Your Partner in Community Health Transformation
Presentation Outline

General Session (All providers)
- Introduction to Iowa Total Care
- Member Services and Eligibility
- Provider Responsibilities, Access, and Availability
- Cultural Competencies
- Fraud, Waste, and Abuse
- Contract and Credentialing
- Claims – Processing, Disputes, Grievances, and Appeals
- Resources

Medical Management
- Clinical Guidelines and Medically Necessary Services
- Care Coordination
- Prior Authorizations

Breakout Sessions:
- Behavioral Health providers – Question and Answer session
- Long-Term Services and Support (LTSS) providers and Question and Answer session
Iowa Total Care—General Session
Iowa Total Care has **local expertise**, and as a subsidiary of Centene Corporation, brings **over 30 years of national experience** in the managed care industry.

**LOCATION:**
- Headquartered in **West Des Moines**

**STAFF:**
- Over **400 Iowa Total Care staff** across the state.
- **Locally based health plan staff**, including Medical Management, Provider Relations, Community Coordinators and more. Led by a local CEO.
- **Call center located in Iowa** and staffed by Iowa Total Care.
Our Purpose

OUR PURPOSE

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

OUR APPROACH

Iowa Total Care exists to improve the health of Iowa members through focused, compassionate and coordinated care. Our approach is based on the core belief that quality healthcare is best delivered locally.

OUR PILLARS

Local
Whole Health
Focus on the Individual
Commitment to our Partners

Our overarching 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** – Strong support for service integration of physical, behavioral, and Long-Term Services and Support through a high degree of healthcare collaboration and communication.

- **Coordination of Care** – Organized member care that requires the involvement of all personal, community and healthcare stakeholders to facilitate the appropriate delivery of health care services.

- **Continuity of Care** – Healthcare driven by relationships between member, health providers, and community services to ensure ongoing health care management through shared goals and multiple care settings to produce high quality, cost-effective care.
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)

Some program and service exclusions include:

- Program for All-Inclusive Care for the Elderly (PACE) and Money Follows the Person (MFP) grant services
- Dental services provided outside of a hospital setting
- School-based services provided by the Area Education Agencies or Local Education Agencies
Member Benefits

Core Medicaid benefits are covered and all services are subject to benefit coverage, limitations, and exclusions, as described in the provider manual. The following is not an all inclusive listing of benefits.

<table>
<thead>
<tr>
<th>Inpatient Hospital Services</th>
<th>Laboratory Services</th>
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<tbody>
<tr>
<td>Outpatient Hospital Services</td>
<td>Durable Medical Equipment (DME)</td>
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<tr>
<td>Emergency Care</td>
<td>Long Term Services Supports (LTSS) – Community Based</td>
</tr>
<tr>
<td>Professional Office Services</td>
<td>Long Term Services and Support (LTSS) – Institutional</td>
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<tr>
<td>Preventative Services</td>
<td>Hospice</td>
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<tr>
<td>Behavioral Health Services</td>
<td>Health Homes</td>
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<tr>
<td>Outpatient Therapy Services</td>
<td>Vision Services</td>
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<tr>
<td>Radiology Services</td>
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</tbody>
</table>
Member Support Services

Additional support services include:

Connections Plus
• Part of Member Connections program that provides free phones to high-risk members who do not have safe, reliable access to a telephone
• Provides 24 hour access to physicians, case managers, health plan personnel, telehealth services and 911

Start Smart for Your Baby®
• Prenatal and Postpartum program that promotes education and communication with case managers and incorporates care management to extend the gestational period and reduce pregnancy-related risks

My Health Pays™
• A healthy rewards account program
• Innovative approach to encourage health behaviors through financial incentives

Nurse Advice Line
• 24 hour service by calling 833-404-1061
• Registered Nurse available to provide health education and nurse triage for complex health issues
• Care Management referrals as appropriate
Members should present both their Iowa Total Care and Medicaid card each time services are received and:

Primary Care Provider (PCP) should verify member assignment through the Secure Provider Portal. Services can still be delivered if the member is not assigned to the PCP.

Also

If you are not familiar with the person seeking care, please ask to see photo identification.
Eligibility can be validated 1 of 3 ways

- Using the Provider Portal: [www.iowatotalcare.com/provider](http://www.iowatotalcare.com/provider)
- Calling the member eligibility IVR self-service system: 833-404-1061
- Calling Provider Services: 833-404-1061

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

- Member name
- Medicaid ID number
- DOB

The Portal and IVR provides 24/7 self-service convenience
The following are sample Iowa Total Care member ID cards

**Iowa Total Care**

**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  
**RX:** XXXX  
**RXBIN:** XXXX  
**RXCNH:** XXXX  
**RXGRP:** XXXX

*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 atención 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:**

*Medical Claims: PO Box 8030, Farmington, MO 63660*  
*Provider/claims information via the web: IowaTotalCare.com*  
*Pharmacy Help Desk: 1-833-776-3681*

**Hawki**

**NAME/NOMBRE:** JANE C. DOE  
**hawk-I ID #:** XXXXXXXXXX  
**DOB:** mm/dd/yyyy  
**PCP Name/Nombre Del PCP:** DR. NAME  
**PCP Phone/Teléfono del PCP:** XXX-XXX-XXXX  
**RX:** XXXX  
**RXBIN:** XXXX  
**RXCNH:** XXXX  
**RXGRP:** XXXX

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Some provider responsibilities include, and are not limited to:

- 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, voluntary termination, addition of practitioners, and other important notifications that impact the provider directory, member services, and Iowa Total Care contract requirements
Provider Responsibilities – Continued

• Maintain accurate and complete medical records
  – Refer to the Provider Manual section on Medical Records Review, subsection Required Information or the Medical Record Review Policy CC.QI.13, both found within the For Providers tab on www.iowatotalcare.com

• 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

• Confidentiality of member personal health information

• 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 twenty-four (24) hours of telephone 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 thirty (30) days
Scheduling Standards

• Reschedule cancelled and no-show appointments when possible
• Identify special member needs for upcoming appointment (e.g., wheelchair)

Telephone Access Standards

PCPs and Specialists must:

• Answer telephone inquires on a timely basis
• Adhere to the following response time for telephone call back wait times
  – Non-emergent symptomatic issues after-hours: 30 minutes
  – Non-symptomatic concerns: same day
• Provide 24 hours, 7 days a week phone access
  – Phones must be answered during normal business hours
  – After hour call services to include covering practitioner, answering service, triage service, and/or voice message
  – After hour method must connect the caller to someone who can render a clinical decision or reach the PCP/Specialist for a clinical decision
Cultural Competency Practices

Iowa Total Care uses the standards of National Culturally and Linguistically Appropriate Services (CLAS) from the Office of Minority Health

The following are the standards providers can use for ensuring cultural competency practices:

• Provide quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs

• Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost, to facilitate timely access to all health care and services

• Establish culturally and linguistically appropriate goals, policies and management accountabilities and infuse them throughout the organization’s planning and operations
The following are the **resources** providers can use for ensuring cultural competency practices:

- Complimentary Interpretation Services - to obtain access to a telephonic interpreter please call Provider Services (have member’s ID # present)
- Members can use the Iowa Total Care customer service phone lines, which are TTY and TDD capable (for different languages and for the deaf)
- Iowa Total Care material is available at a minimum in English and Spanish

For assistance with Cultural Competency issues and/or educational sessions, please contact Provider Services or discuss with you Provider Relations Specialist
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: **877-446-3787**
|---------------------|-----------------------------------------------
|                     | Iowa Total Care Fraud and Abuse Line: **866-685-8664**
| Prevention:         | Through enrollment and education of providers, staff, and suppliers
| Detecting:          | Using data analytics and medical record review
| Correcting:         | Applying fair and firm enforcement policies and implementing corrective action plans |
Mandatory Reporting of Suspected Child and Dependent Adult Abuse

Reporting requirements apply to providers who are mandatory reporters under Iowa law.

Providers have a responsibility to report known or suspected child or dependent adult abuse.

To report suspected child (under age 18) abuse or neglect, call the Child Abuse Hotline at 1-800-362-2178

Additional Information:
www.dhs.iowa.gov/child-abuse

To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call 1-800-362-2178

Additional Information:
www.dhs.iowa.gov/DependentAdultProtectiveServices/Families
Contracting and Credentialing

All forms can be found on IowaTotalCare.com/Providers
*A provider must be enrolled with Iowa Medicaid prior to contracting with Iowa Total Care.

Provider Contracting

- Complete the **Contract Request Form** and return with a copy of your signed and dated W9

Provider Credentialing

- Complete the following forms as applicable:
  - Hospital – Facility Provider Application
  - Home- and Community-Based Services (HCBS) Waiver Provider Request Form
  - Iowa Statewide Universal Practitioner Credentialing Application
  - Practitioner Data Form (applicable if registered with the Council for Affordable Quality Healthcare (CAQH) and have fewer than 30 providers)
Provider Contracting

- Prior to July 1, 2019: All contracts will be effective July 1, 2019
- After July 1, 2019: All contracts will be effective 30 calendar days from the date of Provider signature
  - No Contracted Provider shall provide Covered Services to Members or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Iowa Total Care that such Contracted Provider has successfully completed the credentialing process

Provider Credentialing

- Once all required documents and forms are received by Iowa Total Care, the credentialing process takes approximately 30-45 calendar days
  - The provider credentialing effective date is the Credentialing Committee approval date, at which time the provider will be displayed in the Iowa Total Care directory
Contracting and Credentialing

FOR QUESTIONS RELATED TO CONTRACTING/CREDENTIALING STATUS

Prior to JULY 1, 2019:
Call:  Provider Contracting at 855-688-6589 (or)
Email:  Networkmanagement@iowatotalcare.com

After JULY 1, 2019:
Call:  Provider Services at 833-404-1061 (or)
Email:  NetworkOperations@iowatotalcare.com

SEND CONTRACT FORMS TO:

Email:  NetworkManagement@iowatotalcare.com (Prior to July 1, 2019)
        NetworkOperations@iowatotalcare.com (After July 1, 2019)
        (or)

Mail to:  Iowa Total Care – Attn: Network Management Operations
          1080 Jordan Creek Parkway; Suite 100 South
          West Des Moines, IA 50266

QUESTIONS RELATED TO IOWA MEDICAID ENROLLMENT STATUS:

Contact:  Iowa Medicaid Enterprise (IME) Provider Enrollment Unit at 800-338-7909 (or)
Email:  IMEProviderEnrollment@dhs.state.ia.us
### Claim Submissions

*Iowa Total Care accepts claims submissions via paper or electronic format for expedited processing and payment*

<table>
<thead>
<tr>
<th>PAPER</th>
<th>ELECTRONIC</th>
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</thead>
</table>
| Iowa Total Care  
Attn: Claims Department  
P.O. Box 8030  
Farmington, MO 63640 | Iowa Total Care c/o Centene EDI Dept  
Payor ID: 68069  
800-225-2573 (ext 25525)  
EDIBA@centene.com |

*Effective Aug 1, 2019, paper claims will not be accepted EXCEPT for independent CDAC providers*
Availity is the preferred clearinghouse, offering the following value services:

- **Transactions**: at no charge
- **Availity**: 24 hours a day
- **Web-based training and reporting**
- **Customer Service**: from 7:00 a.m. – 6:00 p.m.

Iowa Total Care medical payer ID is **68069**

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*
The following tables outline claim submission and payment timings

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Submission Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>New clean claim</td>
<td>180 calendar days from date of service</td>
</tr>
<tr>
<td>Retroactive eligibility claims</td>
<td>365 calendar days from the notice date</td>
</tr>
<tr>
<td>Secondary payer</td>
<td>365 calendar days from primary payer claim determination</td>
</tr>
<tr>
<td>Third-party submission and no reply</td>
<td>After 30 calendar days of no reply, claims accepted for 12 months from date of service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Payment Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>New clean claim</td>
<td>90% within 30 calendar days of receipt</td>
</tr>
<tr>
<td></td>
<td>95% within 45 calendar days of receipt</td>
</tr>
<tr>
<td></td>
<td>99% within 90 calendar days of receipt</td>
</tr>
</tbody>
</table>
Clean Claims
A claim in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, lack of any required document, and not requiring special treatment that prevents timely processing and payment.

Claims that are clean but will not be processed under the clean claim timings include situations of suspected fraud and claims of third party payers.

Payment Policies
• Goal is to achieve improved quality of care and outcomes through policy guidance.
• Payment and clinical polices are reimbursement policies that notify providers of payment rules and can be found on [www.iowatotalcare.com](http://www.iowatotalcare.com)
  – Examples include wheelchair accessories, distinct procedural modifiers, cosmetic procedures.
• Applied using an automated claims payment edit.
Non-Payment of Claims

Rejected claims: a claim rejects when there is missing or incorrect information that stops it from being adjudicated, requiring the claim to be corrected and resubmitted.

Rejected claims will need to be resubmitted as a new claim, as well as paper claims returned due to errors.

Denied claims: a claim denies when it has been processed through the claim system and has been adjudicated but payment was not issued due to the following types of reasons:

- Lack of medical necessity or benefit coverage
- Lack of required prior authorization
- Member not eligible

A claim dispute can be filed on a denied claim.
COBA Claims Submission Process

For dates of service from 07.01.19 – 09.30.19: Submit COBA claims using the same process as all other claims for which Iowa Total Care is not the primary payer

• Include primary explanation of payment (EOP) and any other applicable correspondence with all COBA claims submissions

• When Iowa Total Care is the secondary payer, claims must be received within 365 calendar days of the final determination of the primary payer
  – Claims received outside of these time frames will deny for untimely submission

Medicare Primary Claims

For dates of service from 10.01.19 and after: All claims for members that have dual eligible membership, where Medicare is primary, will be submitted to Iowa Total Care by CMS (when the provider has a COBA Agreement)
Payspan

• A faster, easier way to get paid using an Automated Clearing House (ACH)
• Free electronic payment and reconciliation solution
• For more information on our electronic fund options, please contact our Provider Services Department

$ 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
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 be reviewed | Submission of request must be within 180 calendar days from the date of EOP (Explanation of Payment) or PRA (Provider Remittance Advice) | Iowa Total Care will work to have the review completed within 30 calendar days from receipt of all information |
Claim Payment Disputes – *Continued*

<table>
<thead>
<tr>
<th>2nd DISPUTE STEP – APPEAL</th>
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</thead>
<tbody>
<tr>
<td>Provider request must be submitted within 30 calendar days from the reconsideration determination letter</td>
</tr>
<tr>
<td>Include as much information as possible to assist with determination review</td>
</tr>
<tr>
<td>Iowa Total Care will work to have the review completed within 30 calendar days from receipt of all information</td>
</tr>
</tbody>
</table>

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**Claim disputes should be mailed to:**
Iowa Total Care – Attn: Claim Disputes
P.O. Box 8030; Farmington, MO 63640-0830
Member grievances and appeals may be filed by the member, a member’s authorized representative, or a member’s provider

*(with written consent by the member on the Authorized Representative Designation form)*

Refer to the Provider Manual at [www.iowatotalcare.com](http://www.iowatotalcare.com) for information on how to file a member grievance, appeal, and State Fair Hearing, along with details on timely filing deadlines.
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 by Iowa Total Care
- 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

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

CALL:
833-404-1061 (TTY: 711)
Monday – Friday
7:30 a.m. to 6:00 p.m.

FAX:
833-208-1397
The Website is designed to allow providers to have 24/7 access to key information for timely service

- Prior Authorization List
- Clinical Guidelines
- Provider and Billing Manuals
- Contract Request Forms
- Provider Bulletins
- Iowa Total Care Plan News
- Information on Disability Access
- Various Operational and Patient Care Forms
- Provider Relations Specialist Contact Information
- Provider Education Material and Training Schedules
Iowa Total Care will keep providers aware of Medical policy changes, payment, and operational updates, and announcements using the following communication channels:
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)
- Submit claims and adjustments, view claims status
- Verify proper coding guidelines
- Access payment history
- View and submit Prior Authorizations and member health records
- View member gaps in care
- Contact us securely and confidentially
- Add/Remove account users and TINs
- Determine payment/check clear dates
- Access Quality Incentive Reports
- View and print Explanation of Payment (EoP)
- Access to many other resources

To register, go to [www.iowatotalcare.com](http://www.iowatotalcare.com) and select the Login link on the top right corner of the page.
The phone Interactive Voice Response (IVR) allows quick access to key pieces of information

- Verify member demographic information
- Check claim status
- Obtain benefit information such as office, emergency room, inpatient and outpatient coverage, long-term care, and community services
- Obtain co-payment information when checking member eligibility
- Connect with Iowa Total Care representatives such as care coordinators and referral specialist

Access the automated IVR system by calling 833-208-1397
Resources – Provider Services

By calling **833-404-1061** between the hours of **7:30 a.m. - 6:00 p.m.**, providers can access real time assistance including, but not limited to:

- Credentialing/Network Status
- Claims inquiries that cannot be addressed through the portal or IVR
- Request for adding/deleting physicians to an existing group
- Iowa Total Care Website review and portal questions and registration
- Review physician/practice experience for quality and financial risk arrangements associated with Value Based Contracting (VBC) contracts
- Facilitate inquiries related to administrative policies, procedures, and operational issues
- Complimentary Interpretation Services

**The Provider Service department includes trained representatives who are available to respond quickly and efficiently to all provider inquiries and requests.**
Each provider will have a **Provider Relations Specialist** assigned to them by region and serves as the primary liaison between Iowa Total Care and the network providers.

Representatives can assist with the following types of questions or requests:

- Provider education requests
- Obtain clarification of policies and procedures
- Request fee schedule information
- Contract clarifications
- Obtain provider profiles
- Provider roster questions
Provider Relations Specialists are available to assist providers by phone and in their office based on the following region assignments:

**Region 1**
- Julie Anderson, PRS II
- P: 515 322-8866
- TBD – PRS I

**Region 2**
- Michelle Lucas, PRS I
- P: 319-252-2359
- TBD – PRS II

**Region 3**
- Ashley Woods, PRS I
- P: 515-318-9624
- Karmin Erwine, PRS I
- P: 515-493-6442
- TBD – (1) PRS II

**Region 4**
- Sheri Siemen, PRS I
- P: 319-252-8313
- Toni Mieras, PRS II
- P: 319-290-8058
- TBD – (1) PRS II
## Resources – Contacts

### IME

<table>
<thead>
<tr>
<th>Iowa Medicaid Provider Services</th>
<th><a href="mailto:IMEProviderServices@dhs.state.ia.us">IMEProviderServices@dhs.state.ia.us</a></th>
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<tbody>
<tr>
<td></td>
<td>800-338-7909 or 515-256-4609</td>
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<tr>
<td></td>
<td>TTY: 800-735-2942</td>
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<td></td>
<td>Fax: 515-725-1155</td>
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### HEALTH PLAN INFORMATION

<table>
<thead>
<tr>
<th>Website</th>
<th><a href="http://www.iowatotalcare.com">www.iowatotalcare.com</a></th>
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<tbody>
<tr>
<td>Mailing Address</td>
<td>Iowa Total Care</td>
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<tr>
<td></td>
<td>1080 Jordan Creek Parkway</td>
</tr>
<tr>
<td></td>
<td>Suite 100 South</td>
</tr>
<tr>
<td></td>
<td>West Des Moines, IA 50266</td>
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<tr>
<td>Ethics and Compliance Helpline</td>
<td>866-685-8664</td>
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<tr>
<td>Abuse</td>
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## Resources – Contacts

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<th>Iowa Total Care Departments</th>
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<th>Fax</th>
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<td></td>
<td>833-208-1397</td>
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<td>Member Services &amp; Eligibility</td>
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<td></td>
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<tr>
<td>TTY: 711</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Management Concurrent Review</td>
<td></td>
<td>833-257-8320</td>
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<tr>
<td>Care Management</td>
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## Resources – Claims

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<thead>
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<th>PAPER</th>
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P.O. Box 8030  
Farmington, MO 63640-8030 | c/o Centene EDI Department  
payor ID: 68069  
1-800-225-2573, ext. 25525  
or by Email: EDIBA@centene.com |

**Effective Aug 1, 2019, paper claims will not be accepted EXCEPT for independent CDAC providers**
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<tr>
<th>Vendor Partner</th>
<th>Contact Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Envolve Vision</td>
<td>P: 833-564-1205</td>
<td>visionbenefits.envolvehealth.com</td>
</tr>
<tr>
<td>Envolve Pharmacy Services</td>
<td>P: 833-776-3681</td>
<td>Pharmacy.envolvehealth.com</td>
</tr>
<tr>
<td></td>
<td>F: 866-399-0929</td>
<td></td>
</tr>
<tr>
<td>Company - 24 Hour Nurse Advice Line</td>
<td>P: 833-404-1061</td>
<td></td>
</tr>
<tr>
<td>(24/7 availability)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voiance Interpreter Services</td>
<td>P: 866-998-0338</td>
<td></td>
</tr>
<tr>
<td>Access 2 Care</td>
<td>P: 888-644-3547</td>
<td></td>
</tr>
</tbody>
</table>
Medical, Behavioral Health and Utilization Management
Contacting Medical Management

Department hours are Monday - Friday from 8:00 a.m. to 5:00 p.m.

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.

To contact Medical Management, call Provider Services at **833-404-1061**
The following are key Medical Management care coordination processes

• Length of stay extension requests require clinic information to be submitted by 3:00 p.m. on the day review is due

• Concurrent review decisions are made within 1 business day of receipt of clinical information

• Routine, uncomplicated vaginal or C-section delivery does not require concurrent review; however, notification required within 2 business days of delivery with complete information regarding delivery status and condition of newborn

• Retrospective review requests must be submitted promptly and a decision will be made within 30 calendar days following receipt of request, not to exceed 90 calendar days from date of service
  – Presumptive eligibility rules apply

• Health Home Integrated care management with the member’s care team
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
- Center 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 Preventive Health
- American Psychiatric Association

All clinical practice guidelines can be found on www.iowatotalcare.com

Paper copies can be requested by calling Provider Services, 833-404-1061

**Adherence to the guidelines will be evaluated at least annually as part of the Quality Management Program**
Medically Necessary Services

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

- Reasonably expected to, prevent the onset of an illness, condition, injury or disability
- Reasonably expected to, reduce or improve the physical, mental or developmental effects of an illness, condition, or disability
- Assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity or the recipient and those functional capacities are appropriate for recipients of the same age
Care Coordination

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.
Creating Referrals using the Secure Provider Website

- Faster, easier solution for submitting referrals
- Maintains members’ confidentiality
- Enables communication between providers and case management
### Care Management Referral Submission

#### Verify Member Eligibility

![Eligibility Check](image)

<table>
<thead>
<tr>
<th>Eligible</th>
<th>Date of Service</th>
<th>Patient Name</th>
<th>Date Checked</th>
<th>Care Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>12/01/2014</td>
<td>Test Member 1</td>
<td>12/01/2014</td>
<td>No PAP in past 36 months.</td>
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<tr>
<td>✗ Not Found</td>
<td>12/01/2014</td>
<td>Test Member 2</td>
<td>12/01/2014</td>
<td></td>
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</tbody>
</table>
Initiate the referral process by clicking on Referrals.
Complete the appropriate data referral eliminates
Care Management Referral Submission

Click submit and your request is finalized

Your request is submitted Successfully
Prior Authorizations

• A list of services requiring Prior Authorization can be found in the Iowa Total Care provider manual located at www.iowatotalcare.com

• 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
  – Service must be medically necessary as per plan policies and procedures
Prior Authorization Verification Tool

- Use the tool to quickly determine if a service or procedure requires a Prior Authorization
- The same tool is used for submitting an electronic prior authorization

Are Services being performed in the Emergency Department or Urgent Care Center or Family Planning services billed with a Contraceptive Management diagnosis?

<table>
<thead>
<tr>
<th>Types of Services</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the member being admitted to an inpatient facility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are anesthesia services being rendered for pain management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are oral surgery services being provided in the office?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the member receiving hospice services?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Submit Prior Authorizations to Iowa Total Care via:

**PORTAL:** Provider.IowaTotalCare.com

**FAX:** By fax using designated fax form within the portal

**CALL:** Calling Medical Management: 833-404-1061
Business Hours: 8:00 a.m.-5:00 p.m. Monday – Friday (excluding holidays)

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

<table>
<thead>
<tr>
<th>PROVIDER SUBMISSION TIMINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled Admissions/ Elective Outpatient Services</td>
</tr>
</tbody>
</table>
| Emergency | Inpatient: within 24 hours of admit  
Observation: within 1 business day of service |
| Newborn Delivery | Notification within 2 business days of delivery |
| Neonatal Intensive Care Unit (NICU) Admit | Within 24 hours of admit |

<table>
<thead>
<tr>
<th>IOWA TOTAL CARE REVIEW TIMINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Non-Urgent</td>
</tr>
<tr>
<td>Expedited Preservice/Urgent</td>
</tr>
<tr>
<td>Concurrent Review</td>
</tr>
</tbody>
</table>
Peer to Peer Requests

- Must be requested within 48 hours after verbal notification of denial is delivered to the practitioner or facility
- A Peer to Peer consult can be requested by calling Provider Services and selecting Provider/Medical Management using the IVR system

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
NIA Imaging Prior Authorizations

- National Imaging Associates, Inc. (NIA), an affiliate of Magellan Health Services, is contracted to provide radiology imaging benefit management
- Iowa Total Care oversees the NIA program and is responsible for claims adjudication

Services requiring authorization are advanced radiology and cardiac imaging*

- Computerized Tomography (CT)
- Computed Tomography Angiography (CTA)
- Magnetic Resonance Image (MRI)
- Magnetic Resonance Angiogram (MRA)
- Positron Emission Tomography (PET) Scan
- Cardiac Computed Tomography Angiography (CCTA) (members 21 y/o or older)
- Stress Echocardiography (members 21 y/o or older)
- Multigated Acquisition (MUGA) Scan (members 21 y/o or older)
- Echocardiography (members 21 y/o or older)
- Myocardial Perfusion Imaging (MPI) (members 21 y/o or older)

Services that do not require an authorization to be obtained through NIA

- Inpatient
- Observation
- Emergency Room

*A complete list of services that require prior authorization is available at IowaTotalCare.com
NIA Imaging Submissions

- Submit to Iowa Total Care via:
  - PORTAL: www.radmd.com/radmd-home.aspx
  - CALL: NIA at 833-404-1061, including expedited requests
    Business Hours: 8:00 a.m.-5:00 p.m. Monday – Friday (excluding holidays)

- Requests received after normal business hours will be processed the next business day
- Review determinations generally finalized within 2 business days; however, some cases include longer times for clinical determination
- Authorizations are valid for 30 calendar days from date of request
- An appeal of denial determination can be submitted by following the appeal instructions given in the non-authorization letter or Explanation of Payment (EOP) notification
Prior Authorizations – NIA

NIA Webinar Training Dates

**Tuesday, June 11, 2019**  12:00 p.m. CST  

**Wednesday, June 12, 2019**  8:00 a.m. CST  

**Thursday, June 13, 2019**  12:00 p.m. CST  

**Monday, June 17, 2019**  8:00 a.m. CST  

**Friday, June 21, 2019**  12:00 p.m. CST  

*Recommended to RSVP one week in advance of webinar*
Pharmacy Prior Authorization request:

Prior Authorizations are required for medications on the Iowa Medicaid Preferred Drug List that are noted as follows:

- Preferred medications indicated in the Drug List 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 for drugs covered under the pharmacy benefit should be submitted to Envolve Pharmacy Solutions

- Envolve Pharmacy Solutions is the Pharmacy Benefit Manager providing comprehensive services for the pharmacy benefit

Medications covered under the medical benefit will have prior authorization requirements based on the Iowa Total Care medical authorization requirements. Refer to the Provider Manual for additional information on these requirements.
Pharmacy Prior Authorization Submissions:

• The authorization form on CoverMyMeds(www.covermymeds.com/epa/envolverx)
• Faxing the required prior authorization form to 877-386-4695
• Calling 866-399-0928

Pharmacy Review Timings

• 24-hour turnaround time
• 72 hour supply of a medication to any patient awaiting a Prior Authorization determination in the event of an emergency (unless otherwise noted on the PDL)

NOTE: See the Appeals slide for the appeal process

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

Business Hours: 7:00 am–7:00 pm, Monday–Friday, excluding holidays
• A nurse advice line (833-404-1061) is available to assist providers outside regular business hours
• Envolve notification of approvals are provided by fax (877-386-4695)
• During regular business hours, licensed Clinical Pharmacists and Pharmacy Technicians are available to answer questions and assist providers
• When medical necessity criteria is not met based on the clinical information submitted, the prescriber will be notified of the reason via fax
  — The notification will include Preferred Drug List alternatives if applicable
• All reviews are performed using the PA criteria established by the State of Iowa Drug Utilization Review (DUR) Commission
• If clinical information provided does not meet the medical necessity and/or Prior Authorization guidelines for the requested medication, the member and the Prescriber will be notified of alternatives, along with how to file an appeal
Non-Emergent Medical Transportation (NEMT)

- A2C has provided transportation services in Iowa since 2010
- Offers transportation services state-wide, using a network of:
  - 85 transportation providers
  - 16 fixed bus transits
  - 30 regional transit agencies
- Eligible Medicaid members, or Providers on the members behalf, may request a ride for a Medically Necessary appointment
- Non-Emergent appointments should be scheduled at a minimum 3 business days in advance
  - Appointments can be scheduled by phone or on-line
Iowa Total Care’s behavioral health care coordination approach includes:

- Rapid and thorough member identification, especially members with special health care needs
- Immediate member engagement, from initial assessment through planning and implementation of an individualized, holistic care plan
- Care plans that incorporate both covered and non-covered services to reflect the full range of health, behavioral health, functional, social, and other needs.
- Careful attention to compliance with prescribed medications as well as potential impact of each medication
Medicaid Covered services include:

- Inpatient Hospitalization (inclusive of medically managed detoxification treatment)
- Partial Hospitalization
- Intensive outpatient
- Medication management
- Community based outpatient therapy
- Integrated Health Home
- Mobile crisis services
- 23 hours observation
- Peer support
- Applied Behavioral Analysis
- Residential services
- Telehealth
Additional support services to facilitate integrated care for members facing access barriers, preferring less formal and/or more convenient intervention, or for whom sub-clinical need warrants preventative attention

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>myStrength</strong></td>
<td>• Available in Web and mobile formats&lt;br&gt;• Application that assists members in learning more about their diagnoses, tracking of symptoms, and receipt of motivational information</td>
</tr>
<tr>
<td><strong>Peer Support</strong></td>
<td>• A tool that offers on-demand, online peer support anonymously and securely in over 140 languages&lt;br&gt;• 1-on-1 chat available with trained listener&lt;br&gt;• Facilitated Support Communicators available</td>
</tr>
<tr>
<td><strong>Virtual Visits</strong></td>
<td>• National telemedicine vendor providing 24/7 access to clinicians for stress, anxiety, depression, addiction, domestic abuse, and grief counseling&lt;br&gt;• Members speak with a licensed doctor</td>
</tr>
<tr>
<td><strong>Telehealth Services</strong></td>
<td>• Facilitate medication adherence and integrated services&lt;br&gt;• Utilization of remote CBT, via phone or computer</td>
</tr>
</tbody>
</table>
Questions
Thank you for attending!

Copies of training and educational materials can be obtained from the Iowa Total Care Website at www.iowatotalcare.com
Appendices

Portal Claim Submission & Claim Reject Code Definitions
Access the Iowa Total Care Secure Provider Portal page by clicking on the **For Providers** tab
Provider Portal Landing Page

Create an account or log into the portal

The Tools You Need Now!
Our site has been designed to help you get your job done.

Check Eligibility
Find out if a member is eligible for service.

Authorize Services
See if the service you provide is reimbursable.

Manage Claims
Submit or track your claims and get paid fast.

Login
User Name (Email)
name@idemale.com
Password
Login
Forgot Password / Unlock Account

Need To Create An Account?
Registration is fast and simple, give it a try.
Create An Account

How to Register
Our registration process is quick and simple. Please click the button to learn how to register.
Provider Registration Video
Provider Registration PDF
Professional Claim Entry
Select the green “Create a New Claim” button within the patient record
Professional Claim Button
Click the green rectangle button when prompted
General Info Section:

• Complete the Patient’s Account Number field and all related patient condition information as applicable

• Click Next, and follow the prompts to add diagnosis codes, coordination of benefits information, and other required information.
Attachments Screen: use the Browse button for attaching medical records and other documents related to claims submission, when applicable.
Final Step:
Review the entire claim and if all information is correct click the green Submit button in the bottom, right-hand corner.
Institutional Claim: select the green “Create a New Claim” button within the patient record
Institutional Claim: click the green rectangle button when prompted
General Section:

- Populate the admission and condition code information (the fields displayed reflect those on UB-04 form, then click Next

- Follow the prompts to reflect the Billing Provider, Pay-to-Provider, Attending Provider, and other field details, then click Next
Service Lines Section: enter the information about the services provided, click Save/Update

To add a new service line, click the + **New Service Line** button on the left and then click the **Next** button
Attachments Screen: use the browse button for attaching medical records and other documents related to claims submission, when applicable
Final Step:
Review the entire claim and if all information is correct click the green Submit button in the bottom, right-hand corner.
### COMMON HIPAA COMPLIANT Electronic Data Interchange (EDI) REJECTION CODES

- The following codes are the standard national rejection codes for EDI submissions
- All error codes indicated must be corrected before the claim is resubmitted

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<th>ERROR_DESC</th>
</tr>
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<tbody>
<tr>
<td>01</td>
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<tr>
<td>02</td>
<td>Invalid Mbr</td>
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<tr>
<td>06</td>
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<tr>
<td>07</td>
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<tr>
<td>08</td>
<td>Invalid Mbr &amp; Prv</td>
</tr>
<tr>
<td>09</td>
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<td>10</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS</td>
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<tr>
<td>12</td>
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<tr>
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<td>Invalid Diagnostic (Diag)</td>
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<tr>
<td>18</td>
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<td>92</td>
<td>Missing or Invalid Provider NPI at any Level.</td>
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<tr>
<td>95</td>
<td>Operating/Purchasing provider information invalid or missing</td>
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<td>A2</td>
<td>Diagnosis pointer invalid</td>
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<td>A3</td>
<td>Claim exceeded the maximum 97 service line limit</td>
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<tr>
<td>A7</td>
<td>Invalid or Missing Ambulance Point of Pick Up Zip Code</td>
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<tr>
<td>AX</td>
<td>Invalid/missing/duplicate occurrence code</td>
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<tr>
<td>B1</td>
<td>Rendering and Billing NPI are not tied on state file</td>
</tr>
<tr>
<td>B2</td>
<td>Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim</td>
</tr>
<tr>
<td>B3</td>
<td>Rendering or billing NPI/TIN on DOS not enrolled with State</td>
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<tr>
<td>B5</td>
<td>Missing/incomplete/invalid CLIA certification number</td>
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<td>C9</td>
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<tr>
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</tr>
<tr>
<td>CE</td>
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<tr>
<td>CF</td>
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<tr>
<td>CG</td>
<td>Invalid Billing Provider Zip</td>
</tr>
<tr>
<td>CH</td>
<td>Rendering NPI/TIN on DOS not enrolled with state</td>
</tr>
<tr>
<td>CI</td>
<td>NPI IS REQUIRED FOR THIS PAYER</td>
</tr>
<tr>
<td>CJ</td>
<td>ACK/REJECT Info Entities Medicaid Provider Id</td>
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<tr>
<td>D2</td>
<td>BILLING PROVIDER NOT REGISTERED PROMiSe PROVIDER</td>
</tr>
<tr>
<td>D3</td>
<td>Rendering provider not registered Promise provider</td>
</tr>
<tr>
<td>D4</td>
<td>Attending provider not registered Promise provider</td>
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<tr>
<td>H1</td>
<td>ICD9 is mandated for this date of service.</td>
</tr>
<tr>
<td>H2</td>
<td>Incorrect use of the ICD9/ICD10 codes.</td>
</tr>
<tr>
<td>HP</td>
<td>ICD10 is mandated for this date of service.</td>
</tr>
<tr>
<td>NE</td>
<td>Missing or Invalid Provider NPI at any Level.</td>
</tr>
<tr>
<td>R2</td>
<td>Payor ID Number Invalid for DOS</td>
</tr>
<tr>
<td>ZZ</td>
<td>Claim not processed</td>
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</table>
Long Term Services & Support (LTSS)
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

• Home Health – provides services and supports in the member’s home as part of the Medicaid State Plan of services

• Hospice – provides services and care to terminally ill members with a life expectancy of 6 months or less.
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 re-assessments if a significant change is observed

Member protections including appropriate health and welfare assurances and safeguards, critical incident reporting (CIR)
Services are designed to:

- Maximize opportunities for individual to receive services and remain in their community
- Include 7 Waiver programs (1915(c)) and the Habilitation (1915(i)) program
- Services will be delivered according to the approved person-centered service plan driven by the member

The following are HCBS Waiver programs

AIDS/HIV Waiver
Brain Injury Waiver
Children’s Mental Health Waiver
Elderly Waiver

Health and Disability Waiver
Intellectual Disability Waiver
Physical Disability Waiver
Community Based Case Manager (CBCM) Role

• Be a ‘Single Point of Contact’ to member

• Participate in Level of Care assessments with an assessor from Iowa Total Care assessment team (e.g., InterRAI, SIS, etc.) to identify member’s strengths and needs

• Develop Person Centered Service Plan with member and member’s chosen Interdisciplinary Team (IDT).

• Link member to services necessary for member to live in his/her home and community

• Coordinate and monitor services as needed to enable member to live in home and community
CBCM Training

- Local leaders and staff hired with significant Medicaid population experience
- Intensive 4 week Fundamentals training
  - Iowa specific Medicaid population and program training
  - Motivational Interviewing Skills
  - Person Centered Thinking
    - Corporate mentor and trainers trained and certified by The Learning Community for Person Centered Thinking
    - Iowa Total Care will have over 170 trained Care Managers
Integrated Health Home (IHH)
Care Coordinator Role

• Leads the development of the Comprehensive Care Plan (CCP) and oversees implementation of CCP

• Coordinates and assists member in gaining access to needed services—covered, non-covered, medical, social, housing, educational, and other services and supports

• Works with member to identify strengths, goals, development of CCP, evaluations, reassessments

• Ensures Community Integration goals are reviewed and/or updated at least quarterly
Provider Qualifications:

1. Designated Provider must be Medicaid enrolled and at a minimum fulfill the following roles:
   - Designated Practitioner
   - Dedicated Care Coordinator
   - Health Coach
   - Clinic support staff

2. Seek Medical Home recognition or equivalent within 12 months

3. Effectively utilizes population management tools to improve patient outcomes

4. Use an EHR, registry tools, and connect to Iowa HIE (IHIN) to report quality data
Member Qualifications:

- Adults and Children with at least two chronic conditions, (or)
- one chronic condition and at-risk of a second condition from the list below

(Note overweight vs. obese)
Member Choice

• Eligible individuals agree to participate in the health home at the initial engagement of the provider in a health home practice

• A provider presents the qualifying member with the benefits of a health home and the member agrees to opt-in to health home services

• The State or MCO may also attribute members to a health home

• In either situation, the member will always be presented with the choice to opt-out at any time
Referrals to CCHH

• The CCHH would also be the member’s PCP

• If the member doesn’t want to switch to another PCP and the PCP is not a CCHH, a referral to a CCHH would not be appropriate
Consumer Choices Option (CCO)

- Veridian Financial Services (VFS) is the Iowa Total Care financial vendor that will manage reimbursement of budgeted services.
- Providers will submit timesheets to Veridian for reimbursement.
- A sample timesheet can be found on the Iowa Total Care site: www.iowatotalcare.com.
- Semi-monthly billing will be managed according to the following process:
  - Web hours are entered and approved by the member.
  - Paper time sheets and non payroll requests are reviewed, approved and submitted to VFS.
  - VFS validates the payment requests against the authorized services and budget.
  - Payment requests are checked for compliance with the law and program rules.
  - Taxes, garnishments, etc. are withheld and paid.
  - Payments are made on behalf of the member to the provider.
Service Payment

- Payment is issued via paper checks according to the below schedule

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<tr>
<th>Time Period</th>
<th>Due to Veridian</th>
<th>Payment Date</th>
</tr>
</thead>
<tbody>
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</tr>
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<td>7/15/2019</td>
</tr>
<tr>
<td>July 1-15</td>
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<td>7/31/2019</td>
</tr>
<tr>
<td>July 16-31</td>
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<td>8/15/2019</td>
</tr>
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<td>August 1-15</td>
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<td>8/30/2019</td>
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</tr>
<tr>
<td>December 16-31</td>
<td>1/5/2020</td>
<td>1/15/2020</td>
</tr>
</tbody>
</table>
Consumer Directed Attendant Care Services (CDAC):

• Provide an opportunity for members to have assistance to stay in their homes

• CDAC services are designed to help members do things they would normally do for themselves if they were able

• CDAC is available for members in the following waiver programs:
  
  AIDS/HIV Waiver  Health and Disability Waiver
  Brain Injury Waiver  Intellectual Disability Waiver
  Elderly Waiver  Physical Disability Waiver
Services include skilled and unskilled:

• Skilled services are medical services that require the special skills of a trained person:
  – Catheter care
  – Colostomy care
  – Tube feeding
  – Vital signs recording

• Unskilled services assist with normal daily activities of living such as:
  – Housekeeping
  – Meal preparation
  – Bathing
  – Shopping and running errands
Provider Enrollment and Responsibilities

• Complete the Iowa Medicaid CDAC application, which includes obtaining an NPI number and the completion of a background check for criminal history and abuse.

• Complete training requirements associated with any services provided under the Brain Injury Waiver
  – There are two modules that must be completed within 60 days from the beginning date of service.

• Service delivery requires a CDAC agreement with the IDT and delivered services to be thoroughly documented on the CDAC Daily Services Record form.

• CDAC providers will be included as in network for 6 months from ‘Go Live’ and during that period will be contacted regarding the completion of the CDAC Agreement.
Provider Role and Responsibilities

- Supervising, coordinating, and providing all authorized care to each assigned member
- Obtaining prior authorizations as required from the Community Based Care Manager (CBCM)
- Work with the CBCM to address service needs and actively participates in the Person Centered Service Plan
- Work in coordination with the care coordinator, MCO and other pertinent providers regarding the member Lock-In Program
- Coordinates transfers between managed care plans when applicable (includes transferring care coordination records from the prior 12 months to the new managed care plan)
The Claim Submission Wizard was designed for Long Term Care and Home- and Community-Based Service Providers.

Services that can be billed using the Wizard are:

- Adult Day Care
- Personal Emergency Response
- Supported Community Living Facilities
- Home Maker Services
- Adult Day Service Transportation
- Home Health Physical Therapy
- Home Health Occupational Therapy
- Home Health Waiver-Registered Nurse (RN)
- Skilled Nursing Facility (SNF)
LTSS Claim Submission Wizard

Provides a quick and accurate way to bill recurring claims
- Load members once, modify as needed
- Simple interface to bill services for multiple members for the same services/dates of service
- Electronic transactions decrease processing time and increase payment accuracy

Create a New Account or Login
LTSS Claim Submission Wizard

Accessing the Wizard

• To create Long Term Care and Home- and Community-Based Service claims, use the Multiple Claim Submission Wizard by clicking on the Claims tab.
Claims Submission Wizard allows you to:

- Select from various service locations
- Add, view and select a member from a member list
- Create and review claims
- Add service lines and change claim fields
- Print submitted claims

The Claim Submission Wizard user guide can be found in the For Providers tab on the Iowa Total Care Website
Critical Incidents and Reporting

• Events that compromise the member’s health or welfare

• Critical Incidents and reporting are applicable to members receiving HCBS Waiver and Habilitation Services

• There are Major and Minor events that fall under Critical Incidents

  NOTE: Major Incidents must be reported

• Notification timing for Major and Minor events are the following

  Major: Provider must report incident to Iowa Total Care by end of next calendar day

  Minor: Provider must report incident to immediate supervisor within 72 hours
Major incident means an occurrence involving a member during service provision that results in:

1. Physical injury to a member that requires a physician’s treatment or admission to the hospital
2. Death of any person
3. Requiring an emergency mental health treatment for a member
4. Requiring intervention of law enforcement
5. Requiring a report of child or dependent adult abuse
6. Prescription medication error or patterns of medication errors that lead to one of the above bulleted conditions in 1, 2 or 3
7. A member’s location being unknown by provider staff who are assigned protective oversight
Critical Incidents – Minor Events

Minor Incidents include:

• Physical injury to a member that results in:
  – Application of basic first aid
  – Bruising

• Seizure activity that does not result in major incident

• Injury to self, to others, or to property

• Prescription medication error with no resulting major incident
Critical Incidents and Reporting

• Providers must cooperate with State investigations
• Notify Iowa Total Care by:
  - Email: QOCCIR@IowaTotalCare.com
  - Fax: 833-205-1251
  - Website: www.iowatotalcare.com

The Critical Incidents form can be at: www.iowatotalcare.com/Providers
Questions
Thank you for attending!

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