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

About Iowa Total Care

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.

Member Population

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.

- Inpatient Hospital Services
- Outpatient Hospital Services
- Emergency Care
- Professional Office Services
- Preventative Services
- Behavioral Health Services
- Outpatient Therapy Services
- Radiology Services
- Laboratory Services
- Durable Medical Equipment (DME)
- Long Term Services Supports (LTSS) – Community Based
- Long Term Services and Support (LTSS) – Institutional
- Hospice
- Health Homes
- Vision Services

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

My Health Pays™

- A healthy rewards account program
- Innovative approach to encourage health behaviors through financial incentives

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

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

Member Eligibility Verification

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.

Member Eligibility Verification – *Continued*

Eligibility can be validated 1 of 3 ways

Using the Provider Portal:
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

Member ID Cards

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

ia health link

Effective/Fecha Efectiva: MM/DD/YYYY

RX: XXXXX
RXBIN: XXXXX
RXPCN: XXXXX
RXGRP: XXXXX

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

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

IMPORTANT CONTACT INFORMATION/
INFORMACIÓN IMPORTANTE DE CONTACTO

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

PROVIDERS/PROVEEDORES:
Eligibility: **1-833-404-1061 (TTY: 711)** • Prior Authorization: **1-833-404-1061**
Medical Claims: **PO Box 8030, Farmington, MO 63640**
Provider/claims information via the web: **IowaTotalCare.com**
Pharmacy Help Desk: **1-833-776-3681**

iowa total care.

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

Hawki

Effective/Fecha Efectiva: MM/DD/YYYY

RX: XXXXX
RXBIN: XXXXX
RXPCN: XXXXX
RXGRP: XXXXX

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).
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Medical Claims: **PO Box 8030, Farmington, MO 63640**
Provider/claims information via the web: **IowaTotalCare.com**
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Provider Responsibilities

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

Provider Access Standards – *Continued*

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

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

Cultural Competency – *Continued*

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

Child and Dependent Adult Abuse

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))

Contracting and Credentialing

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/CREDENTAILING STATUS

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

Claims Processing

Claim Submissions

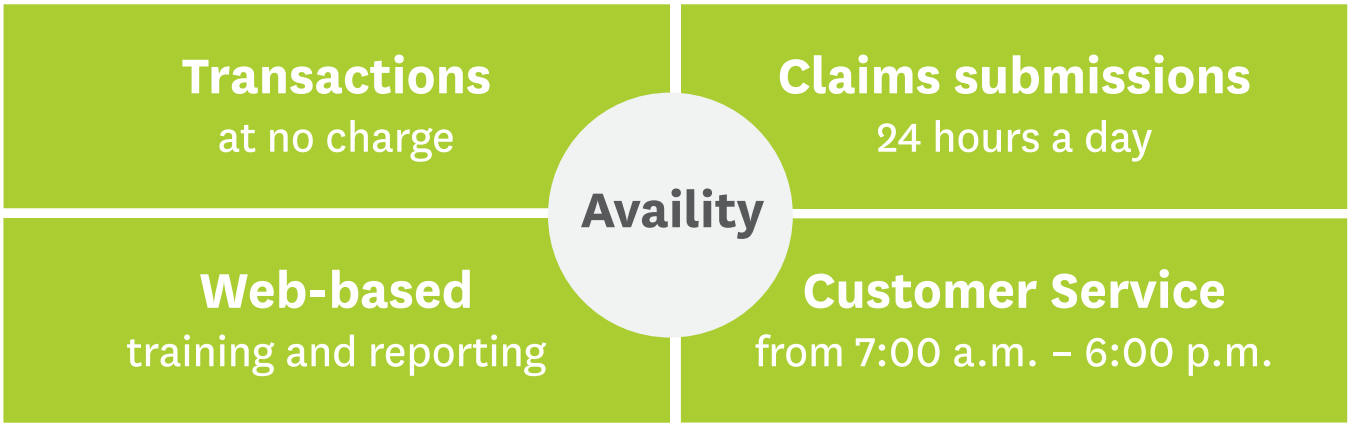
Iowa Total Care accepts claims submissions via paper or electronic format for expedited processing and payment

PAPER	ELECTRONIC
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

Claims Processing – *Continued*

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



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

Claims Processing – *Continued*

The following tables outline claim submission and payment timings

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

Claim Type	Payment Timing
New clean claim	90% within 30 calendar days of receipt
	95% within 45 calendar days of receipt
	99% within 90 calendar days of receipt

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**
  - 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)

Claim Electronic Payment

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

Claim Payment Disputes

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*

2nd DISPUTE STEP – APPEAL

Provider request must be submitted within 30 calendar days from the reconsideration determination letter	Include as much information as possible to assist with determination review	Iowa Total Care will work to have the review completed within 30 calendar days from receipt of all information

Claim disputes should be mailed to:

Iowa Total Care – Attn: Claim Disputes
P.O. Box 8030; Farmington, MO 63640-0830

Member Grievances and Appeals

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** for information on how to file a member grievance, appeal, and State Fair Hearing, along with details on timely filing deadlines

Provider Complaints

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

- Provider complaints can be filed regarding policies, procedures or administrative processes in place 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.

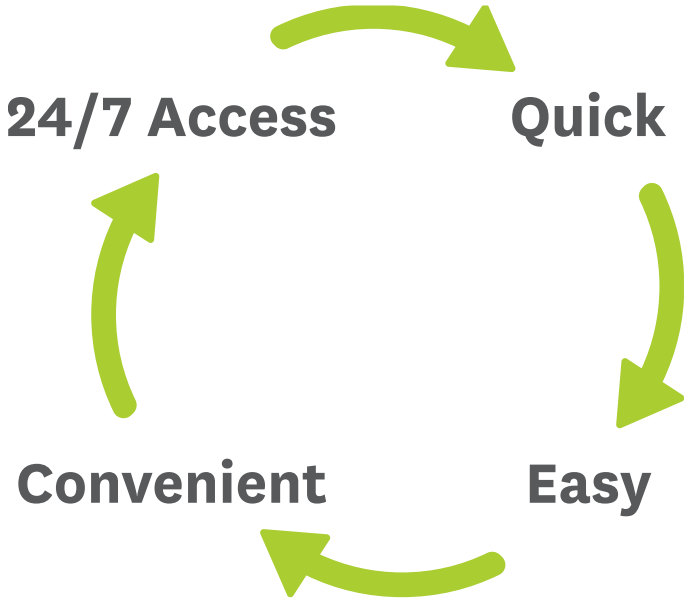
FAX:

833-208-1397

Resources – Iowa Total Care Website

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



Resources – Provider Updates

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

Resources – Secure Provider Portal

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

- Check member eligibility
- View the PCP panel (patient list)
- 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** and select the Login link on the top right corner of the page

Resources – IVR System

The phone Interactive Voice Response (IVR) allows quick access to key pieces of information

Access the automated IVR system by calling **833-208-1397**

- 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

Resources – Provider Services

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

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

Resources – Provider Relations

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

Resources – Provider Relations

Provider Relations Specialists are available to assist providers by phone and in their office based on the following region assignments

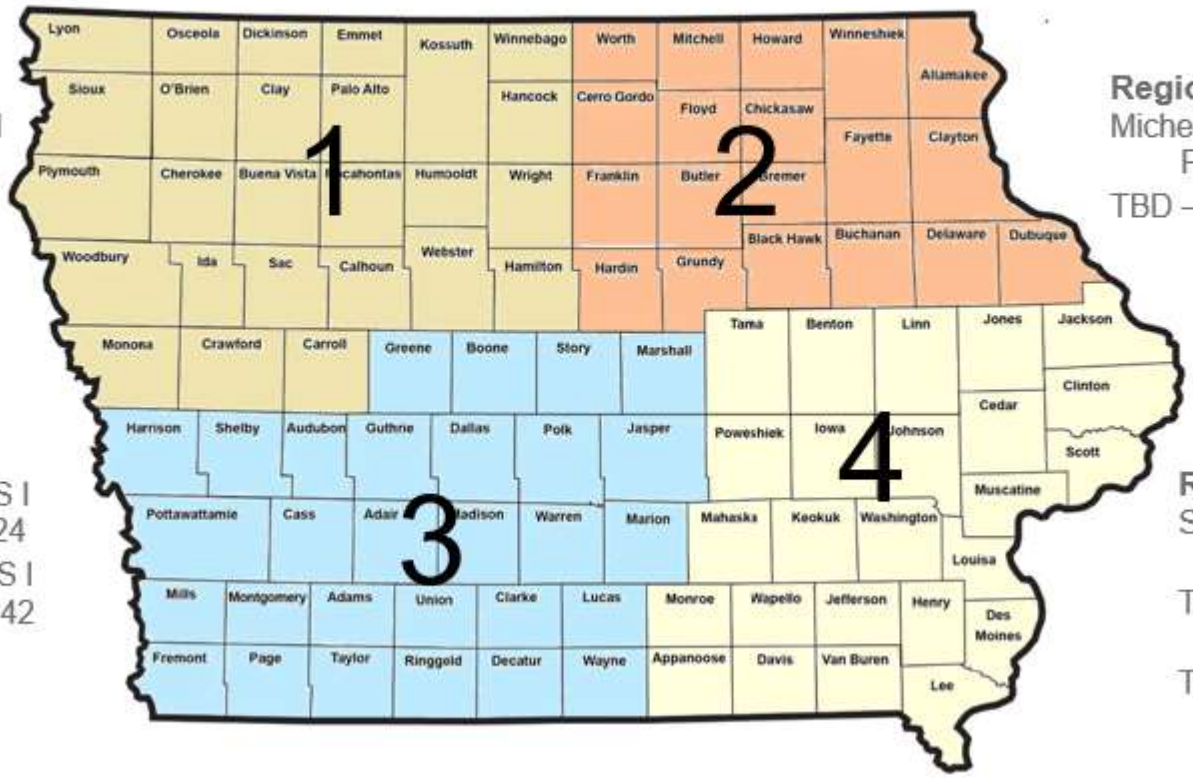
FQHC/Tribal Services Coordinator – Kendra Abel

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

HEALTH PLAN INFORMATION	
Website	www.iowatotalcare.com
Mailing Address	Iowa Total Care 1080 Jordan Creek Parkway Suite 100 South West Des Moines, IA 50266
Ethics and Compliance Helpline and reporting Fraud, Waste and Abuse	866-685-8664

Resources – Contacts

Iowa Total Care Departments	Phone	Fax
Provider Services	833-404-1061 TTY: 711	833-208-1397
Member Services & Eligibility		
Medical Management Concurrent Review		833-257-8320
Care Management		

Resources – Claims

PAPER	ELECTRONIC
Iowa Total Care – Attn: Claims Department 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**

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Resources – ITC Partners

Vendor Partner	Contact Number	Website
Envolve Vision	P: 833-564-1205	visionbenefits.envolvehealth.com
Envolve Pharmacy Services	P: 833-776-3681 F: 866-399-0929	Pharmacy.envolvehealth.com
National Imaging Associates (NIA)	P: 833-404-1061	www1.radmd.com
Company - 24 Hour Nurse Advice Line (24/7 availability)	P: 833-404-1061	
Voiance Interpreter Services	P: 866-998-0338	
Access 2 Care	P: 888-644-3547	

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**

Medical Management – *Continued*

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

Clinical Practice Guidelines

Examples of clinical practice guidelines adopted by Iowa Total Care include:

- American Academy of Pediatrics: Recommendations for Preventative Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- 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

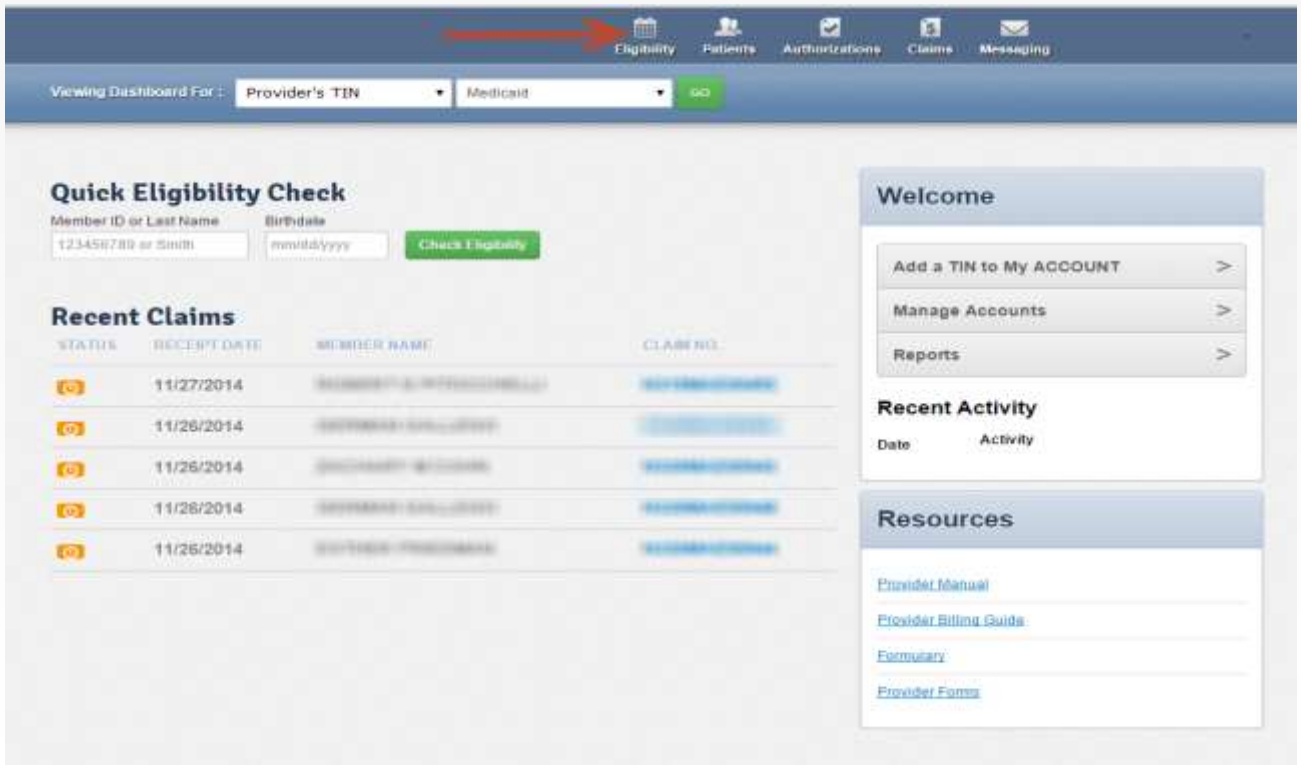
Care Coordination is designed to help members obtain needed services using a multi-disciplinary care management team that promotes:

- 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.

Care Management Referral Submission

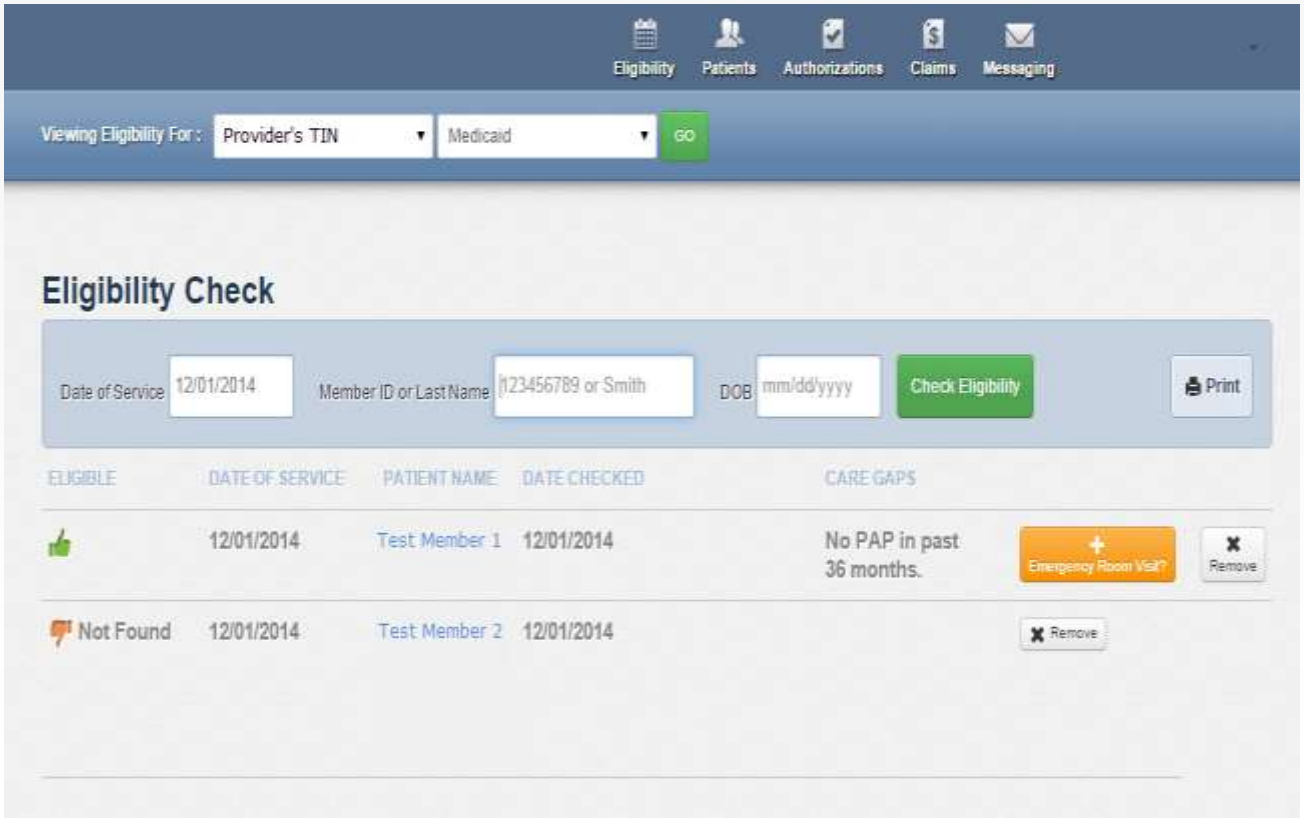
Creating Referrals using the Secure Provider Website



- Faster, easier solution for submitting referrals
- Maintains members' confidentiality
- Enables communication between providers and case management

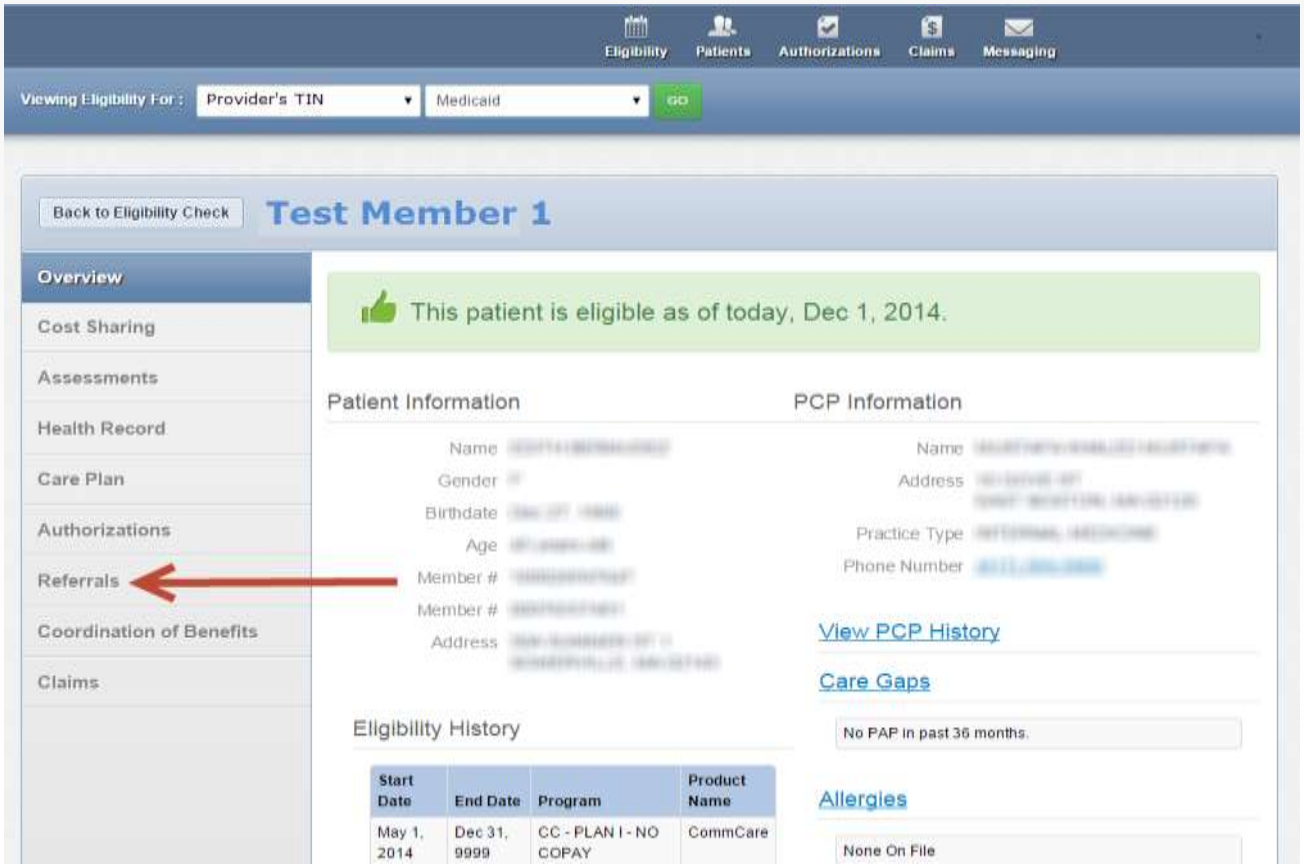
Care Management Referral Submission

Verify Member Eligibility



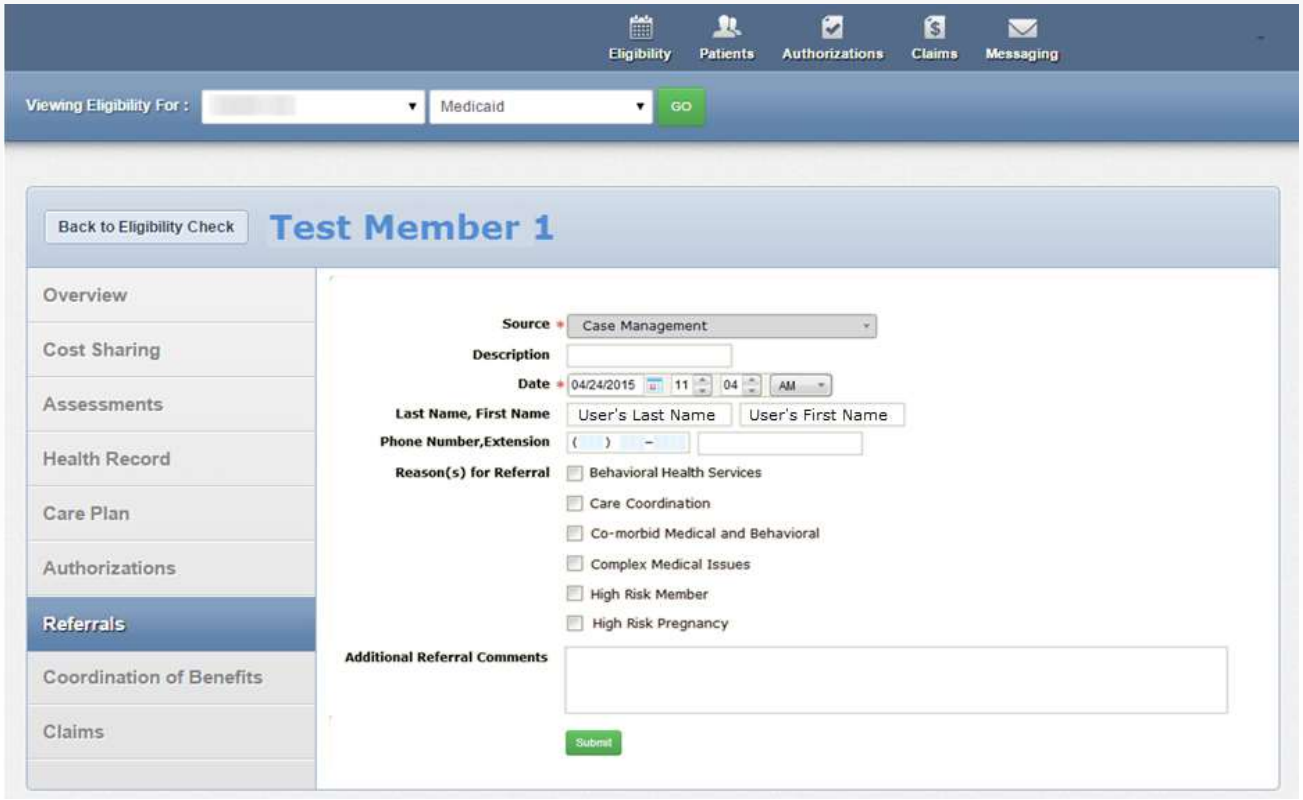
Care Management Referral Submission

Initiate the referral process by clicking on **Referrals**



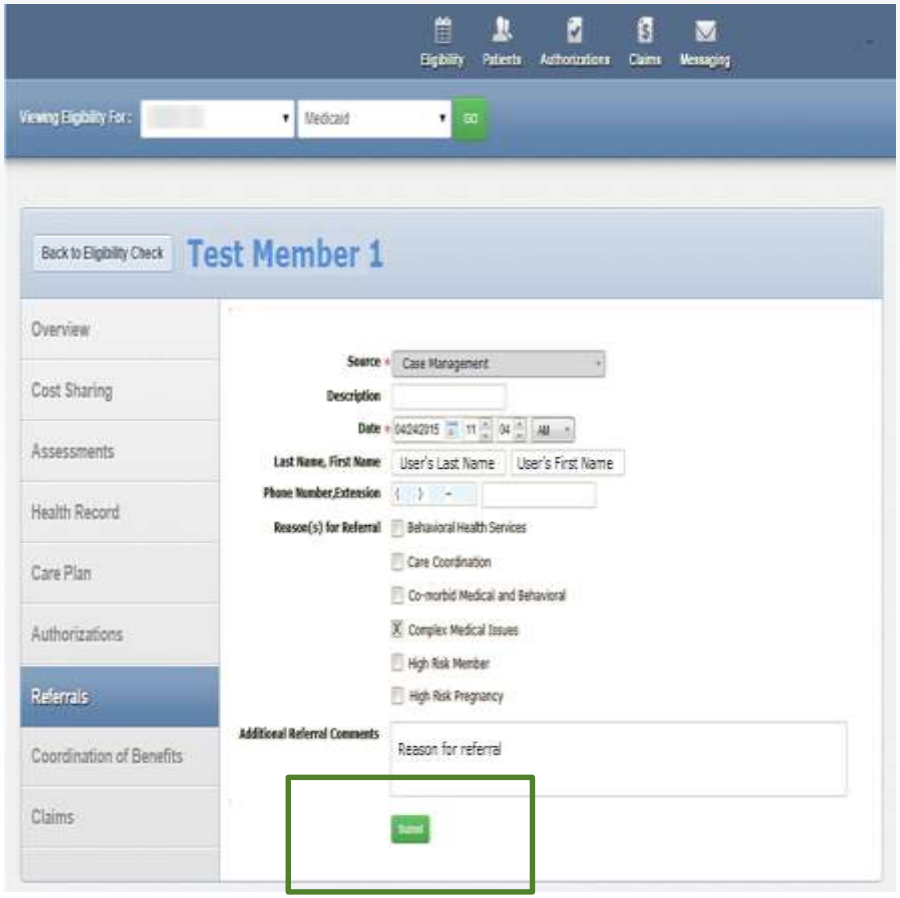
Care Management Referral Submission

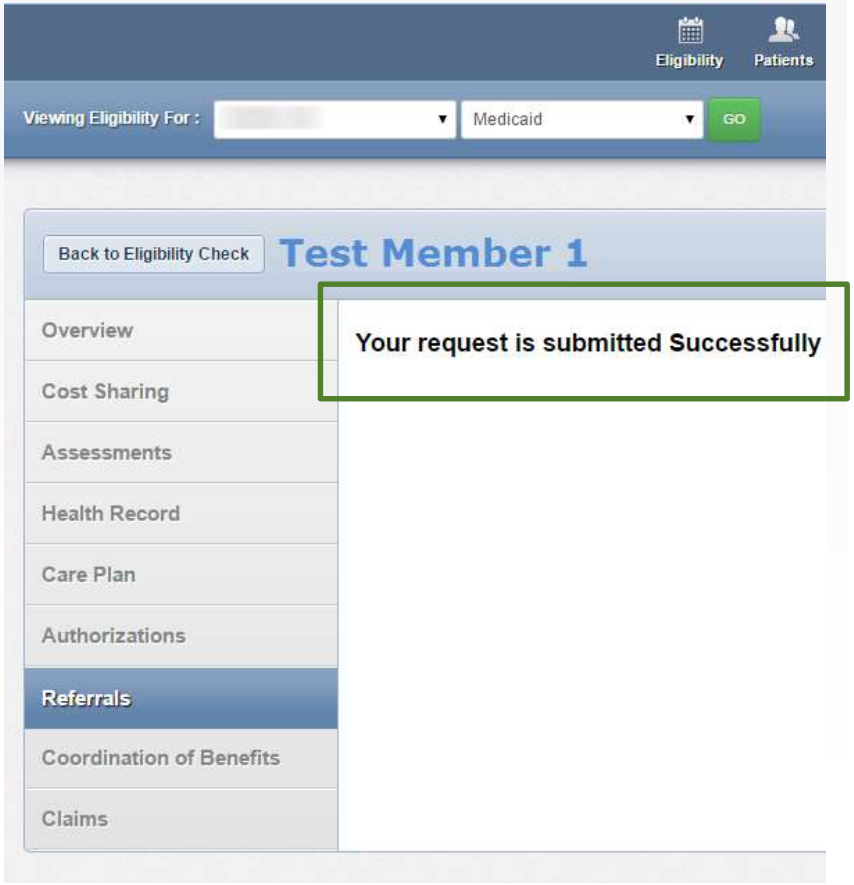
Complete the appropriate data referral eliminates



Care Management Referral Submission

Click submit and your request is finalized





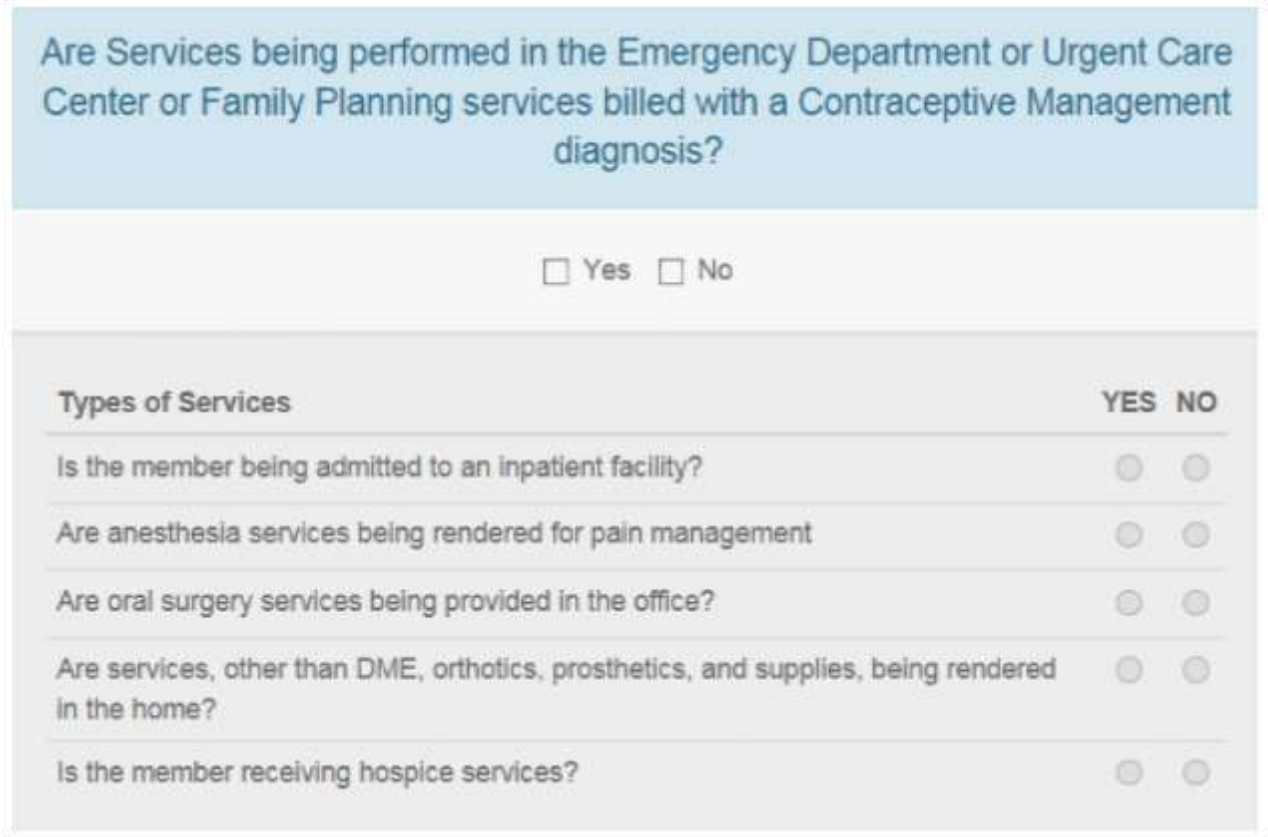
Prior Authorizations

- 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 Authorizations – *Continued*

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?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are anesthesia services being rendered for pain management	○	○
Are oral surgery services being provided in the office?	○	○
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○
Is the member receiving hospice services?	○	○

Prior Authorizations – *Continued*

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 Authorizations – *Continued*

Prior Authorization Timings

PROVIDER SUBMISSION TIMINGS	
Scheduled Admissions/ Elective Outpatient Services	5 business days prior to service
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

IOWA TOTAL CARE REVIEW TIMINGS	
Standard Non-Urgent	14 calendar days
Expedited Preservice/Urgent	72 hours
Concurrent Review	24 hours

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

Prior Authorizations – *Iowa Total Care, Continued*

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**

Prior Authorizations – *Iowa Total Care, Continued*

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
Register: http://bit.ly/magellanhealth0611191200pm

Wednesday, June 12, 2019 8:00 a.m. CST
Register: http://bit.ly/magellanhealth061219800

Thursday, June 13, 2019 12:00 p.m. CST
Register: http://bit.ly/magellanhealth0613191200pm

Monday, June 17, 2019 8:00 a.m. CST
Register: http://bit.ly/magellanhealth061719800

Friday, June 21, 2019 12:00 p.m. CST
Register: http://bit.ly/magellanhealth0621191200pm

*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.

Prior Authorizations – *Envolve, Continued*

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

Prior Authorizations – *Envolve, Continued*

- 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

Access 2 Care (A2C)

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

Behavioral Health Services

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

Behavioral Health Services – *Continued*

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

Behavioral Health Services – *Continued*

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

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

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

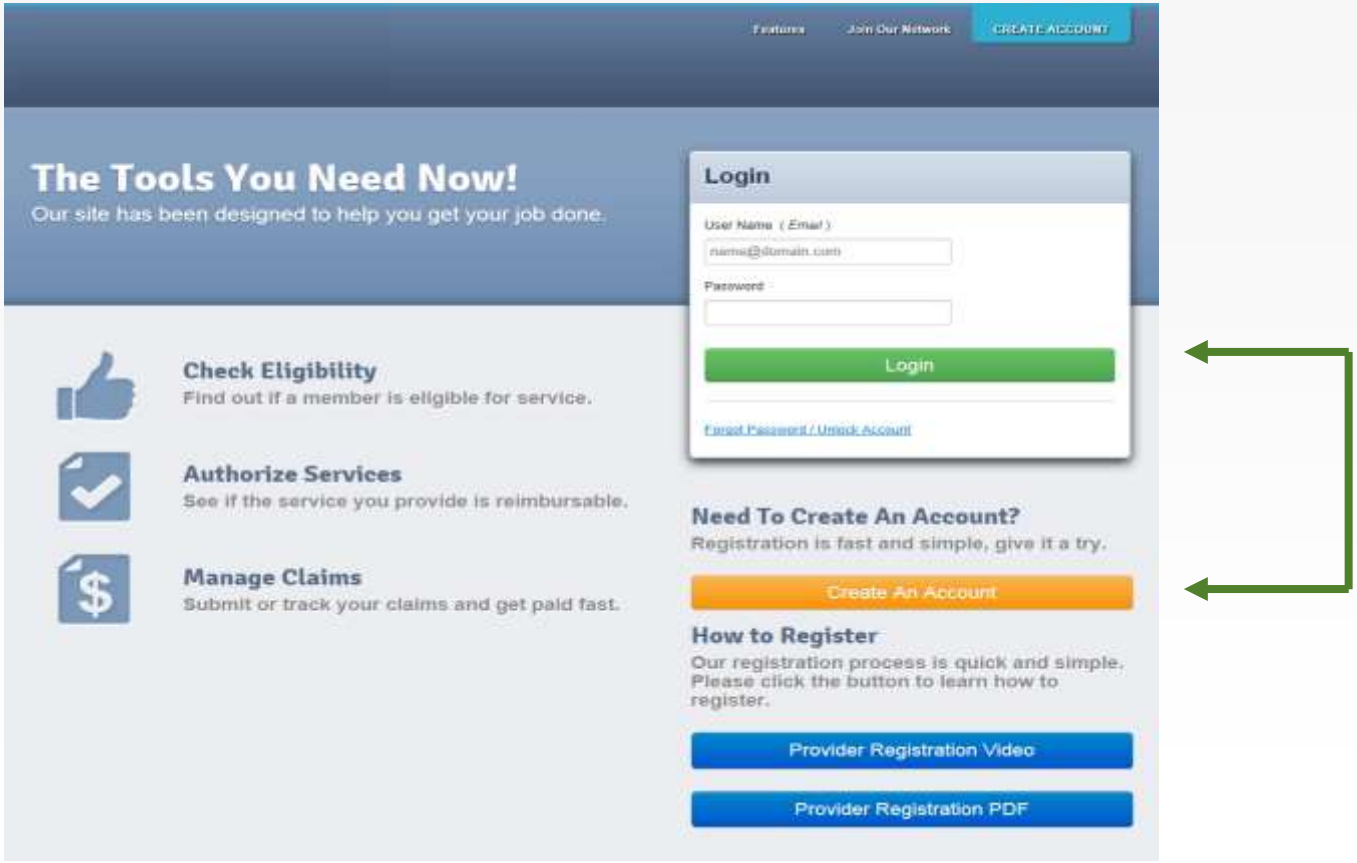
Portal Claim Submission & Claim Reject Code Definitions

Iowa Total Care Website

Access the Iowa Total Care Secure Provider Portal page by clicking on the **For Providers tab**

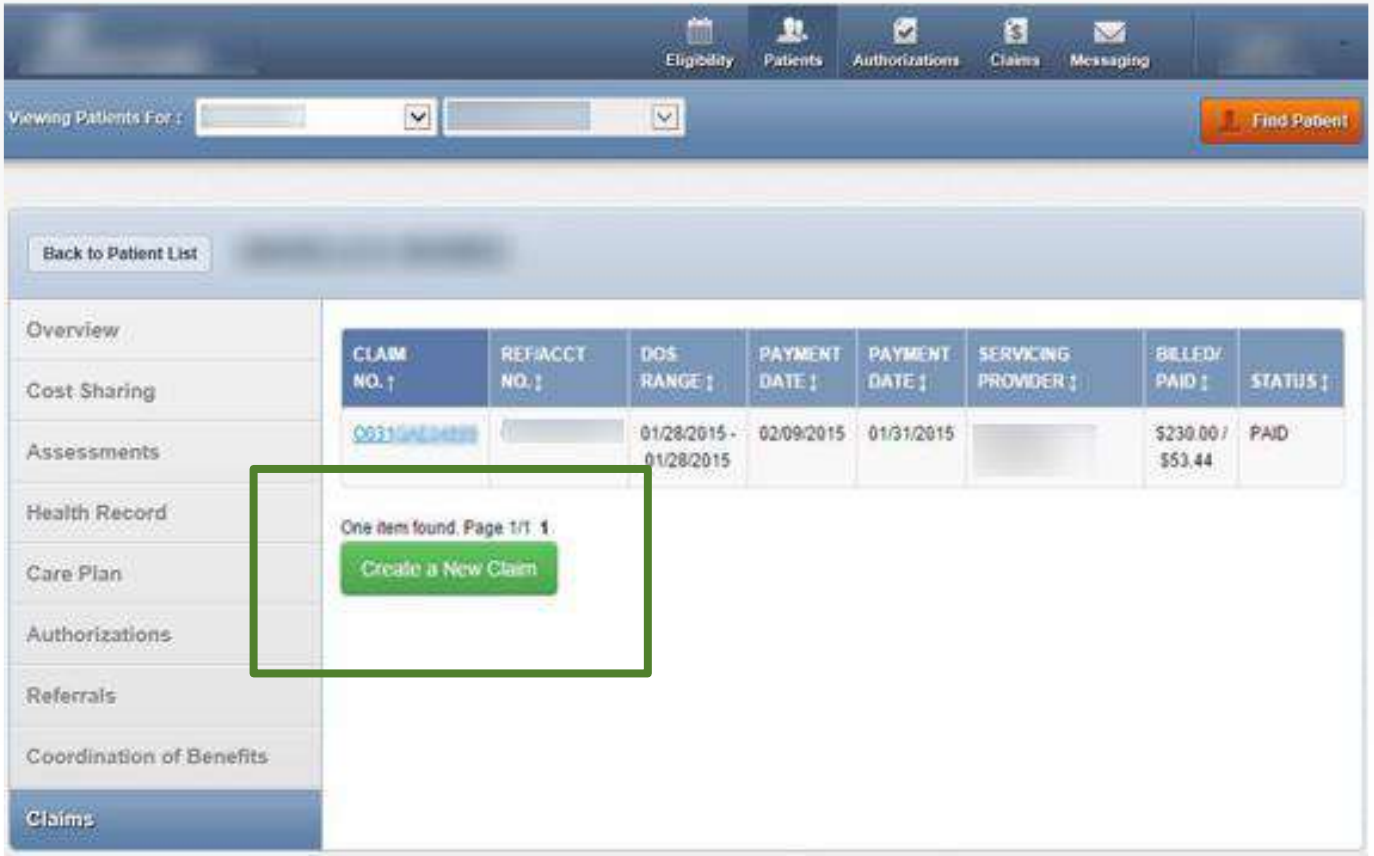
Provider Portal Landing Page

Create an account or log into the portal



Professional Claim Entry

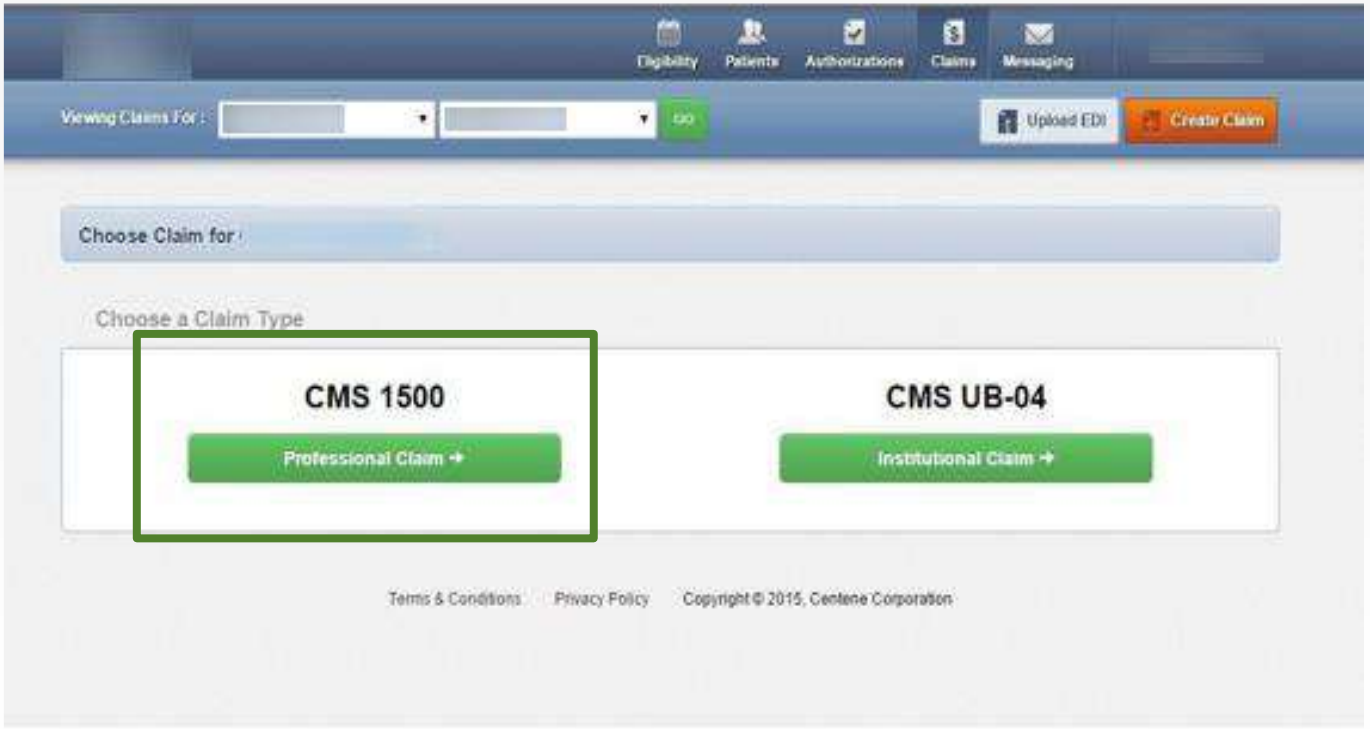
Select the green “Create a New Claim” button within the patient record



Claims Submissions - *Professional*

Professional Claim Button

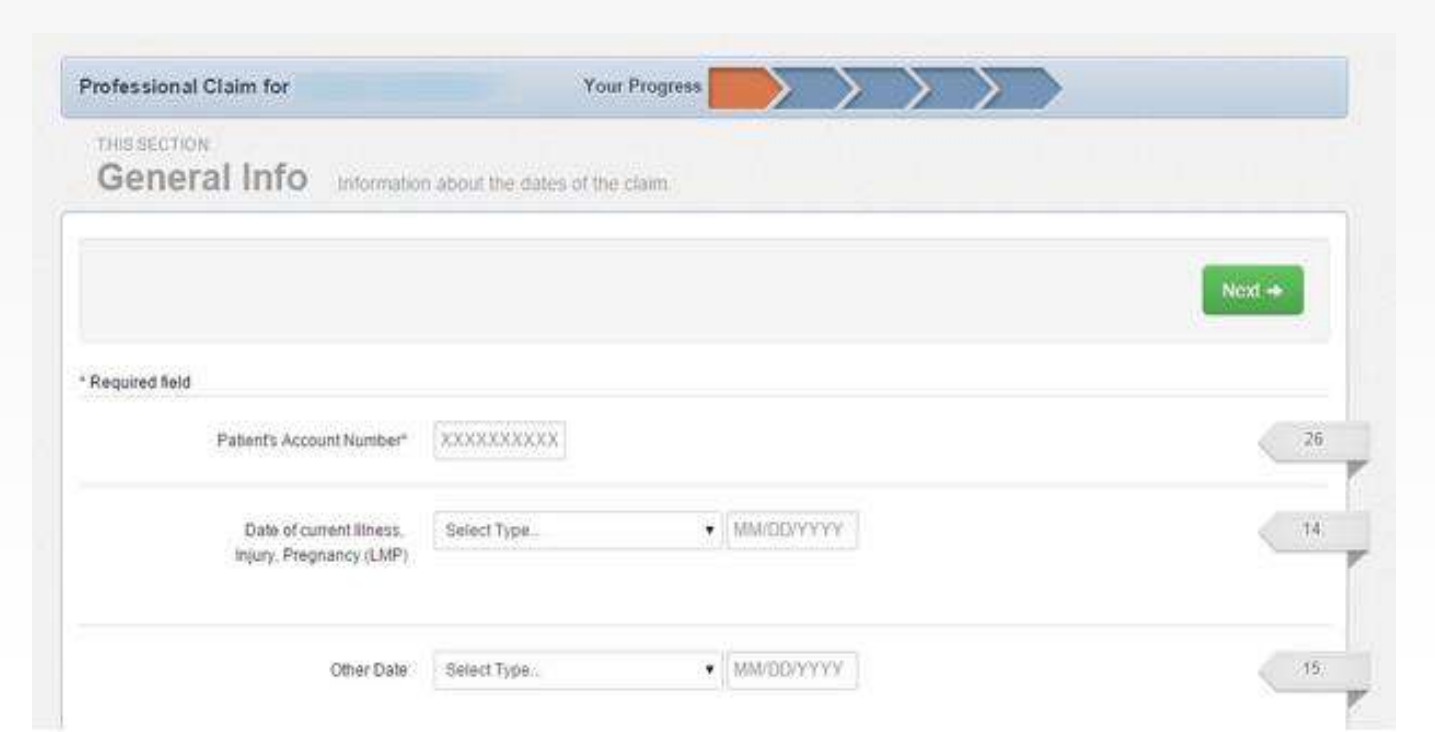
Click the green rectangle button when prompted



Claims Submissions - *Professional*

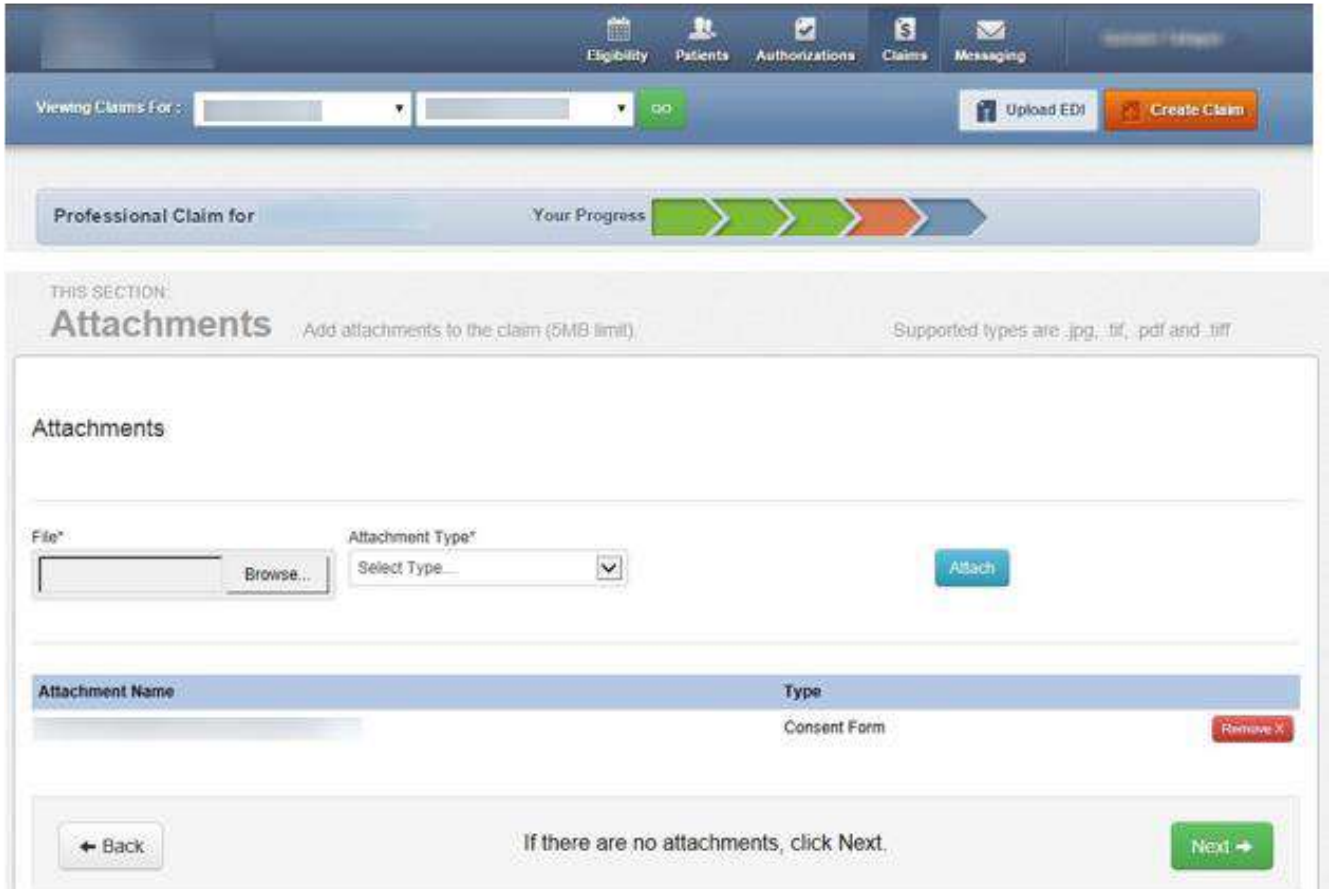
General Info Section:

- 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.



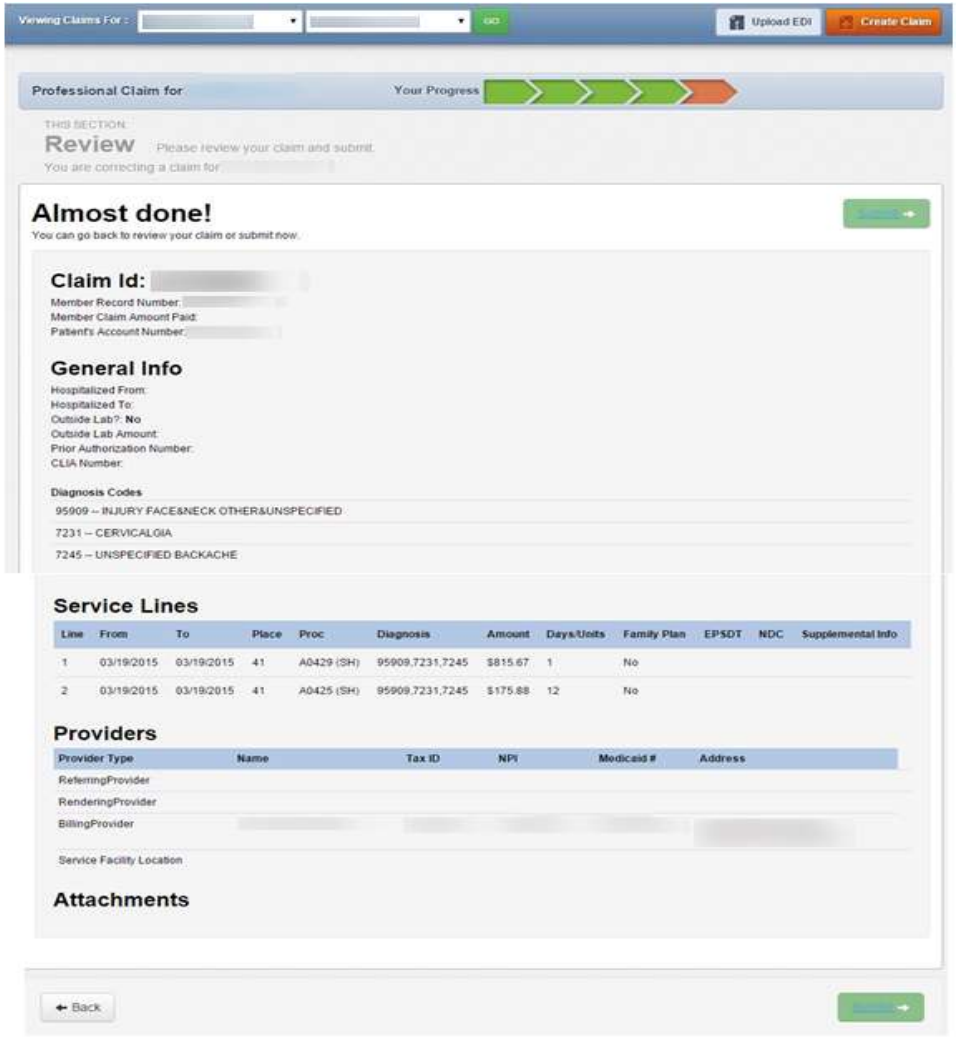
Claims Submissions - *Professional*

Attachments Screen: use the Browse button for attaching medical records and other documents related to claims submission, when applicable



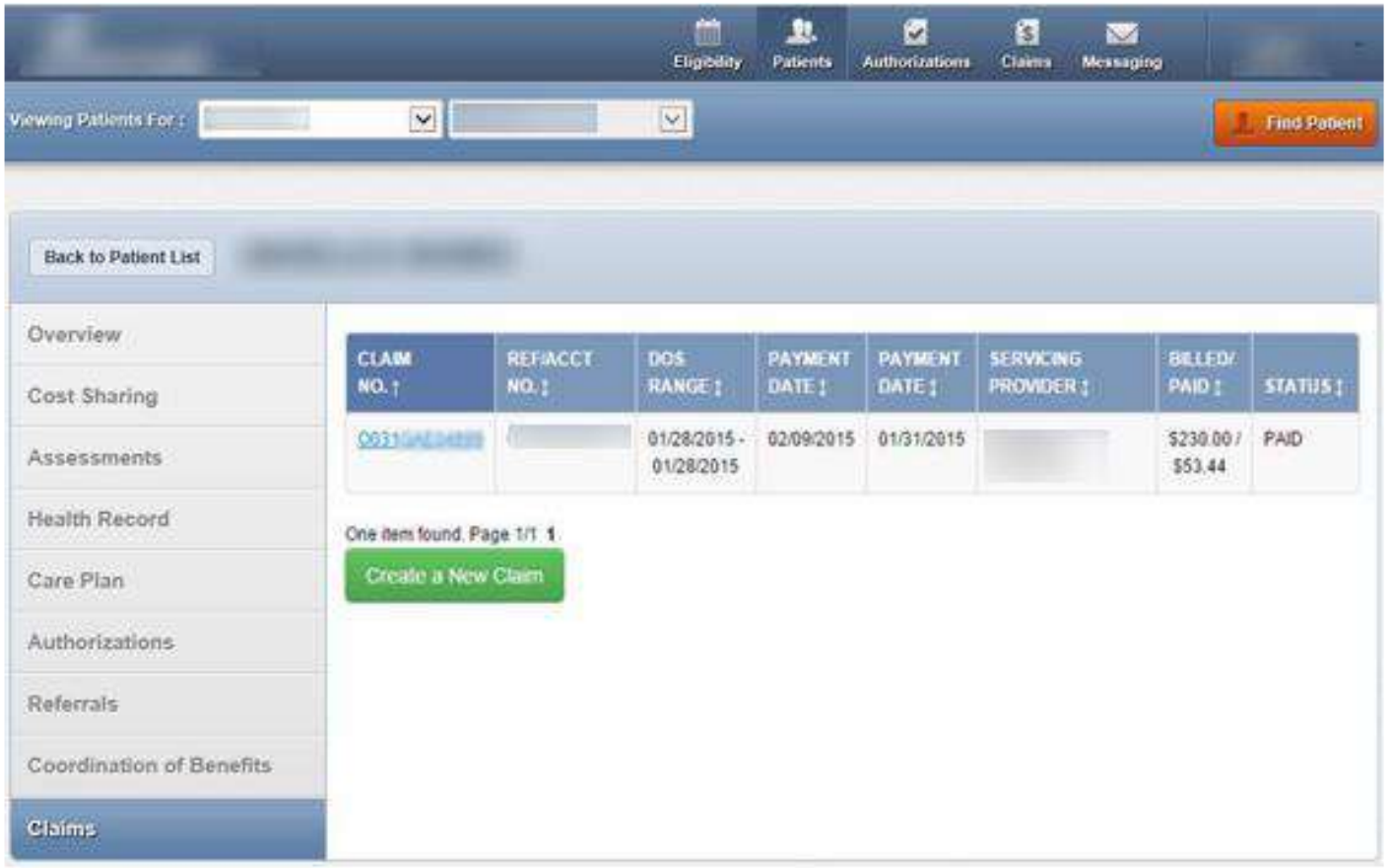
Claims Submissions - *Professional*

Final Step:
Review the entire claim and if all information is correct click the green Submit button in the bottom, right-hand corner



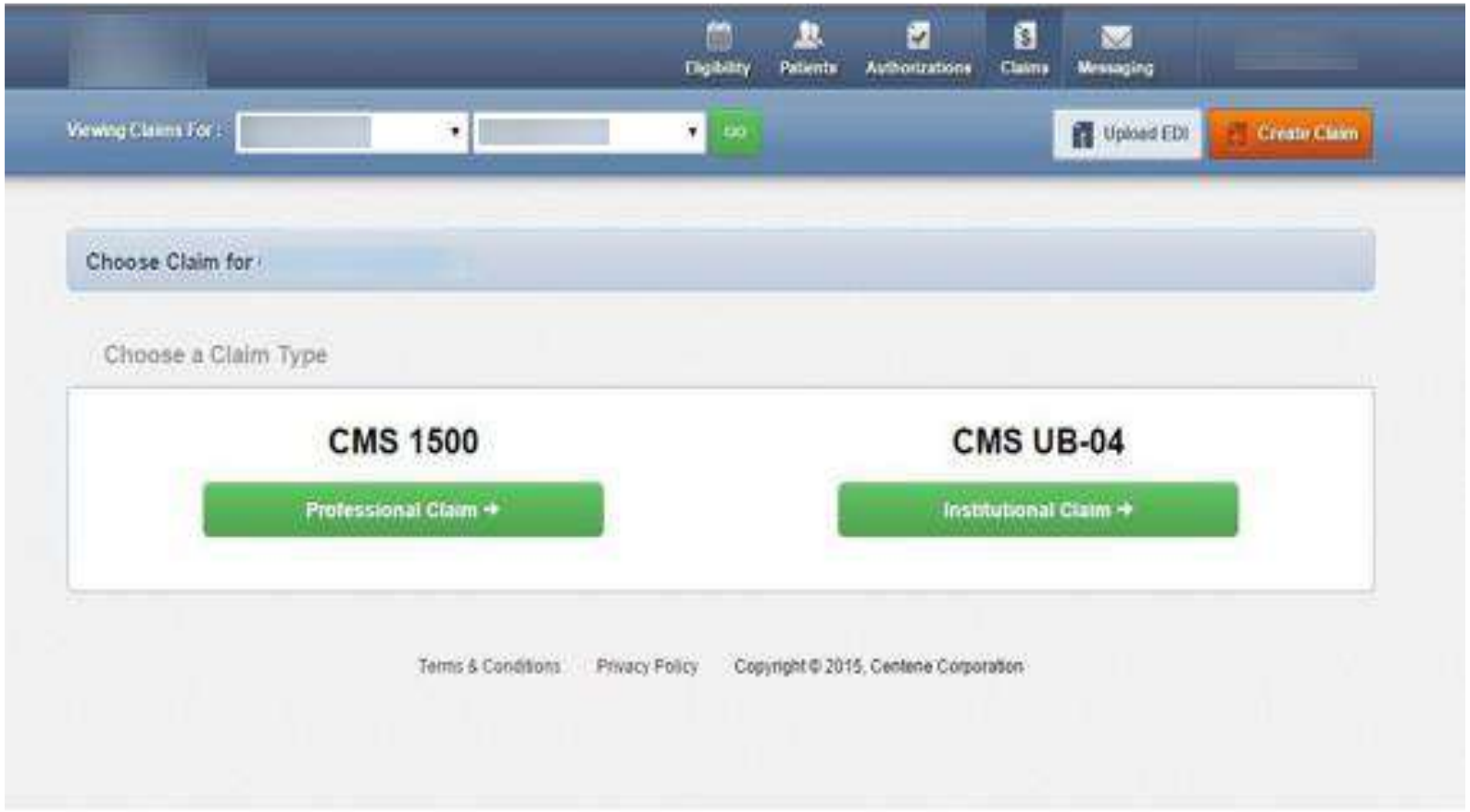
Claims Submissions - *Institutional*

Institutional Claim: select the green “Create a New Claim” button within the patient record



Claims Submissions - *Institutional*

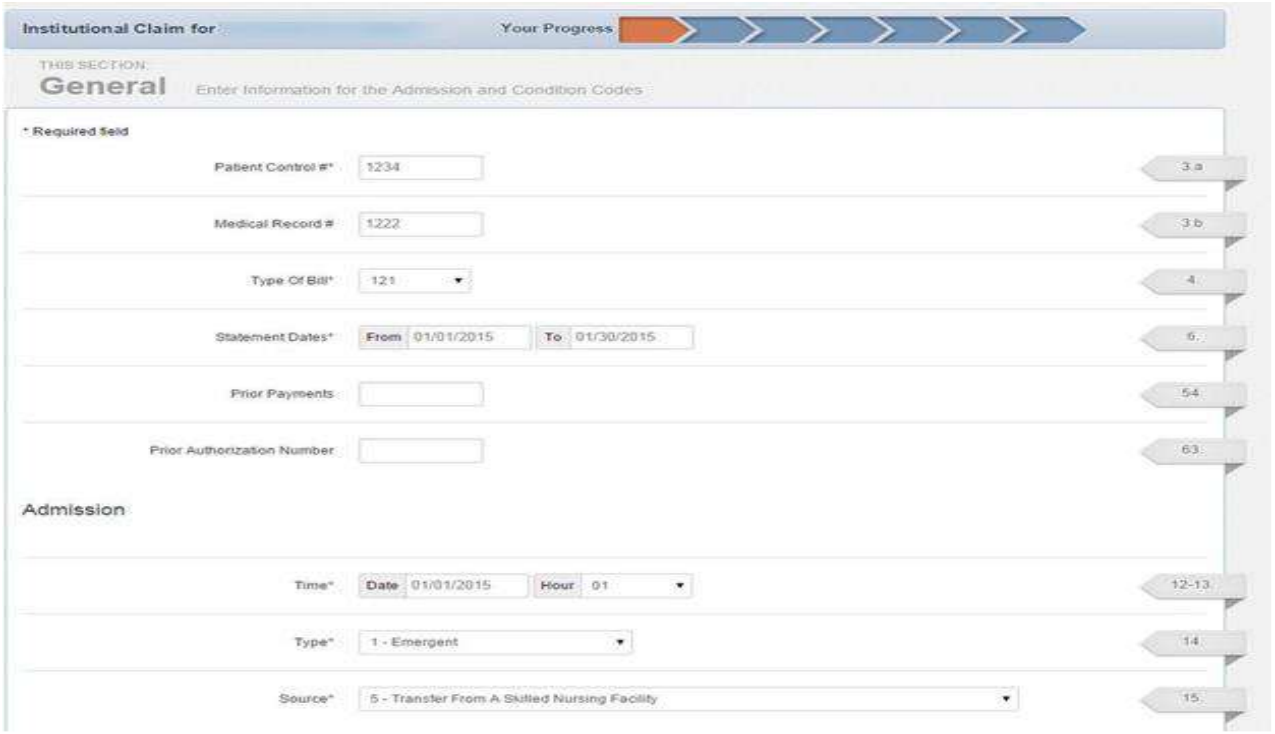
Institutional Claim: click the green rectangle button when prompted



Claims Submissions - *Institutional*

General Section:

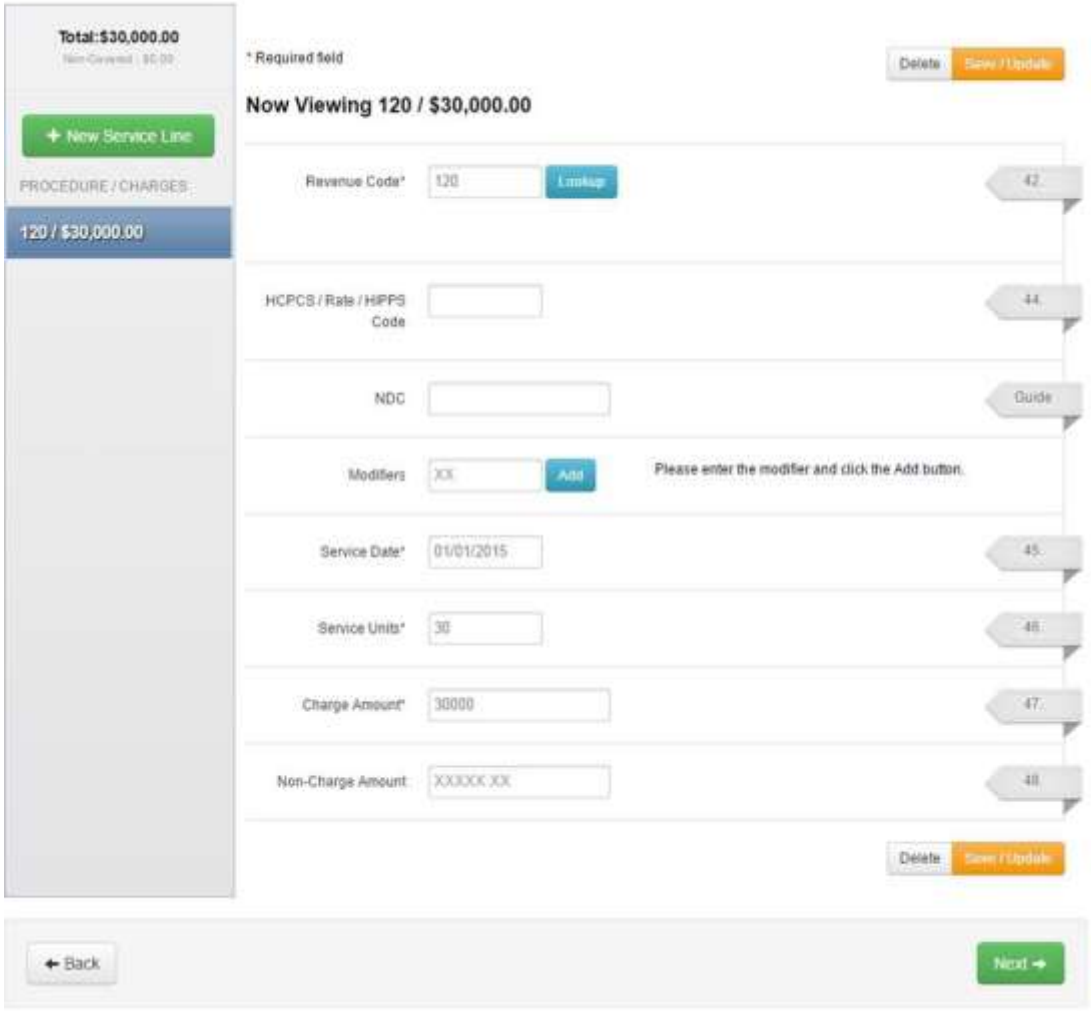
- Populate the admission and condition code information (the fields displayed reflect those on UB-04 form, then click Next
- Follow the prompts to reflect the Billing Provider, Pay-to-Provider, Attending Provider, and other field details, then click Next



Claims Submissions - *Institutional*

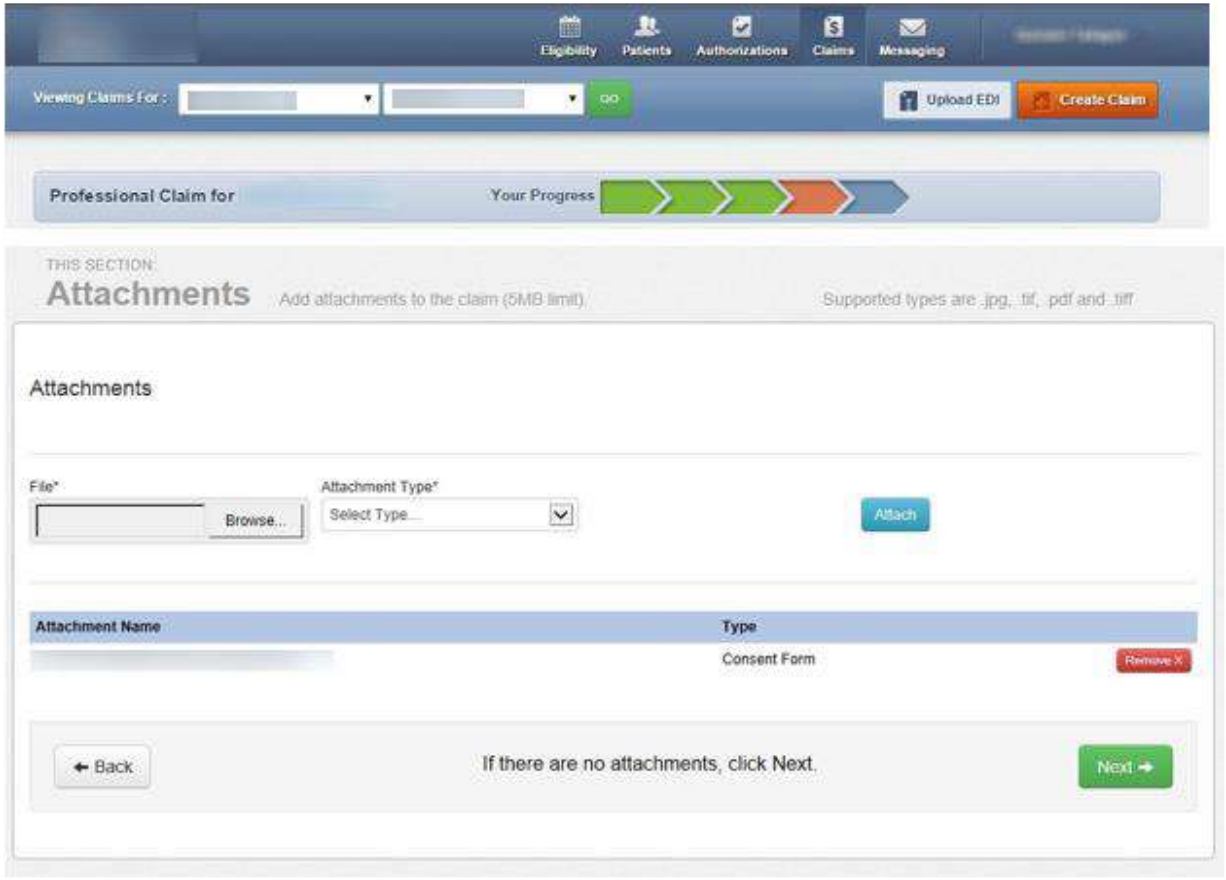
Service Lines Section: enter the information about the services provided, click **Save/Update**

To add a new service line, click the **+ New Service Line** button on the left and then click the **Next** button



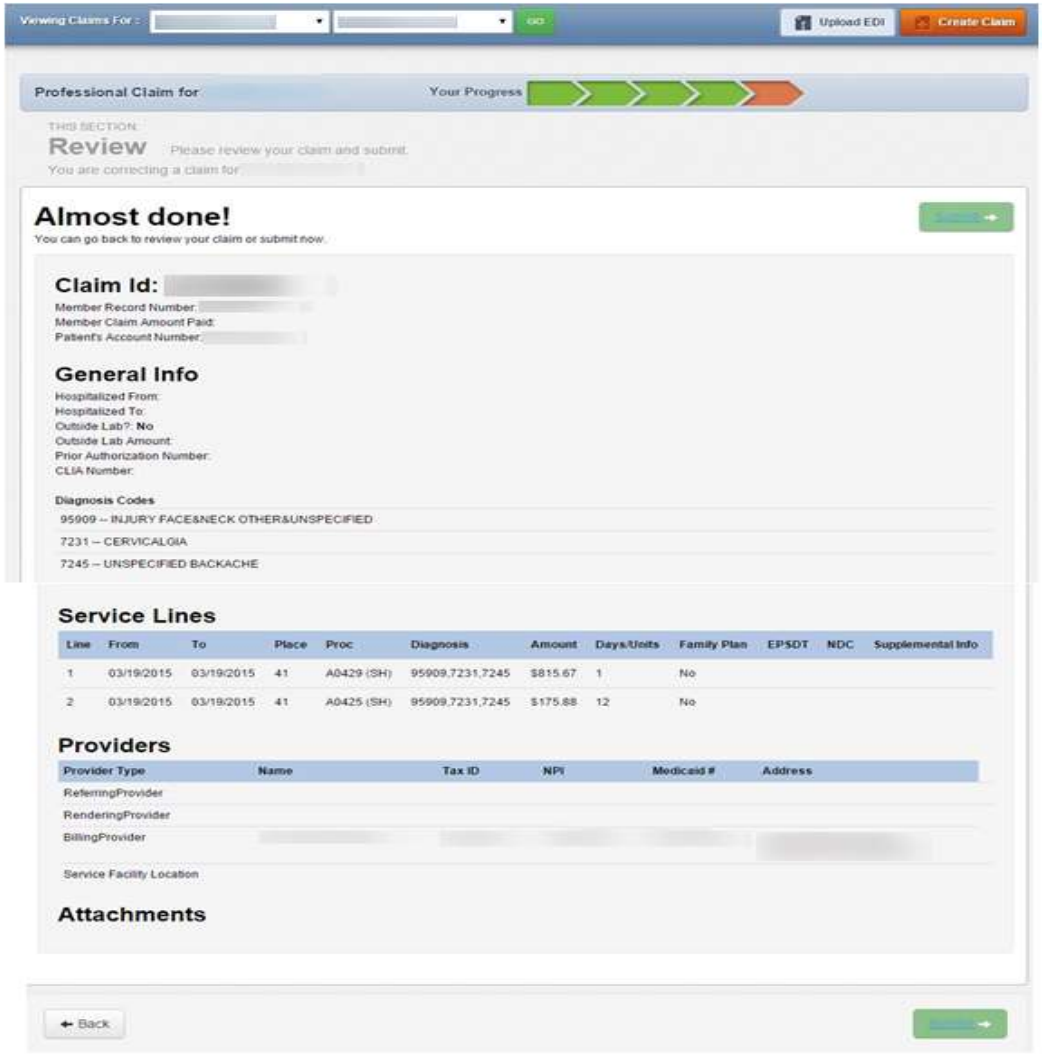
Claims Submissions - *Institutional*

Attachments Screen: use the browse button for attaching medical records and other documents related to claims submission, when applicable



Claims Submissions - *Institutional*

Final Step:
Review the entire claim and if all information is correct click the green Submit button in the bottom, right-hand corner



Claim Reject Codes

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

ERROR_ID	ERROR_DESC
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag

ERROR_ID	ERROR_DESC
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS;Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS;Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date

ERROR_ID	ERROR_DESC
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006
75	Invalid Unit

ERROR_ID	ERROR_DESC
81	Invalid Unit;Invalid Prv
83	Invalid Unit;Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
92	Missing or Invalid Provider NPI at any Level.
95	Operating/Purchasing provider information invalid or missing
A2	Diagnosis pointer invalid
A3	Claim exceeded the maximum 97 service line limit
A7	Invalid or Missing Ambulance Point of Pick Up Zip Code
AX	Invalid/missing/duplicate occurrence code
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B3	Rendering or billing NPI/TIN on DOS not enrolled with State
B5	Missing/incomplete/invalid CLIA certification number
C4	Invalid COBA Member
C9	Attending Provider Required
CA	Dates of service cannot span two calendar months, please resubmit
CE	Invalid Billing Provider NPI
CF	Invalid Billing Provider Taxonomy Code
CG	Invalid Billing Provider Zip
CH	Rendering NPI/TIN on DOS not enrolled with state
CI	NPI IS REQUIRED FOR THIS PAYER
CJ	ACK/REJECT Info Entities Medicaid Provider Id
D2	BILLING PROVIDER NOT REGISTERED PROMISe PROVIDER
D3	Rendering provider not registered Promise provider
D4	Attending provider not registered Promise provider
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
NE	Missing or Invalid Provider NPI at any Level.
R2	Payor ID Number Invalid for DOS
ZZ	Claim not processed

Long Term Services & Support (LTSS)

LTSS Benefits

Long Term Services and Support (LTSS) benefits include:

- Home and Community Based Services (HCBS) – Provides services and supports through the waiver and Habilitation programs to help members remain as independent as possible in their home and community.
- Facility – Provides long-term care in an inpatient setting
- 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.

HCBS Care Management

- **A Person Centered Planning** approach incorporates the full range of physical health, behavioral health, and support services that address functional, social, and other needs. Case Managers:
  - Engage with member's chosen team
  - Coordinate services to minimize silos
- **Members** remain at the center of our award winning Integrated Care Model (ICM)
- **Qualified Provider Partners** ensure members:
  - Receive authorized services
  - Reside in appropriate settings
  - Engage in their community
  - Have the opportunity to work/volunteer
  - Receive re-assessments if a significant change is observed

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

LTSS HCBS

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

Chronic Condition Health Home (CCHH)

Provider Qualifications:

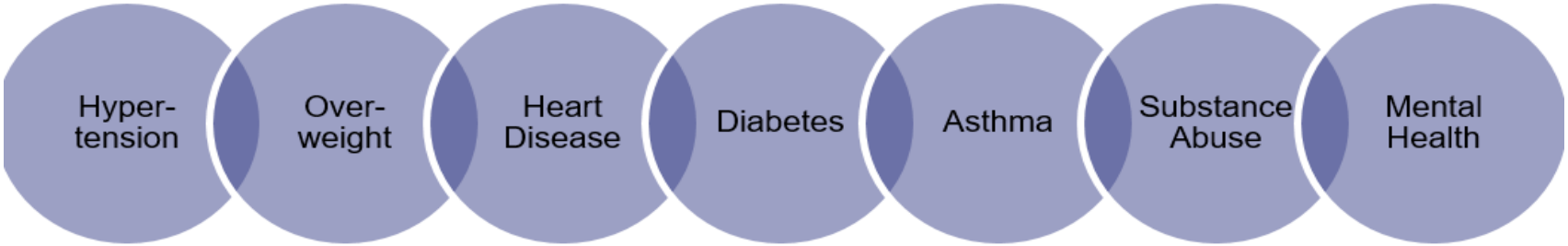
1. Designated Provider must be Medicaid enrolled and at a minimum fulfill the following roles: • Designated Practitioner • Dedicated Care Coordinator • Health Coach • Clinic support staff	2. Seek Medical Home recognition or equivalent within 12 months
3. Effectively utilizes population management tools to improve patient outcomes	4. Use an EHR, registry tools, and connect to Iowa HIE (IHIN) to report quality data

Chronic Condition Health Home (CCHH)

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

Time Period	Due to Veridian	Payment Date
January 1-15	1/20/2019	1/31/2019
January 16-31	2/5/2019	2/15/2019
February 1-15	2/20/2019	2/28/2019
February 16-28	3/5/2019	3/15/2019
March 1-15	3/20/2019	3/29/2019
March 16-31	4/5/2019	4/15/2019
April 1-15	4/20/2019	4/30/2019
April 16-30	5/5/2019	5/15/2019
May 1-15	5/20/2019	5/31/2019
May 16-31	6/5/2019	6/14/2019
June 1-15	6/20/2019	6/28/2019
June 16-30	7/5/2019	7/15/2019
July 1-15	7/20/2019	7/31/2019
July 16-31	8/5/2019	8/15/2019
August 1-15	8/20/2019	8/30/2019
August 16-31	9/5/2019	9/13/2019
September 1-15	9/20/2019	9/30/2019
September 16-30	10/5/2019	10/15/2019
October 1-15	10/20/2019	10/31/2019
October 16-31	11/5/2019	11/15/2019
November 1-15	11/20/2019	11/29/2019
November 16-30	12/5/2019	12/13/2019
December 1-15	12/20/2019	12/31/2019
December 16-31	1/5/2020	1/15/2020

LTSS CDAC Services

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
Brain Injury Waiver
Elderly Waiver
Health and Disability Waiver
Intellectual Disability 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)

LTSS Claim Submission Wizard

The Claim Submission Wizard was designed for Long Term Care and Home- and Community-Based Service Providers

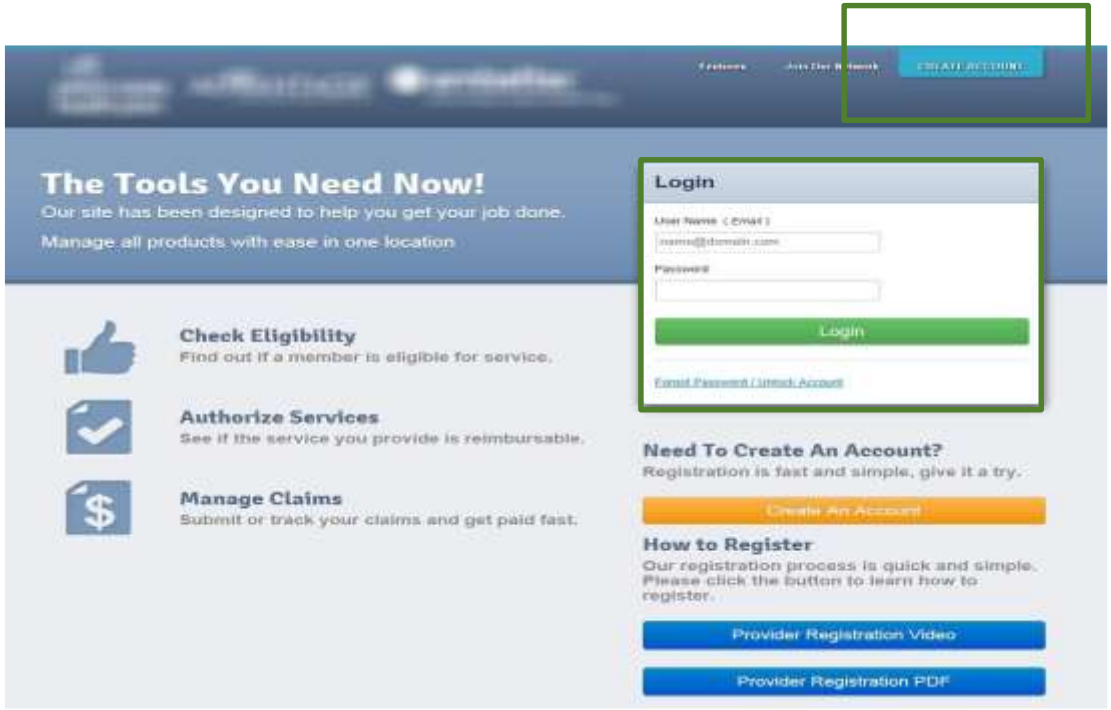
Services that can be billed using the Wizard are:

- 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

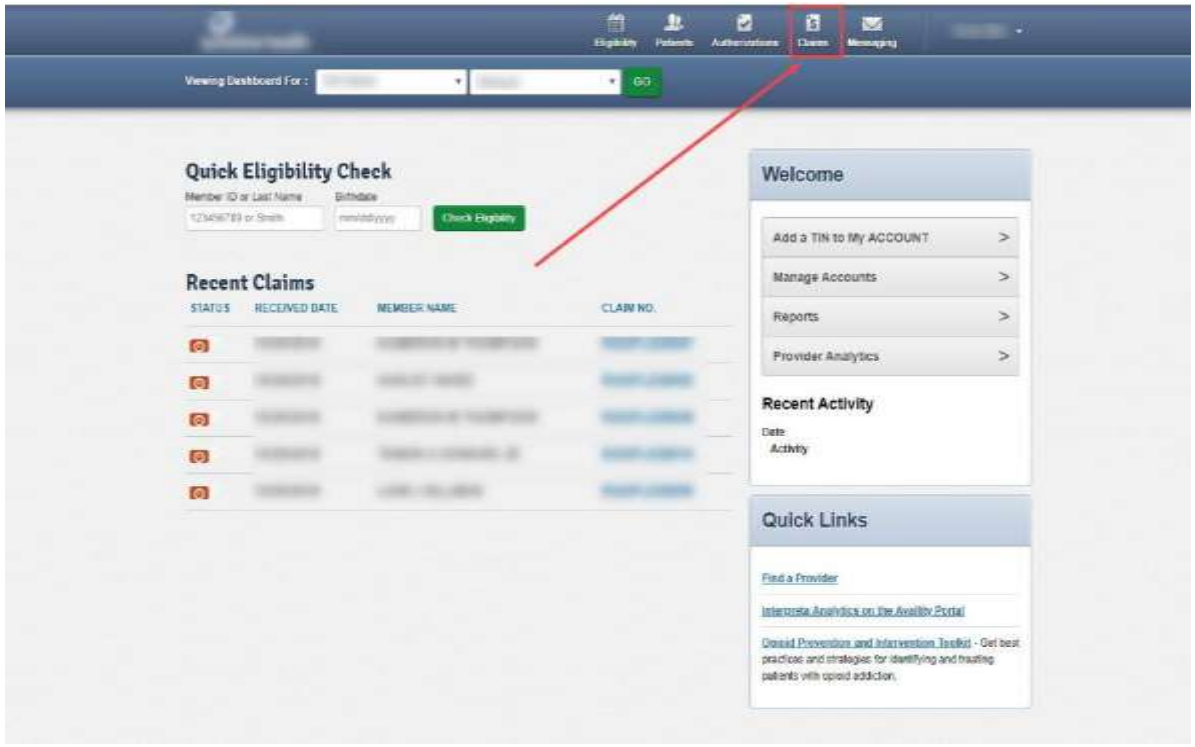


Create a New Account or Login

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



LTSS Claim Submission Wizard

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

Critical Incidents – Major Events

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