Department of HUMAN SERVICES

Iowa's Medicaid Program

2020 Annual Provider Training

November 2020

Department of HUMAN SERVICES

Housekeeping – Zoom Style

- Please select “Speaker View” in the top right hand corner of your zoom presentation.
- Please keep your zoom on mute.
- This presentation is being **recorded** and will be available on IMEs website for review.
- Please type in questions throughout the presentation and at the entire presentation we will have a question and answer session.

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Housekeeping – Zoom Style

- When asking questions, please do not provide PHI.
- Targeted or specific questions related to your provider should be addressed outside of this presentation.
- IME contacts for specific questions:
  - MCO escalations: mjames@dhs.state.ia.us
  - IME Claims Questions: IMEProviderServices@dhs.state.ia.us
  - IME Enrollment Questions: IMEProviderEnrollment@dhs.state.ia.us
  - **Escalated** Provider Issues: IMEProviderOutreach@dhs.state.ia.us

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Agenda

Session 1

- IME: 9:00 am – 10:00 am
- Amerigroup:
  10:00 am – 10:30 am
- Iowa Total Care:
  10:30 am – 11:00 am
- Question and Answer Session:
  11:00 am – 12:00 noon

Session 2

- IME: 1:00 pm – 2:00 pm
- Amerigroup:
  2:00 pm – 2:30 pm
- Iowa Total Care:
  2:30 pm – 3:00 pm
- Question and Answer Session:
  3:00 pm – 4:00 pm

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Agenda – Iowa Medicaid

- New Prior Authorization Forms
- EVV – Electronic Visit Verification
- Secondary Claims
- Crossover Claims
- TPL (Third Party Liability)
- CCHH – Chronic Condition Health Home
- Covid 19 Updates
- EDISS – EDI Support Services
- EFT Change Request

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New Prior Authorization Form

Agenda:

- To review the new “universal” prior authorization forms.
- To educate on how to fill out and submit forms.
- Direction to submit to the proper entity: IME OR Iowa Total Care OR Amerigorup

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New Prior Authorization Form - Three Forms

- There are 3 universal forms: Supplemental, Inpatient and Outpatient.
- There are no changes in the MCO's or FFS documentation requirements.
- If you have questions on documentation requirements, please refer back to your MCO portal, FFS Medical or your Provider Representative.
- All providers will use the same forms.

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New Prior Authorization Form - Supplemental Form

Use the supplemental form on **all** submissions with either inpatient or outpatient form.

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New Prior Authorization Form – Form Overview

- There is a bar code to the upper right of the Outpatient and Inpatient forms, this is for ITC use only.
- At the bottom of the inpatient and outpatient forms are areas that are specific to AGP, ITC and FFS, which must be filled out completely.

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New Prior Authorization Form

- For FFS, ITC and AGP, fill out the top portion of the Outpatient and Inpatient forms.
- At the bottom of the form, AGP information is on the left hand side or ITC on the right hand side.
- The fax number and link for FFS is at the bottom of the form

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New Prior Authorization Form

The Medicaid number listed on the forms is for the STATE ID number - this will be corrected on a future update. The State ID is on the member's ID card if provider cannot locate it.

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New Prior Authorization Form – Additional Questions

- For additional questions, there is a link provided at the bottom of both the inpatient and outpatient forms.
- The provider would need to contact or review the MCOs Provider website for documentation requirements. Again, these have NOT changed.

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New Prior Authorization Form - Submitting Forms

- All * (asterisks) are required in order to submit the forms.
- For MCOs there are several ways to submit: Fax, MCO portal, Secure Email, or IMPA
- Prior authorization requests can be submitted using the following methods: IMPA, Fax: 515-725-1356, Email: paservices@dhs.state.ia.us

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New Prior Authorization Form - Informational Letter No. 2147-MC-FFS

- Starting, October 1, 2020, providers for both MC and FFS are required to use the new universal forms for requesting medical PAs.
- The new universal forms include one PA request form for outpatient services2, another PA form for inpatient services3, and a supplemental form4 for additional provider addresses, member diagnosis, and procedure codes.
- All three universal forms can be downloaded and printed from the DHS website5.

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New Prior Authorization Form - Conclusion

- No changes in required documents
- 3 forms: Supplemental, In Patient, Out Patient
- Supplemental can be submitted every time a prior auth is submitted OR only when additional procedure/diagnosis codes are required.

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New Prior Authorization Form - Conclusion

- Anything with an * is REQUIRED in order for your prior authorization to be submitted.
- You must fill out the top portion of the outpatient or inpatient forms AND the section for Amerigroup, Iowa Total Care OR Fee For Service at the bottom of the form.

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EVV – Electronic Visit Verification

- Implemented for Managed Care by the IME (Iowa Medicaid Enterprise) on January 1, 2021.
- In December 2016, the 21st Century Cures Act was signed into law.
- This law requires EVV for personal care and home health services.

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EVV – Electronic Visit Verification

- EVV will be used to monitor the delivery and utilization of personal care and home health services in non-traditional settings and will provide verification of the visit with location information and a time stamp.
- EVV will be used to ensure quality and program integrity (PI).

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EVV – Electronic Visit Verification

- EVV will be used to monitor the delivery and utilization of personal care and home health services in non-traditional settings and will provide verification of the visit with location information and a time stamp.
- EVV will be used to ensure quality and program integrity (PI).
- This system will help provide real time alerts when a provider is late or misses a medically necessary service included in a member's service plan.

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EVV – Electronic Visit Verification - Resources

CareBridge EVV Resources

Contact CareBridge: **(844) 343-3653**

OR

iaevv@carebridgehealth.com

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EVV – Electronic Visit Verification

Starting with dates of service January 1, 2021 and after, appropriate claims not submitted via EVV will be denied by the MCOs.

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EVV – Electronic Visit Verification

Registration Information EVV training with CareBridge.

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EVV – Frequently Asked Questions

Use this link for additional Frequently Asked Questions

https://dhs.iowa.gov/ime/providers/evv/faqs

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EVV - Frequently Asked Questions

1. **Do EVV requirements apply if the individual receiving personal care or home health care lives with the caregiver providing the service?**

   Answer: No, unless additional oversight is needed on a case by case basis. CDAC and CCO providers who live with members are required to submit EVV for services that are billed in 15-minute increments.

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EVV – Frequently Asked Questions

- There is not a difference in reimbursement or documentation requirements for payment of a claim to a live-in caregiver.
- This will provide a complete picture of personal care service utilization for purposes of program management and program integrity.
- This information will be of benefit to members, providers, and care coordinators.

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EVV – Frequently Asked Questions

1) Do EVV requirements apply if the individual receiving personal care or home health care lives with the caregiver providing the service?

No, EVV requirements do not apply when the caregiver providing the service and the beneficiary live together.

PCS (Procedure Coding System) or HHCS rendered by an individual living in the residence does not constitute an “in-home visit”.

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EVV – Frequently Asked Questions

- The Department will require EVV for Consumer-Directed Attendant Care (CDAC) services that are billed in 15-minute increments.
- There is not a difference in reimbursement or documentation requirements for payment of a claim to a live-in caregiver.

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EVV - Frequently Asked Questions

2. Do EVV requirements apply to the component of home health services authorizing the provision of medical supplies, equipment or appliances?

Answer: No, for the delivery, set-up, and/or instruction on the use of medical supplies.

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EVV – Frequently Asked Questions

3. Do EVV requirements apply to the component of home health services authorizing the provision of medical supplies, equipment or appliances?

Answer: Only in the home, unless additional oversight is needed on a case by case basis. Use terms "home" and/or community as the designation.

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EVV – Frequently Asked Questions

3. Continued: For example, if a service visit starts in the community and ends in the home, the caregiver would check in from the community to note the visit's start time (without recording location), check in again when they enter the home to begin recording the location, and then check out when they leave the home to note the visit's end time.

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EVV – Frequently Asked Questions

4. Are web-based electronic timesheets with dual verification a permissible form of EVV?

Answer: No, most states' EVV systems use GPS and/or landlines to capture the location of PCS and HHCS.

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Secondary Claims

- To update the information for the FFS (Fee For Service) member if effective/term policy is not accurate.

  Use Form 470-5445

- Refer to IL 2131 which discusses checking TPL (Third Party Liability) and updating via the form.

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Crossover Claims

Iowa Medicaid State Plan for calculating Medicaid's payment for Medicare Part A and Part B crossover claims for both Medicaid covered services and non-covered services.

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Crossover Claims

- For services covered under the Iowa Medicaid State Plan, the new methodology will consider the amount Medicaid would have paid had it been the sole payer.
- The amount Medicaid pays will be the lesser of the full Medicare coinsurance and deductible, or the difference between the Medicare payment and Medicaid rate.

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Crossover Claims

- If the reimbursement paid by Medicare exceeds the Medicaid allowable payment, Medicaid will pay nothing additional on the claim. This change will treat Medicare the same as Medicaid treats other types of primary insurance.
- For Medicare services which are not otherwise covered by the Iowa Medicaid State Plan, IME will use a special rate or method to calculate the amount Medicaid would have paid for the service.

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Crossover Claims

- The Medicare paid amounts/deductible/coinsurance etc. are typically indicated in the following fields: 2320 AMT (amount Medicare paid).
- The 1500 would be at line level so it is the 2430 CAS (Medicare coinsurance, deductible, copay amounts).
- The UB can be recognized at the claim and line level.
- Line level-2430 CAS (Medicare coinsurance, deductible, copay amounts).
- Claim level-2320(Medicare coinsurance, deductible, copay amounts).

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Secondary Claims

The Medicare paid amounts/deductible/coinsurance etc. which are typically indicated in the following fields:

- 2320 AMT (amount Medicare paid) - The 1500 would be at line level so it is the 2430 CAS (Medicare coinsurance, deductible, copay amounts).
- The UB can be recognized at the claim and line level. Line level-2430 CAS (Medicare coinsurance, deductible, copay amounts).
- Claim level-2320(Medicare coinsurance, deductible, copay amounts).

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TPL - Third Party Liability Updates

Information Letter No. 2131-MC-FFS-D:

- ELVS no longer provides TPL verification for members assigned to a MCO or dental PAHP. MCOs and dental PAHPs will provide verified TPL information for their members.
- Providers should report TPL leads or changes for member's health insurance or dental coverage to the member's assigned MCO or dental PAHP.

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TPL – Third Party Liability Updates

- **Managed Care of North America (MCNA):** Providers may access TPL information when logging in to the Provider Portal at http://portal.mcna.net or by calling Provider Services at 1-855-856-6262.
- If you have any questions, please contact IME Provider Services at 1-800-338-7909 or email IMEProviderServices@dhs.state.ia.us.

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TPL – Third Party Liability

IME is not the source of truth for TPL. Providers need to go the MCOs/dental plans to verify the coverage and report changes to them.

- For FFS (Fee For Service) member TPL verification, continue to use ELVS (Eligibility and Verification Information System). TPL leads or changes for members in FFS should be reported using form, 470-5445, Insurance Update Fee-for-Service (FFS) Members.
- Time to process TPL - 60 business day

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CCHH – Chronic Condition Health Home

Goal:

- Target members with chronic conditions, engage them in their health, coordinate their care and show improved health outcomes.
- Provides primary care delivered through a patient-centered medical home (PCMH) model.

CCHH – Chronic Condition Health Home

Information:
https://dhs.iowa.gov/ime/providers/enrollment/healthhome

There are requirements to be met, called Health Home Standards, to be able to participate in the Health Home Program. Minimum requirements listed below:

- Use some form of a Patient Registry
- Electronic Health Record (EHR)

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CCHH – Chronic Condition Health Home

- Agree to participate in the Iowa Health Information Network
- Dedicated care coordinators
- Expanded hours for access
- Alternative means to communicate with patients and get them engaged, such as email, personal health records, reminders, etc.
- On the path to PCMH recognition or certification

CCHH – Chronic Condition Health Home

- Based on the member's enrollment tier. Members are enrolled in the Tier that corresponds to the number of identified chronic conditions for which the member has been diagnosed.
- The rate is developed according to the actual cost of providing each component of the service for the child population.
- No other payments for these services shall be made.

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CCHH – Chronic Condition Health Home

- Designed to only pay for Health Home services as described in the six service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services)
- May or may not require face-to-face interaction with a health home patient.

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CCHH – Chronic Condition Health Home

However, when these duties do involve such interactions, they are not traditionally clinic treatment interactions that meet the requirements of currently available billing codes.

CCHH – Chronic Condition Health Home

The criteria required to receive a monthly PMPM payment is:

- The member meets the eligibility requirements as identified by the provider and documented in the members electronic health record (EHR).
- Member's eligibility requirements verified within the last 12 months.
- The member has full Medicaid benefits at the time the PMPM payment is made.

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CHH – Chronic Condition Health Home

- The member has agreed and enrolled with the designated health home provider.
- The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards. 2

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CHH – Chronic Condition Health Home

- The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home Services in this State Plan.
- The Health Home must document Health Home services that were provided for the member.

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CHH – Chronic Condition Health Home

- The patient medical record will document health home service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of PMPM (Per-Member Per-Month) attestation.

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Telehealth – Informational Letters

- IL 2115-MC-FFS
- IL 2119-MC-FFS-CVD
- IL 2124 –FFS-D-CVD
- IL 2127-MC-FFS-CVD
- IL 2129-MC-FFS-CVD
- IL 2103-MC-FFS-CVD
- IL 2141-MC-FFS-CVD

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Telehealth – Originating Sites

The offices of physicians (provider types 02, 03) and other practitioners (psychologists, social workers, behavioral health providers, habilitation services providers, and ARNPs).

- Hospitals
- Critical Access Hospitals (CAHs)
- Community Mental Health Centers (CMHCs)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

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Telehealth - Originating sites paid a facility fee

- The facility fee is an amount paid to the originating site for hosting the patient during a telehealth visit.
- The originating site would charge the facility fee using Healthcare Common Procedure Coding System (HCPCS) Code Q3014 (telehealth originating site facility fee).
- Federal Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) would not bill Q3014 as a separate service because reimbursement for the related costs would occur through the annual cost settlement process.

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Telehealth - Distant Sites

Distant site is the location of a physician or practitioner at the time the service is furnished via a telecommunications system.

Distant site practitioners submit claims for telehealth services using the appropriate Current Procedural Terminology (CPT) or HCPCS code.

Practitioners at the distant site who can furnish and receive payment for telehealth services include:

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Telehealth - Distant Sites

- Physicians
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)

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Telehealth - Distant Sites

- Certified registered nurse anesthetists (CRNAs)
- Clinical psychologists
- Clinical social workers (CSWs)
- Behavioral Health Service providers (licensed independent social workers (LISW), licensed master social workers (LMSW), licensed marital and family therapists (LMFT), licensed mental health counselors (LMHC), or certified alcohol and drug counselors (CADC)

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Telehealth Expanded Services

- The expanded telehealth services will be in effect until at least the end of the federal public health emergency which is January 20, 2021.
- The Department is currently reviewing the continuation of expanded telehealth services beyond this date.

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EDISS – EDI Support Services Gateway Transition

IL 2135, 2168 and 2174

- EDISS is working to transition all Iowa Medicaid Managed Care Organization (MCO) encounter transactions, FFS web portal users and all existing Iowa Medicaid web portal functionality out of the legacy EDI Gateway.

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EDISS – EDI Support Services Gateway Transition

- This Gateway transition was scheduled to take place on October 11, 2020, but EDI has decided to move this go live date to October 18, 2020.

Remove

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EDISS – EDI Support Services Gateway Transition

- EDISS will not require any additional forms or re-registration for this transition.
- All existing submitters and their associated transactions will be migrated into the new gateway via automated processes.
- EDISS will require submitters who utilize the legacy web portal to verify their EDISS Connect account profile FAX number and email address.

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EDISS – EDI Support Services Gateway Transition

Web Portal User Specific Changes

- Web Portal (Asynchronous) connectivity for batch and real-time transactions will continue to be supported in the new processing solution.
- The core functionality and output to submitters the same. New user guides to assist with navigating the updated portal.
- The existing URL of https://ime-ediss5010.noridian.com should remain the same

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EFT Change Request

Reference IL 2167

- All EFT change requests must be submitted via a secure upload using the Iowa Medicaid Portal Access system (IMPA) system, rather than by fax or email.

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EFT Change Request - Registration

1. Go to: https://secureapp.dhs.state.ia.us/impa/Default.aspx
2. Click on the “Register New Account” link at the top of the page
3. Complete the registration form. Your password must be at least eight characters and include one uppercase character, one lowercase character, one digit, and one special character (!@#$%^&+=). Enter the verification words and click the “Create” link
4. When you receive the “Congratulations” message, click “OK”

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EFT Change Request – Uploading Documents

1. Log into IMPA. When you login for the first time, you will be required to answer three security questions before proceeding.
2. Under the main menu, hover over File>Upload File> click on- Document to IME
3. In the Document Types drop down menu, select “Provider EFT” 2

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EFT Change Request – Uploading Documents

4. Follow the instructions on the screen in the blue box. Once you have logged into IMPA, you will find two (2) options:

- If you already have the EFT form and your voided check or bank letter as one PDF you can bypass the “Merge and Open PDF” step and go directly to the “Select” button. Select the document on your PC, next click the Upload button, your uploaded document will appear in the history table and has been sent to IME Provider Enrollment for processing.
- If you do not already have the EFT form and your voided check or bank letter merged as one document follow the steps on the screen to merge into one PDF. Note all of your documents must be saved in a location on your local PC. After the documents are merged and saved to your local PC, you are ready to upload.

EFT Change Request – Uploading Documents

5. Click the “Select” button to open the saved merged document.
6. Click the “Upload” button to send the document to the IME.

This process can only be used for the submission of an EFT change. The initial EFT request must be submitted with the enrollment application packet during initial enrollment.

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EFT Change Request – Receipt Notification

When using this process, please use the following practices to ensure your EFT is received as intended:

- The EFT form can be found on the IMPA landing page under featured functionality. This will be the most up-to-date version; submission of an outdated version will slow down the process.

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EFT Change Request – Receipt Notification

- When the document is uploaded to the IME, you will see the history of uploaded documents on your screen in a table.
- Document size is limited to 20 MBs.

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EFT Change Request – Final Comments

- All EFT changes are verified prior to processing.
- Any non-EFT documents submitted through this process will be discarded and will not reach the intended destination.
- If you have questions, or need help submitting your organization's EFT form, please contact the Iowa Medicaid Provider Services Unit at imeproviderservices@dhs.state.ia.us.

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New Webpage, Search Options for Informational Letters (ILs) - IL 2113

- The IME publishes provider bulletins called ILs that are necessary to clarify and explain new and existing programs and policies. ILs are an important cross reference for any new policy changes that have been implemented but are not yet reflected in the published Provider Manual.
- ILs are organized on the Department's website by their year of publication and then in descending numerical order.

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New Webpage, Search Options for Informational Letters (ILs) - IL 2113

- Effective April 2, 2020, the webpage where the ILs are posted is changing and will have a new look and new search options.
- Because of this, any Internet favorites, or bookmarks, you had for the Department's ILs will need to be updated.

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New Webpage, Search Options for Informational Letters (ILs) - IL 2113

- The new IL webpage will display a search bar with the latest 10 published ILs underneath.
- To access previous ILs, users can type in a keyword or phrase in the search bar, or choose one or more of a series of suggested choices under the following drop-down menus: provider type, provider topic, or program.

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Quarterly Provider Training will resume 2021.

More details will be provided in future Informational Letters

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Question and Answer Session

- Please type in your general questions in the “chat box”
- If specific questions, please utilize the resources that IME, Iowa Total Care and Amerigroup have provided.

Thank you for your attendance and look forward to 2021!!