EVV Discussion Topics

EVV Stakeholder Session 9/23/2025

ICDAC Transition:
General Provider Information

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IOWA Health and Human Services

LUPA Rates

Hillery Roach, Iowa Total Care

- **LUPA Rates**
  Core-Based Statistical Area (CBSA)
- The state is divided into eleven CMS geographical areas. Identify the geographical area in which your home health agency is located. This is the basis for your LUPA reimbursement. The basis of the LUPA reimbursement is **not** the residence of any specific member that you may be serving.

Payment Processing & Timelines

Hillery Roach, Iowa Total Care

Corrected claims

- Corrected claims need to be submitted through EVV.

Claims processing

First time clean claims submissions will be adjudicated (finalized as paid or denied) at the following levels:

- 90% within 30 calendar days of receipt.
- 95% within 45 calendar days of receipt.
- 99% within 90 calendar days of receipt.

Claims adjustments (claims previously paid or denied) will be adjusted at the following levels:

- Adjustments with configuration required: 60 business days.
- Adjustments with no configuration required: 30 business days.
- Adjustments to claims with Manual Errors: 15 business days.

Claims processing continued

Clean Claim Definition:

- A clean claim is a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

Non-Clean Claim Definition:

- Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. Non-clean claims can result in either claim rejections or claim denials and can involve issues regarding medical necessity or claims not submitted within the filing deadlines.

Timely guidelines

Timely Filing

Providers must submit all claims and encounters within 180 calendar days of the date of service. All retroactive eligibility claims need to be received at Iowa Total Care within 365 days of the notice date. When Iowa Total Care is the secondary payor, claims must be received within 365 calendar days of the final determination of the primary payor. Corrected claims or reconsiderations are allowed 365 days from the last date of adjudication on the original claim for receipt of a corrected claim not to exceed two years from the last date of service on the claim. Please reference the timely filing requirements below:

Claim Submission Type	Timely Filing Guidelines
Initial Claim Submission	180 days*.
Initial Claim Submission with Third Party Liability (TPL)	365 days from the last date of EOP from primary carrier.
Corrected Claim Submission	365 days from the last adjudication date up to two years from the date of service.
Disputes/First Level Appeal	180 days from EOB for first level dispute/appeal.
Second Level Appeal	30 days from the original decision notated on the provider remittance advice from the dispute/first level appeal.

* Out of Network providers have 12 months for initial claim submission.

Claims Escalations

All MCOs

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CareBridge Provider Portal Demo & Manual Entries

Matthew Saylor, CareBridge

EVV Compliance

Quin Johnson, Iowa Total Care

IOWA Health and Human Services

Manual Entries:

Less than 25% of documented visits will be manual entries or revisions

- Manual entries should only be completed when there is no ability to utilize one of the two normal methods to check in/out of the visit (mobile app or IVR)
- A manual revision is completed when the visit needs to be adjusted. For instance, the caregiver forgot to check out, so the check-out time needs to be modified
- Manual entries and manual revisions should be used as a last resort to ensure that visit data is correct

Iowa Medicaid has approved an exception for live-in caregivers to use manual entry each day worked for the amount of time they have provided services that day. The entry should include documentation in the care plan for all the tasks they completed that day. The entry should also be completed the same day the service was provided.

Care Plan Completion:

- The Care Plan should be completed for home health and personal care services. Every visit should include completed Care Plan tasks unless provider is maintaining documentation outside of CareBridge.

- The Care Plan is where staff documents the services they provided during the visit (check boxes)
  - Examples: Observation and evaluation, Wound care, Administration of medications CDAC: N6 Essential Housekeeping, N10 Essential Transportation, N12 Medication Assistance, S4 Catheterizations

- The Care Plan activities should be completed at the end of the visit before the Caregiver checks out

CDAC Specific Expectations:

- Stay under Daily CDAC Cap: current Iowa Administrative Code has a daily dollar amount cap for CDAC services:
  - $93.68/day for ICDAC (T1019 & T1019:U3)
  - $139.18/day for Agency CDAC (S5125 & S5125:U3)
    - About 23 units max/day (or 5 hours and 45 minutes)
- Follow CDAC Agreement. The CDAC Agreement is an agreement between the member and the CDAC agency or caregiver to provide the services outlined within it, including:
  - Frequency of visit
  - Visit duration
  - Tasks completed during the visit

Home Health Care High Acuity

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Home Health Care High Acuity

- The Home Health Care High Acuity opportunity aims to support Iowa Medicaid members recently hospitalized or assessed by a provider as needing high-acuity home care. It includes three (3) tiers based on care level, with higher payments requiring specific diagnosis codes for each tier.
- Home Health Care Services provide short-term medical and non-medical support to help members recover at home and reduce hospital stays. Medical services include wound care, IV medications, medication management, and education on complex conditions. Non-medical support includes help with transitions and personal care, like bathing. The provider orders a personalized plan of care (POC), which nursing staff update through collaboration. Iowa Medicaid reimburses providers for medically necessary services.

Home Health Care High Acuity continued

- Program began on July 1, 2025.
- Acuity is determined by a member's diagnosis and personalized plan of care (POC). Higher acuity levels reflect more complex needs and care requirements. Since needs can be subjective, providers must document services thoroughly to justify higher reimbursement for high-acuity care.
- The member must have been hospitalized or been seen by a provider within the past 14 days, to report a condition change.
- Subject to post pay review/ audit of medical records.
- If the review/audit of the documentation does not meet the requirement of the Tier Level, the claim will be recouped.
- The provider can submit a corrected claim to submit the claim without the high acuity modifier for reimbursement.
- Only applies to claims where Iowa Total Care is the primary insurance.

Home Health Care High Acuity continued

- Reimbursement is as follows:

Tier 1	Receiving a 10% increase to the LUPA rate	Provider submits the claim with the U1 modifier
Tier 2	Receives a 30% increase to the LUPA rate	Provider submits the claim with the U2 modifier
Tier 3	Receives a 60% increase to the LUPA rate	Provider submits the claim with the U3 modifier

Questions

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