proc #	CPT, HCPCS or revenue codes billed.
Modifiers	Modifier billed.
Days/Ct/Qty	Total number of days, count or quantity being billed.
Charged/Allowed	Charged: The amount billed for the procedure or service. Allowed: The contracted amount allowed for the procedure or service.
Deduct	The amount of the member's deductible that has been applied to the procedure or service.
CoPay	The amount of the member's copay that has been applied to the procedure or service.
Coinsur	The amount of a member's client participation deducted from the allowed amount.
Discount/Interest	Discount or interest to be applied to claim.
Med Allowed/Med Paid	The amount allowed and paid by Medicaid.
TPP	The amount paid by a third-party payer.
Denied	Total amount denied on claim.
EXPL Codes	Iowa Total Care explanation codes that indicate payment, reduction or denial reason.
Payment/Withheld	Total amount paid or withheld for the procedure or service.

Denial Code Explanations



Explanation	Code Description
92	PAID IN FULL
JU	ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM
Sr	PAY: SERVICES REIMBURSED ACCORDING TO MULTIPLE SURGERY GUIDELINES
bt	INFO - POSSIBLE TPL
pB	REIMBURSEMENT REDUCTION BASED ON PAYMENT POLICY SEE PLAN WEBSITE
v2	REVIEWED BY CODING EDITING SOFTWARE-HCI-PCI
wB	REIMBURSEMENT REDUCTION BASED ON PAYMENT POLICY SEE PLAN WEBSITE

How to Read the Claim Details

Understanding the codes used on the claim details is key to knowing whether a claim was processed.

Clean Paid Claim

- The ‘Serv’ line 0100 indicates this is an original first-time claim.

Serv	Dates	Proc #	Modifiers	Days Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	EXPL Codes	Payment/ Withheld
0100	11620	T1019		312.00	1092.00	.00	.00	.00		.00	.00	.00	92	1092.00
					1092.00				.00	.00				.00

Clean Denied Claim

- The ‘Serv’ line 0100 indicates this is an original first-time claim. If there is an amount in the Denied column, the denial codes will be listed. In this example below, denial codes are EF, eS, and eU. Explanations for these codes are provided on the EOP.

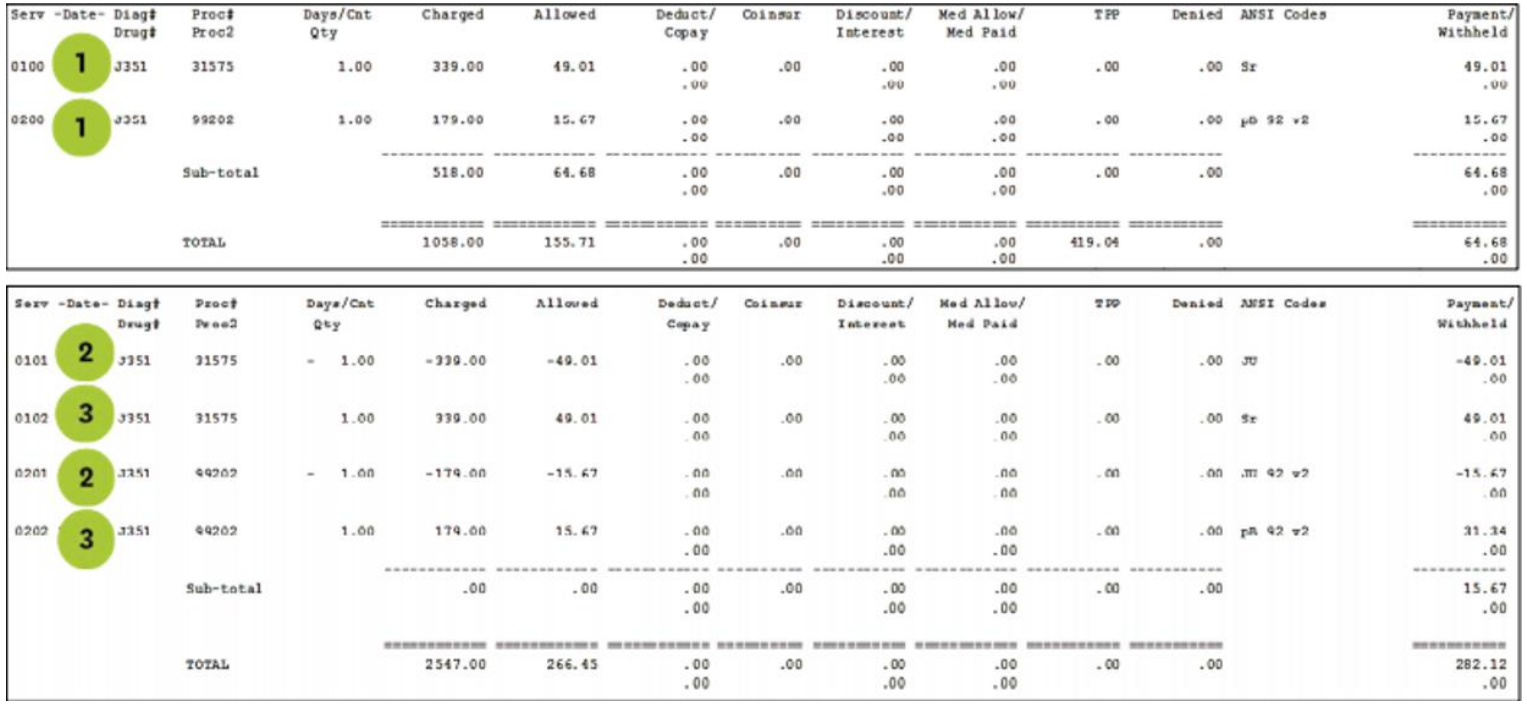
Serv -ate-	Diag# Drug#	Proc# Proc2	Days/Cat Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denie	ANSI Codes	Payment/ Withheld
0100 07 219	F331	99213	1.00	100.00	43.23	.00	.00	.00	.00	.00	100.	EF eS eU	.00
						.00		.00	.00				.00

Adjusted Claim Details: Positive Payment

An example of an EOP to the reprocessing of claims, which results in a positive net payment is shown below.

1. The original claim is indicated on service line ending ‘00’.
2. The adjusted line is the service line ending in odd number (e.g., ‘01’). This is not a recoupment, but rather a financial adjustment to allow for the fully adjusted payment amount.
3. The payment indicated by an even number (e.g., ‘02’) at the end of the service line is the final adjudicated payment of the claim.

By subtracting the original payment amount (e.g., ‘01’) 1 from the final adjudicated payment (e.g., ‘02’) 3 provides the net amount that you will receive in addition to the original payment. In this example, a positive net payment resulted.



Serv	-Date-	Diag# Drug#	Proc# Proc2	Days/Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	ANSI Codes	Payment/ Withheld
0100	1	J351	31575	1.00	339.00	49.01	.00 .00	.00	.00 .00	.00 .00	.00	.00	Sr	49.01 .00
0200	1	J351	99202	1.00	179.00	15.67	.00 .00	.00	.00 .00	.00 .00	.00	.00	μδ 92 ν2	15.67 .00
			Sub-total		518.00	64.68	.00 .00	.00	.00 .00	.00 .00	.00	.00		64.68 .00
			TOTAL		1058.00	155.71	.00 .00	.00	.00 .00	.00 .00	419.04	.00		64.68 .00

Serv	-Date-	Diag# Drug#	Proc# Proc2	Days/Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	ANSI Codes	Payment/ Withheld
0101	2	J351	31575	- 1.00	-339.00	-49.01	.00 .00	.00	.00 .00	.00 .00	.00	.00	JU	-49.01 .00
0102	3	J351	31575	1.00	339.00	49.01	.00 .00	.00	.00 .00	.00 .00	.00	.00	Sr	49.01 .00
0201	2	J351	99202	- 1.00	-179.00	-15.67	.00 .00	.00	.00 .00	.00 .00	.00	.00	JU 92 v2	-15.67 .00
0202	3	J351	99202	1.00	179.00	15.67	.00 .00	.00	.00 .00	.00 .00	.00	.00	pA 92 v2	31.34 .00
			Sub-total		.00	.00	.00 .00	.00	.00 .00	.00 .00	.00	.00		15.67 .00
			TOTAL		2547.00	266.45	.00 .00	.00	.00 .00	.00 .00	.00	.00		282.12 .00

Note:

- The original claims (service line 0200), the provider was paid $15.67.
- The adjusted service line 0201, $15.67 was subtracted in full.
- The final adjudicated claim was paid out (service line 0202) at the rate of $31.34.
- The net payment you would receive with this remit is $15.67.

Adjusted Claim Details: Zero Payment

In some cases, when claims were reprocessed the original claim payment was the same as the reprocessed payment. To determine the net amount, you will receive in addition to the original payment, subtract the original claim payment (service line ending in odd number, (’01’) from the final adjudicated payment amount (service line ending in even number, (‘02’).

In this example, the net payment result is $0. This means the original payment received was correct after the adjustment project was completed.

Clean Paid Claim

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0101	10/28/2019	V5266	LT	30.00	$-54.00 $-53.70	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	JU	$-53.70 $0.00
0201	10/28/2019	V5266	RT	30.00	$-54.00 $-53.70	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	JU	$-53.70 $0.00
			Sub-total		$-108.00 $-107.40	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00		$-107.40 $0.00

Final Adjudicated Claim Payment

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0102	10/28/2019	V5266	LT	30.00	$54.00 $53.70	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	92	$53.70 $0.00
0202	10/28/2019	V5266	RT	30.00	$54.00 $53.70	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	92	$53.70 $0.00
			Sub-total		$108.00 $107.40	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00		$107.40 $0.00

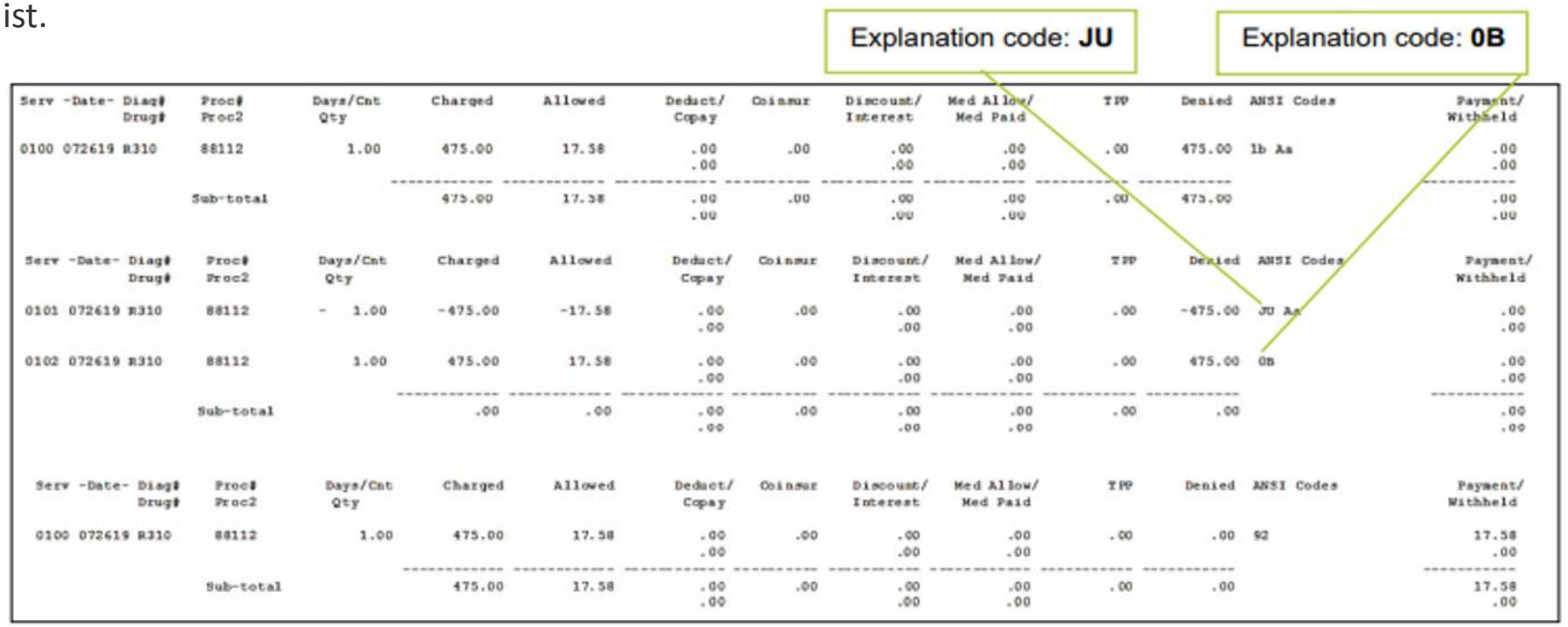
Adjusted Claim Details: Zero B (0B) Adjustments

In some cases, a claim may need to be readjusted under a new claim number due to provider system configuration changes. When this happens, the negative adjustment will process with an explanation code of JU to indicate an adjustment, and the positive adjustment will indicate Explanation Code 0B.

If you have OB adjustments and would like your detailed crosswalk report listing the old and the new claim number, please reach out to your Provider Relations Specialist.

In the example to the right:

- The original claim (e.g., 0100), the provider was denied $475.00 incorrectly.
- The adjusted line (e.g., 0101) for $475.00 was subtracted in full with a JU explanation code.
- The final adjudicated claims (e.g., 0102) was denied the $475.00 with an 0B explanation code.
- The new claim is the final adjudicated payment you would receive with the new claim number results in $17.58.



Serv -Date-	Diag# / Drug#	Proc# / Proc2	Days/Cnt / Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	ANSI Codes	Payment/ Withheld
0100 072619	R310	88112	1.00	475.00	17.58	.00 .00	.00	.00 .00	.00 .00	.00	475.00	1b Aa	.00 .00
		Sub-total		475.00	17.58	.00 .00	.00	.00 .00	.00 .00	.00	475.00		.00 .00

Serv -Date-	Diag# / Drug#	Proc# / Proc2	Days/Cnt / Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	ANSI Codes	Payment/ Withheld
0101 072619	R310	88112	- 1.00	-475.00	-17.58	.00 .00	.00	.00 .00	.00 .00	.00	-475.00	JU Aa	.00 .00
0102 072619	R310	88112	1.00	475.00	17.58	.00 .00	.00	.00 .00	.00 .00	.00	475.00	0B	.00 .00
		Sub-total		.00	.00	.00 .00	.00	.00 .00	.00 .00	.00	.00		.00 .00

Serv -Date-	Diag# / Drug#	Proc# / Proc2	Days/Cnt / Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	ANSI Codes	Payment/ Withheld
0100 072619	R310	88112	1.00	475.00	17.58	.00 .00	.00	.00 .00	.00 .00	.00	.00	92	17.58 .00
		Sub-total		475.00	17.58	.00 .00	.00	.00 .00	.00 .00	.00	.00		17.58 .00

Explanation Code	Description
92	PAID IN FULL
JU	ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM
1b	DENY REFERRING PROVIDER NPI/NAME IS MISSING
Aa	INFORMATIONAL: CLAIM PROCESSED THROUGH COORDINATION OF BENEFITS
0b	Adjust: Claim to be re-processed corrected under new claim number

Claim Dispute Process

A claim payment dispute involves a finalized claim in which a provider disagrees with the outcome.

1st DISPUTE STEP: RECONSIDERATION

- Provider can request to have the outcome of the finalized claim reviewed.
- There are two methods of submission:
  - **Submit via the Secure Provider Portal** *(this is the recommended method)*.
  - **Submit Provider Dispute form** (available on Iowa Total Care website) **by mail** to the address below.
- **Submission of request must be within 180 calendar days** from the date of EOP (Explanation of Payment) or PRA (Provider Remittance Advice).

2nd DISPUTE STEP: APPEAL

- Provider can request an appeal of the outcome.
- **Request must be submitted on a Provider Dispute Form**.
  - **Form must be submitted by mail** to the address below.
- **Submission of request must be within 30 calendar days** from the reconsideration determination letter.
- Include as much information as possible to assist with determination review.

To submit disputes by mail:

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

Link to Provider Portal:
https://provider.iowatotalcare.com/

Link to Provider Dispute Form:
https://www.iowatotalcare.com/providers/resources/forms-resources.html

Provider Resources

Provider Complaints

Providers have the right to file a complaint with Iowa Total Care.

- Provider complaints can be filed regarding policies, procedures or administrative processes in place at Iowa Total Care.
  - **Link to Provider Formal Administrative Complaint Form:** https://www.iowatotalcare.com/providers/resources/forms-resources.html
- Provider complaints should be resolved within 30 calendar days.
  - An extension of an additional 14 days can be requested for resolving the complaint, by either Iowa Total Care or the Provider.

ProviderRelations@IowaTotalCare.com

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

Monday – Friday from 7:30 a.m. to 6:00 p.m.

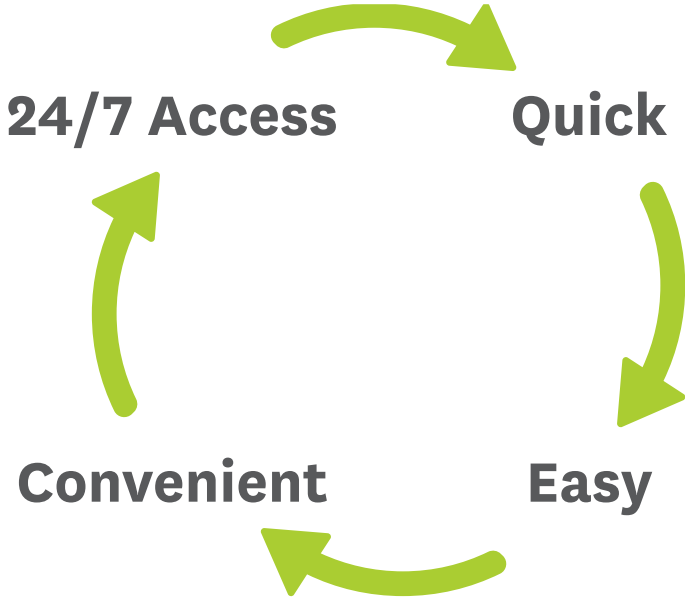
Fax: 1-833-208-1397

Iowa Total Care
Attn: Complaints
1080 Jordan Creek Parkway, Suite 100 South
West Des Moines, Iowa 50266

Provider Resources: Iowa Total Care Website

The Iowa Total Care website is designed to allow providers to have 24/7 access to key information for timely service.

- Prior authorization checker
- Clinical guidelines
- Provider and billing manuals
- Contract request forms
- Iowa Total Care provider newsletter
- Information on disability access
- Various operational and patient care forms
- Provider relations specialist contact information
- Provider training
- Provider alerts
- System configuration list of known claims issues



Visit iowatotalcare.com for more resources.

Provider Resources: Informational Updates

Iowa Total Care will keep providers aware of medical policy changes, payment and operational updates, and announcements using the following communication channels:

Iowa Total Care follows all laws applicable to state and federal including, but not limited to:

- 42 CFR,
- Part 438
- 441 IAC Chapter 73

Iowa Total Care follows policy changes distributed in Iowa Medicaid Informational Letters.

Visit iowatotalcare.com to sign up for provider communications.

Provider Resources: Secure Provider Portal

After registering to access the secure provider portal, the following tools are available to easily view and share information:

- Check member eligibility
- View the PCP panel (patient list)
- View and submit prior authorizations and member health records
- Determine payment/check clear dates
- View and print explanation of payment (EOPs)
- Access payment history
- Manage and submit claims
- Submit claims disputes
- Access daily patient lists
- Patient care gaps
- View patient demographics and history
- Download member roster
- Complete member assessments and referrals
- Access pay-for-performance reporting, payment, and member gap in care list

Register for the provider portal: Visit provider.iowatotalcare.com, then click the 'Create New Account' link under the Log In button.

Provider Resources: Provider Services

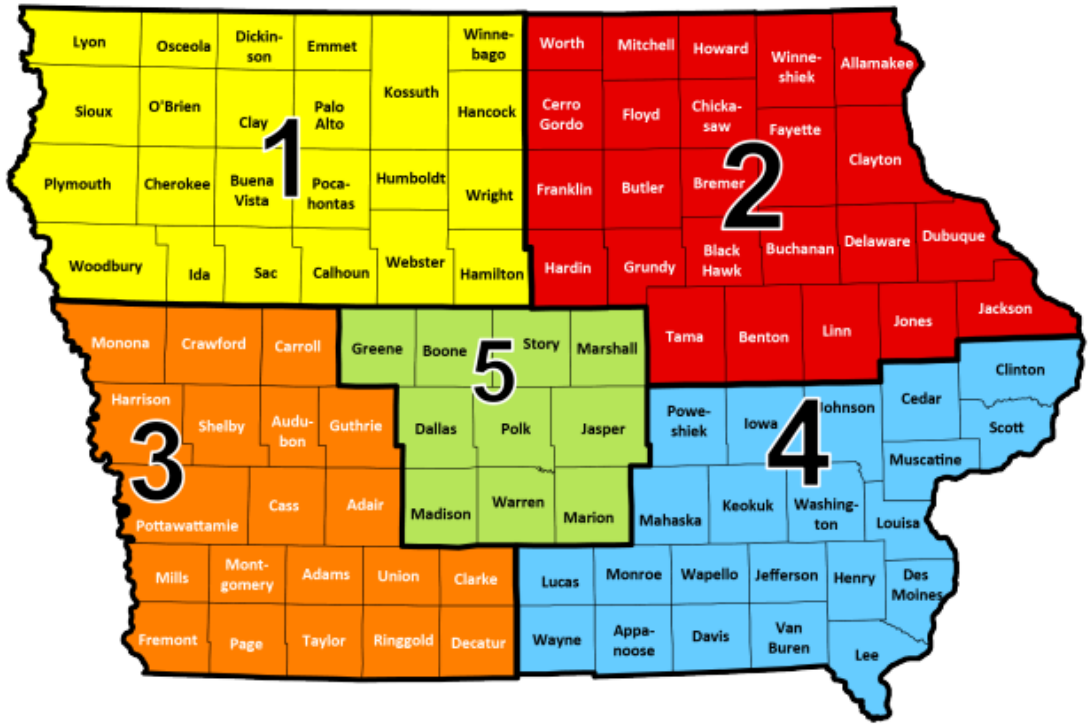
The Provider Services department includes trained representatives who are available to respond quickly and efficiently to all provider inquiries and requests.

By calling **1-833-404-1061 (TTY: 711)** between the hours of **7:30 a.m. to 6 p.m.**, providers can access real-time assistance including, but not limited to:

- Credentialing/network status
- Claims status inquiries
- Facilitate requests for adding/deleting physicians to an existing group
- Iowa Total Care website review and provider portal questions/registration
- Facilitate inquiries related to administrative policies, procedures, and operational issues
- Complimentary interpretation services

Provider Resources: Provider Relations

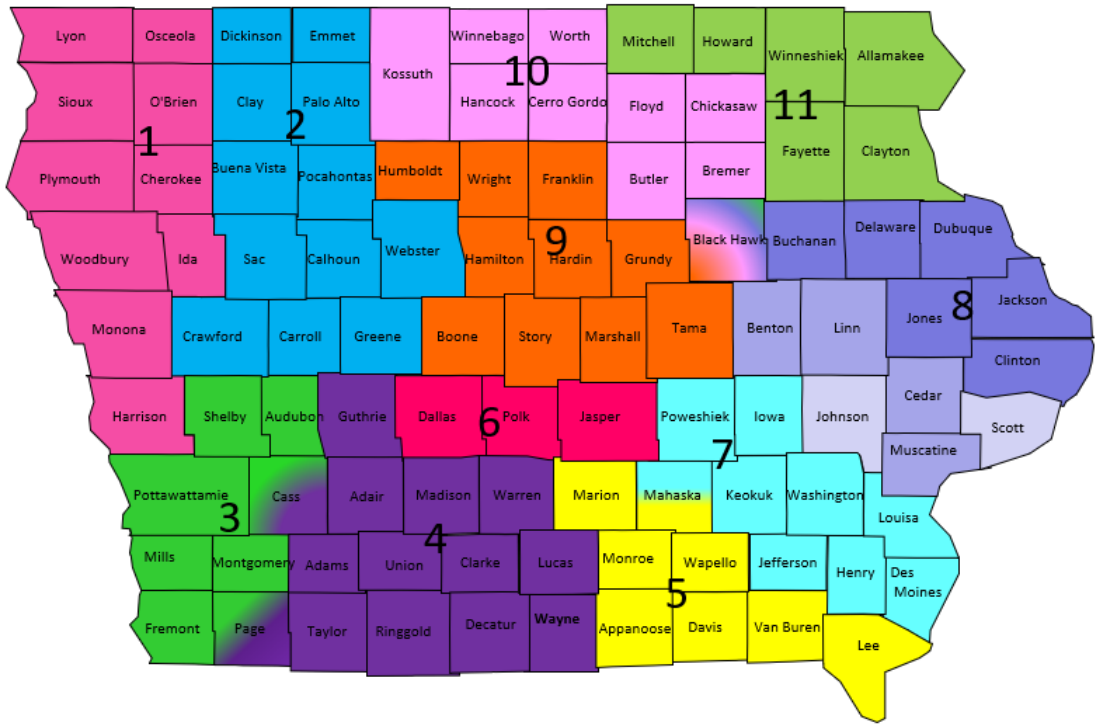
Each provider will have a **Provider Relations Specialist** assigned to them (by region) who serves as the primary liaison between Iowa Total Care and the network providers.



Need a current Provider Relations Specialist Territory Map?
Visit https://www.iowatotalcare.com/providers/resources.html.

Provider Resources: Long-Term Services and Supports (LTSS)

The LTSS team has managers assigned across the state who are available to assist with LTSS questions regarding case management, service authorizations, service plans, etc.



Need a current LTSS Community-Based Case Managers Map?
Visit https://www.iowatotalcare.com/providers/resources.html.

HCBS Care Management

A person-centered planning approach incorporates the full range of physical health, behavioral health, and support services that address functional, social, and other needs.

Case Managers:

- Engage with member's chosen team
- Coordinate services to minimize silos

Members remain at the center of our award-winning Integrated Care Model (ICM)

Qualified Provider Partners ensure members:

- Receive authorized services
- Reside in appropriate settings
- Engage in their community
- Have the opportunity to work/volunteer
- Receive reassessments if a significant change is observed

Member protections including appropriate health and welfare assurances and safeguards, critical incident reporting (CIR)

LTSS Benefits

Long-Term Services and Support (LTSS) benefits include:

- **Home- and Community-Based Services (HCBS)**
  - Provides services and supports through the waiver and habilitation programs to help members remain as independent as possible in their home and community.
- **Facility**
  - Provides long-term care in an inpatient setting.
- **Health Home**
  - Provides services and supports in the member's home as part of the Medicaid State Plan of Services.

Prior Authorizations: Long-Term Services and Supports

For all waiver and Habilitation services, the service plan is the prior authorization request. The Care Case Manager or IHH coordinator will meet with the service plan team to discuss what services are needed for the member to be successful in the next year. The Care Case Manager or IHH coordinator will then submit the service plan for UM review.

Medical & Utilization Management

Medical Management

Contacting Medical Management

- A 24/7 nurse advice hotline is available after hours and on holidays to answer questions about prior authorizations and for notifying Community-Based Case Management for urgent Long-Term Services and Support (LTSS) situations.

Department Hours: Monday – Friday from 8 a.m. to 5 p.m.

To contact Medical Management, call Provider Services:
1-833-404-1061 (TTY: 711)

Care Management

Care Coordination is designed to help members obtain needed services using a multi-disciplinary care management team that promotes:

- Continuity of care
- A holistic approach yielding better outcomes
- Discharge planning and personalized care plans
- The delivery of quality, comprehensive care services within the community
- Rapid and thorough identification and assessment of program participants, especially members with special health care needs

It is critically important to notify Iowa Total Care, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalization or recommendations for additional services.

Care Management: Key Care Coordination

- Integrated Health Home care management meet with the member's care team.
- Timely notification of discharge allows Iowa Total Care to begin post-hospitalization outreach to assist members with needed follow-up care.
  - Post-discharge outreach attempted within 24 hours of discharge notification to review D/C instructions, confirm needed services have been set up and to ensure safe transition home.

Clinical Practice Guidelines

Examples of Clinical Practice Guidelines adopted by Iowa Total Care include:

- American Academy of Pediatrics: Recommendations for Preventative Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Centers for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventative Health
- American Psychiatric Association

Adherence to the guidelines will be evaluated at least annually as part of the Quality Management Program.

All clinical practice guidelines can be found on the Iowa Total Care website:
https://www.iowatotalcare.com/providers/resources/practice-guidelines.html.
Paper copies can be requested by calling Provider Services: 1-833-404-1061 (TTY: 711).

Prior Authorizations

Iowa Total Care uses prior authorizations to ensure that all care delivered to our members is medically necessary and appropriate, based on the member's type and severity of condition. We work with our contracted providers to review certain testing and treatment decisions and verify that they are consistent with our clinical policies and philosophy of care.

- Medically necessary services
- Failure to obtain a prior authorization may result in claim denials
  - Members cannot be billed for services denied for lack of prior authorization
- Non-Par providers must have all services prior authorized except for:
  - Family planning, emergency room, post-stabilization services and tabletop x-rays
    - These services are also excluded for par provider authorization requirements
- An authorization is **not** a guarantee of payment
  - Members must be eligible at time of service
  - Service must be a covered benefit
  - Services must be billed correctly

Use our Prior Authorization Check Tool:

https://www.iowatotalcare.com/providers/preauth-check.html

Prior Authorizations: How to Submit

There are three ways to submit prior authorizations to Iowa Total Care:

Provider Portal

- provider.iowatotalcare.com
- Fax form from the Provider Portal: 1-833-257-8320

Fax

- Forms on website: https://www.iowatotalcare.com/providers/resources/forms-resources.html
- **Physical Health:** Fax: 1-833-257-8327
- **Behavioral Health:** Fax Outpatient: 1-844-908-1170 Fax Inpatient: 1-844-908-1169

Call for Assistance

- **Medical Management:** 1-833-404-1061 (TTY: 711) **Behavioral Health:** x603-2924
- Hours: 8 a.m. to 5 p.m. Monday – Friday *(excluding holidays)*

Requests received after normal business hours will be processed the next business day.

Prior Authorizations: Provider Submission Timings

Failure to obtain Prior Authorization may result in claim denials.

PROVIDER SUBMISSION TIMINGS	
Scheduled Admissions/ Elective Outpatient Services	5 business days prior to service Behavioral Health is up to 30 days in advance
Emergent Inpatient Admissions	Inpatient: within 24 hours or next business day of admission
Observation	No authorization or notification required for in-network providers
Crisis Intervention	Within 2 business days
Delivery	Notification within 2 business days of delivery
Neonatal Intensive Care Unit (NICU) Admit	Within 24 hours or next business day of admission

Convenience/scheduling alone do not equal “Urgent” status.

Prior Authorizations: Iowa Total Care Review Timings

Definition of Urgent

- **Inpatient (IP) Urgent :**
  - Medically necessary to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 24 hours.
- **Outpatient (OP) Urgent:**
  - Medically necessary to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 72 hours.

IOWA TOTAL CARE REVIEW TIMINGS	
Standard Non-Urgent	14 calendar days
Expedited Preservice/Urgent	Inpatient: 24 hours; Outpatient: 72 hours
Inpatient/Concurrent Review	72 hours
Retrospective Review	30 days

Provider Authorizations: Peer-to-Peer and Retrospective Reviews

Peer-to-Peer Requests

- Request within **2 business days** after verbal notification of denial.
- To request, call **Provider Services:**
  - **1-833-404-1061 (TTY: 711)**.
  - Select option 2, then option 5.
- For **Behavioral Health**, call:
  - **1-833-404-1061 (TTY: 711).**
  - Select option 2, then option 13.

Retrospective Reviews

- Applies to authorizations not obtained timely due to extenuating circumstances (e.g., member unconscious).
- Submit promptly but no later than 90 calendar days from date of service.
- Iowa Total Care will make a decision 30 days from the date of request contingent on submission timings being met.
- Submission and payment timing on retroactive eligibility claims are 365 calendar days from the notice date.

Pharmacy Medication Billed to Medical Benefit Example (J code, Q code, S code, etc.)

As of July 1, NCQA has added the requirement that all prior authorization requests for ***Covered Outpatient Drugs*** be completed within 24 hours, which we interpret to be by the end of the next calendar day after we receive a request.

It is possible to extend that time out if:

- we have not received enough information to make a determination, and we have specifically requested that information from the provider, and
- there is agreement that we may extend the time allowed to make a decision (72 hours for an urgent and 14 calendar days for a standard).

For pharmacy prior authorization requests (things you go to the pharmacy to pick up and take at home), this standard is already followed. What has changed is that we are now also following this turnaround time for requests for medical side (CPT-code) drugs that are given in a clinic or a doctor's office.

IOWA TOTAL CARE COVERED OUTPATIENT DRUG REVIEW TIMINGS	
Standard Review (no additional information needed)	End of next calendar day after Iowa Total care receives request
Approved Extended Review: Standard	14 calendar days
Approved Extended Review: Urgent	72 hours after Iowa Total Care receives request

Prior Authorizations: National Imaging Associates

Iowa Total Care has contracted with National Imaging Associates Inc. (NIA), an affiliate of Magellan Health Services, for radiology benefit management, certain cardiac studies, and physical medicine therapy.

To access the NIA Portal:
https://www1.radmd.com/radmd-home.aspx

Phone: 1-833-404-1061 (TTY: 711), including expedited requests
Hours: 7:30 a.m. to 6:00 p.m. Monday – Friday *(excluding holidays)*

Advanced Imaging

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA
- PET Scan

Cardiac

Prior authorization is required for the following cardiac procedures:

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

Physical Medicine

Services managed and authorized by NIA will include outpatient:

- Physical Therapy
- Occupational Therapy
- Speech Therapy

Pharmacy

Pharmacy

Iowa Total Care adheres to the State of Iowa Preferred Drug List (PDL) to determine medications that are covered under the Iowa Total Care Pharmacy Benefit, as well as which medications may require prior authorization (PA).

For the **State of Iowa Preferred Drug List (PDL)**, visit: http://www.iowamedicaidpdl.com/preferred_drug_lists.

Some members may have copayment or cost share when utilizing their prescription benefits. For additional information, refer to the Iowa Total Care member ID card or call Iowa Total Care: **1-833-404-1061 (TTY: 711)**.

Pharmacy Benefit Manager: CVS

CVS is the Pharmacy Benefit Manager (PBM) providing comprehensive services for the maintenance of the pharmacy program.

Iowa Total Care works with our internal Centene Pharmacy Services (CPS) team and CVS to administer pharmacy benefits, including the prior authorization (PA) process.

Medications that require PA can be found on the Iowa Medicaid Preferred Drug List noted as follows:

- Preferred medications indicated in the comment section as ‘PA required’.
- Non-Preferred and Non-Recommended (NR) medications on an individual basis with supporting medical necessity documentation.
- New drug entities prior to review by the IME P&T Committee and formal placement on the Preferred Drug List.

Prior authorization requests should be submitted to CPS.

Centene Pharmacy Services: Prior Authorizations

Pharmacy Prior Authorization Submissions

- **Electronic Portal:** https://www.covermymeds.com/main/prior-authorization-forms/
- **Provider Fax:** 1-866-399-0929
- **Help Desk Phone:** 1-866-399-0928

Pharmacy Prior Authorization Review Timings:

- 24-hour turnaround time for decision.
- 72-hour supply of medication may be dispensed by the pharmacy to any patient awaiting a prior authorization determination in the event of an emergency, unless otherwise noted on the **Iowa Medicaid Preferred Drug List**: http://www.iowamedicaidpdl.com/.
- Requests received after normal business hours will be processed the next business day.
- **Centene Pharmacy Services Prior Authorization Department Business Hours:**
  7:00 a.m. to 8:30 p.m. CST, Monday – Friday *(excluding holidays)*

For additional pharmacy information, visit:
https://www.iowatotalcare.com/providers/pharmacy.html

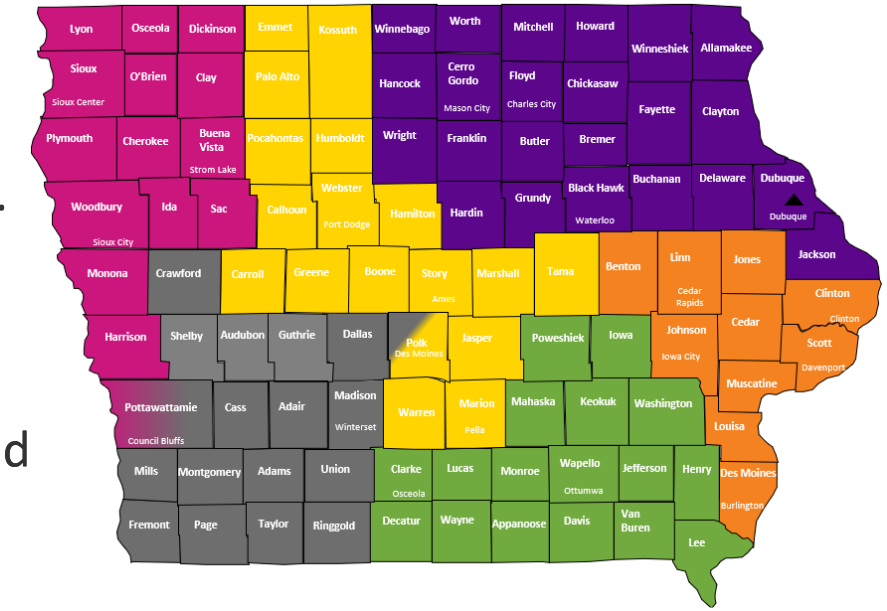
Quality

Provider Engagement

Iowa Total Care's primary quality goal is to improve members' health status through a variety of meaningful quality improvement activities, implemented across all care settings and aimed at improving the quality of care and services delivered. We focus on collaborating with providers to generate positive member health outcomes, improved population health and ensuring our members are receiving the highest level of quality care.

To assist in providing quality health outcome, Iowa Total Care has developed an innovative Clinical Quality Consultant (CQC) program.

- CQCs consist of a diverse team of registered nurses who will serve as your individual point of contact.
- They assist in the education and management of clinical requirements that are part of Risk Adjustment, HEDIS, State and CMS regulatory requirements, and other quality measures.



For more information, visit:
https://www.iowatotalcare.com/providers/quality-improvement/clinical-quality-consultant.html

Provider Pay for Performance Programs

Quality Pay for Performance (P4P)

- **Program Goal:** To promote engagement with our member and improve quality metrics.
- **Objective:** To enhance quality of care through a Primary Care Provider (PCP)-driven contribution with a focus on preventative and screening services.

Health Home P4P

- **Program Goal:** To promote Health Home (HH) professionals/facilities engagement with our members and improve quality metrics.
- **Objective:** To enhance quality of care through a HH-driven program by focusing on preventative and screening services.

Provider Pay for Performance Programs, *continued*

Behavioral Health (BH) Incentive

- **Program Goal:** To promote BH professionals' engagement with our members to improve quality metrics.
- **Objective:** To enhance quality of care through a focus on follow-up care, preventative care and screening services.

Home- and Community-Based Services (HCBS)

- **Program Goal:** To increase health outcomes for LTSS members.
- **Objective:** To enhance quality Social Determinants of Health through increased participation of LTSS providers.

Provider Incentive Programs

Continuity of Care (CoC)

- **Program Goal:** To identify high-risk members for care management/additional resources, close care gaps, avoid potential drug/disease interactions, promote routine preventative and chronic care services, and recognize/reward providers who collaborate to deliver quality care and improve documentation.
- **Objective:** To encourage providers to accurately assess members' pre-existing or suspected chronic conditions thoroughly.

Coding Accuracy Program (I-CAP)

- **Program Goal:** To identify high-risk members, close quality care gaps, avoid potential interactions and coordinate care collaboratively.
- **Objective:** To ensure medical record documentation reflects accurately in medical claim submission.

Notification of Pregnancy (NOP)

- **Program Goal:** To identify pregnancies as early as possible, decrease barriers to prenatal/postpartum services and improve maternal and neonatal birth outcomes.
- **Objective:** To enhance communication with pregnant members through provider interaction.

HEDIS 101: Healthcare Effectiveness Data and Information Set

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). NCQA holds Iowa Total Care accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership.

HEDIS rates can be calculated in two ways:

- **Administrative data** consists of claim or encounter data submitted to the health plan.
- **Hybrid data** consists of other administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but were not reported to the health plan through claims/encounter data.

How to Improve HEDIS Scores:

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each, and every service rendered.
  - All providers must bill or report by encounter submission for services delivered, regardless of contract status.
  - Claim/encounter data is the most clean and efficient way to report HEDIS.
  - If services are not billed or not billed accurately, they are not included in the calculation of a provider's quality score.
- Ensure chart documentation reflects all services provided.
- Bill CPTII codes related to HEDIS measures such as BMI calculations, eye exam results and blood pressure readings.

For additional information, visit:
https://www.iowatotalcare.com/providers/quality-improvement/hedis.html

CAHPS: Consumer Assessment of Healthcare Providers & Systems

CAHPS is a standardized patient survey developed by the Agency for Healthcare Research and Quality (AHRQ) to determine patient satisfaction with their providers, health plan and healthcare.

What does the survey ask patients about their physicians?

- Explaining things in a way that is easy for the patient to understand
- Listening carefully to the patient
- Showing respect for what the patient had to say
- Spending enough time with patient
- Advising the patient on health improvement strategies
- Seeming informed and up-to-date about the care the patient got from their specialist(s)

How to Improve CAHPS Scores

Providers can directly influence their CAHPS scores with every interaction they have with their patients. A.L.E.R.T is a model intended to help physicians.

- **A**lways
- **L**isten to patients carefully
- **E**xplain in an understandable way
- **R**espect what the patient says
- **T**ime management perceptions

Mail protocol begins: February 2022 → Phone protocol begins: April 2022 → Last day to accept completed surveys: May 15, 2022 → Data submitted to NCQA: Summer 2022

Visit https://www.iowatotalcare.com/providers/quality-improvement/cahps--corner.html for more information.

Behavioral Health (BH) ECHO Survey

BH ECHO (Experience of Care and Health Outcomes) survey is a standardized patient survey developed by the Agency for Healthcare Research and Quality (AHRQ) to assess and improve the patient experience with behavioral health, mental health, and/or substance abuse services.

What does the survey ask patients about their experience?

- Getting treatment quickly
- How well clinicians communicate
- Informed about treatment options
- Access to treatment/information from health plan
- Office wait time
- Informed about medication side effects
- Received information about managing condition
- Informed about patient rights
- Ability to refuse medication and treatment
- Rating of counseling or treatment

How to Improve BH ECHO Scores

Providers can directly influence their CAHPS scores with every interaction they have with their patients. A.L.E.R.T is a model intended to help physicians.

- **A**lways
- **L**isten to patients carefully
- **E**xplain in an understandable way
- **R**espect what the patient says
- **T**ime management perceptions

Mail protocol begins: August 8, 2022 → Phone protocol begins: September 12, 2022 → Last day to accept completed surveys: October 3, 2022 → Results provided: November 1, 2022

Member Outreach

Effective Frequency of Contacts

- Increase awareness/education of preventative and chronic care wellness, to positively influence members intent to activate care.

Channel Maximization

- Utilization of multiple channels to influence member behavior while building a plan to engage members holistically:
  - Auto dialer calls (POM), texting, electronic (website/portal), community engagement, live calls, and mailings.

For more member information, visit:
https://www.iowatotalcare.com/members/medicaid.html

Member Outreach

Member Incentive Program: My Health Pays® Rewards

What is it?

- Rewards program for members to encourage preventative care.

How to Earn:

- Member completes healthy activities like a yearly wellness exam, annual screenings, tests and other ways to protect their health.
- Provider submits claim with correct code to prompt reward.

Where to Spend Rewards:

- Walmart/Sam's Club for everyday items.
- Household utilities.
- Phone bills (cell phone or home phone).
- Public transportation or rideshare *(card cannot be used for gasoline).*

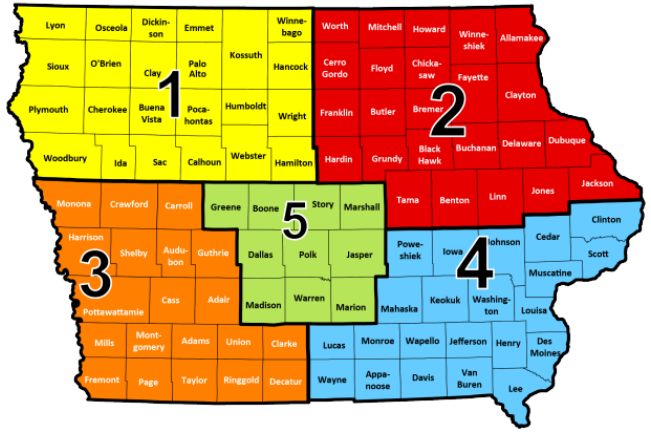
Additional Questions:

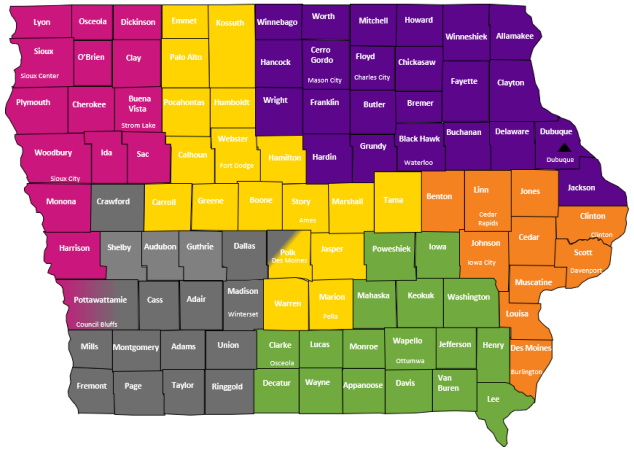
- Provider Codes for My Health Pays® Rewards
- My Health Pays® FAQs

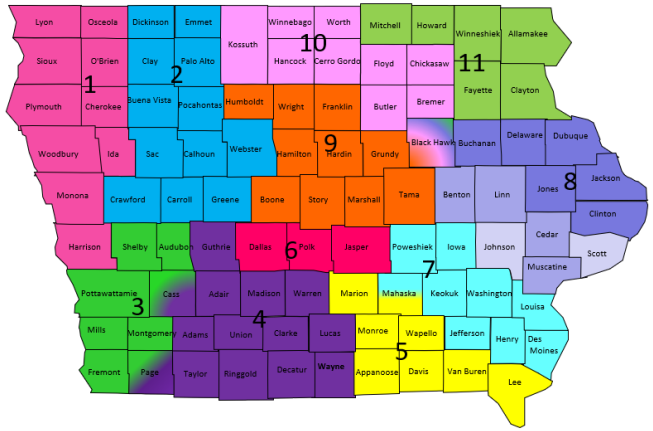
For more member information, visit:
https://www.iowatotalcare.com/members/medicaid.html

Resources

Resources: Iowa Total Care Territory Maps







For the most up-to-date Provider Relations Territory Map, Clinical Quality Consultant Territory Map, and LTSS Community-Based Case Manager Territory Map: https://www.iowatotalcare.com/providers/resources.html.

Resources: IME and Health Plan Information

Iowa Medicaid	
Iowa Medicaid Provider Services	IMEProviderServices@dhs.state.ia.us 1-800-338-7909 or 1-515-256-4609 TTY: 800-735-2942 Fax: 515-725-1155

Health Plan Information	
Website	www.iowatotalcare.com
Mailing Address	Iowa Total Care 1080 Jordan Creek Parkway, Suite 100 South West Des Moines, IA 50266
Fraud, Waste and Abuse **Ethics and Compliance Officer** **Email**	1-866-685-8664 1-833-404-1064 (TTY: 711) Compliance@IowaTotalCare.com

Resources: Iowa Total Care Contacts

Iowa Total Care 1-833-404-1061 (TTY: 711)	
Member Services	Option 1
Health Care Provider	Option 2
Eligibility	Option 2, then Option 1
Claims	Option 2, then Option 2
Vision	Option 2, then Option 18
Behavioral Health	Option 2, then Option 13
Medical Authorizations	Option 2, then Option 9
Case Management (Medical/LTSS/Waiver)	Option 2, then Option 12
Pharmacy	Option 2, then Option 8
Provider Services	Option 2, then Option 0

Resources: Iowa Total Care Vendor Support

Resource	Contact Number	Website
24/7 Nurse Advice Line for Members	1-833-404-1061 (TTY: 711)	https://www.iowatotalcare.com/
Interpreter Services Available	1-833-404-1061 (TTY: 711)	**Member Language Access Services Request Form:** https://www.iowatotalcare.com/content/dam/centene/iowa-total-care/PDF/LanguageAccessSvcsRequestForm_Member.pdf **Provider Language Access Services Request Form:** https://www.iowatotalcare.com/content/dam/centene/iowa-total-care/PDF/LanguageAccessSvcsRequestForm_Provider.pdf
Access2Care	1-833-404-1061 (TTY: 711) Option 2, then Option 1	**Transportation** https://www.iowatotalcare.com/members/medicaid/benefits-services/transportation.html

Resources: Iowa Total Care Partners

Vendor Partner	Contact Number	Website
Envolve Vision	1-800-531-2818 (Provider Participation) 1-833-564-1205 (Claims)	visionbenefits.envolvehealth.com
Pharmacy Network Services	1-833-587-2012 1-888-996-0082 (Pharmacy Claims) Fax: 833-404-2392	www.caremark.com
CareBridge	1-844-343-3653 IAEVV@CareBridgeHealth.com	carebridgehealth.zendesk.com/hc/en-us
National Imaging Associates (NIA)	1-866-493-9441	www1.radmd.com
Payspan	1-877-331-7154	www.payspanhealth.com

Thank you for attending!
Questions?

Copies of training and educational materials can be obtained from the Iowa Total Care website: www.iowatotalcare.com