2020 Provider Manual

IowaTotalCare.com

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WELCOME

Welcome to Iowa Total Care! Thank you for being part of our network of healthcare professionals. We look forward to working with you to improve the health of our communities, one person at a time.

About Us

Iowa Total Care is a Managed Care Organization (MCO) health plan contracted with the Iowa Department of Human Services (DHS) to serve Medicaid members enrolled in IA Health Link, the Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (Hawki*)*.

As a subsidiary of Centene Corporation, Iowa Total Care's mission is to improve the health of our members through focused, compassionate and coordinated care, one person at a time. Our approach is based on the core belief that quality healthcare is best delivered at the local level through regional and community-based care.

About This Manual

The Provider Manual contains comprehensive information about Iowa Total Care's operations, benefits, policies, and procedures. The most up-to-date version may be viewed in the "For Providers" section of our website at: www.iowatotalcare.com. Providers will be notified of updates by notices posted on our website, by bulletins and/or in Explanation of Payment (EOP) notices. To obtain a hard copy of this Manual, contact Provider Services at the number provided in the Key Contacts section of this Manual. Billing guidelines and information may be found in the Iowa Total Care Provider Billing Manual, located in the "For Providers" section of our website at: www.iowatotalcare.com. The Provider Billing Manual includes information on:

- Encounter data submission guidelines
- Claims submission protocols and standards, including timeframe requirements
- Instructions/Information for Clean Claims
- Claims Dispute Process
- Payment Policies
- Client Participation Requirements
- Cost-Sharing Requirements
- Third Party Liability and Other Instructions

Discrimination

Iowa Total Care complies with applicable federal civil rights laws and does not discriminate or treat people differently on the basis of race, color, national origin, age, disability, or sex.

KEY CONTACTS

The following chart includes several important telephone and fax numbers providers are likely to need. When calling Iowa Total Care, please have the following information available:

- National Provider Identifier (NPI) number
- Tax ID number (TIN)
- Member's Iowa Total Care ID number or Medicaid ID number

Health Plan Information		
Website	www.iowatotalcare.com	
Main Address	Iowa Total Care 1080 Jordan Creek Parkway Suite 100 South West Des Moines, IA 50266	
Department	**Toll Free Telephone Numbers**	**Fax Number**
Provider Services	833-404-1061 TTY: 711	833-208 1397
Member Services	833-404-1061 TTY: 711	N/A
Member Eligibility	833-404-1061 TTY: 711	N/A
Prior Authorization Request	833-404-1061 TTY: 711	TBD
Concurrent Review	833-404-1061 TTY: 711	833-257-8320
Self-Referral	833-404-1061 TTY: 711	N/A
Care Management	833-404-1061 TTY: 711	N/A

Department	Toll Free Telephone Numbers	Fax Number
Envolve Vision visionbenefits.envolvehealth.com	833-564-1205	N/A
Envolve Pharmacy Services Pharmacy.envolvehealth.com	866-399-0928	877-386-4695
24-Hour Nurse Advice Line (24/7 Availability)	833-404-1061	N/A
National Imaging Associates (NIA) www.radmd.com	833-404-1061	N/A
Non-Emergency Medical Transportation (NEMT)	833-404-1061	N/A
Iowa Medicaid Provider Service IMEProviderServices@dhs.state.ia.us	1-800-338-7909	515-725-1155
Iowa Medicaid Member Services IMEMemberServices@dhs.state.ia.us	1-800-338-8366 (Toll Free) 515-256-4606 (Des Moines Area) TTY: 1-800-735-2942	515-725-1351
Iowa Total Care Face Sheets	N/A	833-257-8321
Iowa Total Care Admissions	N/A	833-257-8322
Iowa Total Care Assessments	N/A	833-257-8323
Iowa Total Care Prior Authorizations for Behavioral Health	N/A	Inpatient- 844-908-1169 Outpatient- 844-908-1170
Managed Care Ombudsman State Ombudsman	866-236-1430 888-426-6283	515-242-6007

Department	Toll Free Telephone Numbers	Fax Number
Ethics and Compliance Helpline	866-685-8664	N/A
Reporting suspected waste, fraud, and/or abuse to Iowa Total Care	866-685-8664	N/A
Interpreter Services – Voiance	866-998-0338	N/A
Electronic Claims Submission		
Iowa Total Care c/o Centene EDI Department Payor ID: 68069 1-800-225-2573, ext. 6075525 or by email to: EDIBA@centene.com		
Iowa Total Care Claims Disputes		
Iowa Total Care Claims Disputes Attn: Claims Dept. P.O. Box 8030 Farmington, MO 63640-8030		

POPULATIONS SERVED

Iowa Total Care provides health coverage for enrollees of:

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

Most members who get health coverage under Iowa Medicaid are enrolled in the IA Health Link managed care program. The Iowa Health and Wellness Plan provides health coverage at low or no cost to Iowans. Members are between the ages of 19 and 64.To participate and avoid monthly payments after the first year, members must get a wellness exam and a dental exam and complete a Health Risk Assessment (HRA) each year.

The Healthy and Well Kids Iowa (Hawki) program offers health insurance to children of working families who have no other health insurance or who do not qualify for Medicaid. Members are under age 19. No family pays more than $40 per month, and some families pay nothing at all.

VERIFYING ELIGIBILITY

Iowa Total Care providers should verify Member eligibility before every service is rendered, using one of the following methods:

Log on to our Secure Provider Web Portal at www.iowatotalcare.com. Using our secure Provider Portal, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth.

Call our automated Member eligibility IVR system. Call our toll-free Provider Services number at 833-404-1061 from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member Medicaid ID and the month of service to check eligibility.

If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 833-404-1061. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the member name, member Medicaid ID, and member date of birth to check eligibility. Possession of an Iowa Total Care member ID card is not a guarantee of eligibility. Use one of the above methods to verify member eligibility on the date of service.

Iowa Total Care's Secure Provider Portal, allows Primary Care Providers (PCPs) to access a list of eligible members who have selected their services or were assigned to them. The list of eligible members also provides other important information, including indicators for members whose claims data shows a gap in care, such as the need for an adult BMI assessment. To view this list, log on to www.iowatotalcare.com.

Eligibility changes can occur throughout the month and the member eligibility list does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service.

Member Identification Card

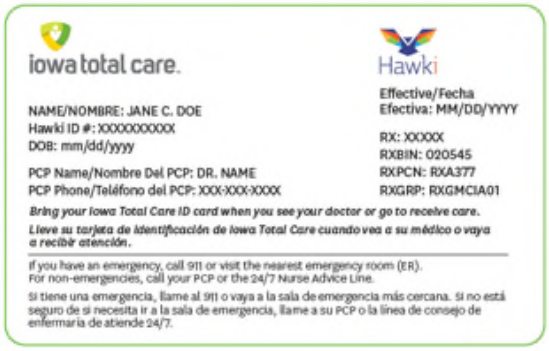
All new Iowa Total Care members receive an Iowa Total Care member ID card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card.

Whenever possible, members should present both their Iowa Total Care member ID card and a photo ID each time they seek services from a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services toll-free at **833-404-1061** immediately.

Members must also keep their state-issued Medicaid ID card (pictured below) in order to receive benefits that are not covered by Iowa Total Care.


iowa total care.
ia health link
Effective/Fecha Efectiva: MM/DD/YYYY
NAME/NOMBRE: JANE C. DOE
MEDICAID ID #: XXXXXXXXXX
DOB: mm/dd/yyyy
RX: XXXXX
RXBIN: 020545
RXPCN: RXA377
RXGRP: RXGMCIA01
PCP Name/Nombre Del PCP: DR. NAME
PCP Phone/Teléfono del PCP: XXX-XXX-XXXX
Bring your Iowa Total Care ID card when you see your doctor or go to receive care.
Lleve su tarjeta de identificación de Iowa Total Care cuando vea a su médico o vaya a recibir atención.
If you have an emergency, call 911 or visit the nearest emergency room (ER).
For non-emergencies, call your PCP or the 24/7 Nurse Advice Line.
Si tiene una emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Si no está seguro de si necesita ir a la sala de emergencia, llame a su PCP o la línea de consejo de enfermería de atiende 24/7.


iowa total care.
Hawki
Effective/Fecha Efectiva: MM/DD/YYYY
NAME/NOMBRE: JANE C. DOE
Hawki ID #: XXXXXXXXXX
DOB: mm/dd/yyyy
RX: XXXXX
RXBIN: 020545
RXPCN: RXA377
RXGRP: RXGMCIA01
PCP Name/Nombre Del PCP: DR. NAME
PCP Phone/Teléfono del PCP: XXX-XXX-XXXX
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IMPORTANT CONTACT INFORMATION/
INFORMACIÓN IMPORTANTE DE CONTACTO
MEMBERS/MIEMBROS: 1-833-404-1061 (TTY: 711)
Member Services/Servicios para los miembros
24/7 Nurse Advice Line/Línea de consejo de enfermería 24/7
PROVIDERS/PROVEEDORES:
Eligibility: 1-833-404-1061 (TTY: 711) • Prior Authorization: 1-833-404-1061
Medical Claims: PO Box 8030, Farmington, MO 63640
Provider/claims information via the web: IowaTotalCare.com
Pharmacy Help Desk: 1-877-281-9627


IMPORTANT CONTACT INFORMATION/
INFORMACIÓN IMPORTANTE DE CONTACTO
MEMBERS/MIEMBROS: 1-833-404-1061 (TTY: 711)
Member Services/Servicios para los miembros
24/7 Nurse Advice Line/Línea de consejo de enfermería 24/7
PROVIDERS/PROVEEDORES:
Eligibility: 1-833-404-1061 (TTY: 711) • Prior Authorization: 1-833-404-1061
Medical Claims: PO Box 8030, Farmington, MO 63640
Provider/claims information via the web: IowaTotalCare.com
Pharmacy Help Desk: 1-877-281-9627

ONLINE RESOURCES

Iowa Total Care's website allows 24/7 access to provider and member information. The website is located at www.iowatotalcare.com. Providers can find the following information on the website:

- Prior Authorization List
- Applicable Forms
- Iowa Total Care Plan News
- Clinical Guidelines
- Provider Bulletins
- Billing Manual
- Information on Disability Access
- Contract Request Forms
- Provider Relations Specialist Contact Information
- Provider Training Manual
- Provider Education Training Schedule

Please contact your Provider Relations Representative or Provider Services toll-free at **833-404-1061** with any questions or concerns regarding the website.

SECURE PROVIDER WEB PORTAL

Iowa Total Care's Secure Provider Web Portal allows providers to check member eligibility and benefits, submit and check the status of claims, request authorizations, and send messages to communicate with Iowa Total Care staff.

Providers and designated office staff may register to use the Provider Web Portal in four easy steps. Once registered, tools are available that make obtaining and sharing information easy.

Go to www.iowatotalcare.com to register. On the home page, select the "Login" link in the center of the page to start the registration process. Click on the red Create an Account button. Enter the required data and follow the prompts. Please allow 24-48 hours to have your request approved if you are a new provider. If you have been given access from the Account Manager of your Provider Group, that manager will need to approve your request.

A quick video is available under the Create an account button.

Providers may use the Provider Web Portal to:

- Check member eligibility
- View member health records
- View the patient list (for PCPs only)
- View and submit claims
- Correct and resubmit a claim
- Submit a Dispute, Reconsideration
- Verify claim status
- Verify proper coding guidelines
- View payment history
- View and submit Prior Authorizations
- Check Prior Authorization requirements
- Verify Prior Authorization status
- View member gaps in care
- Contact us securely and confidentially
- Add/Remove account users
- Determine payment/check clear dates
- Add/Remove TINs from a user account
- View and print Explanation of Payment (EOP)

Providers must agree that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

PROVIDER GUIDELINES

Medical Homes

Iowa Total Care is committed to supporting providers in achieving recognition as Medical Homes and will promote and facilitate the capacity of primary care practices to function as Medical Homes by using systematic, patient-centered and coordinated Care Management processes.

Iowa Total Care will support providers in obtaining either NCQA's Patient-Centered Medical Home (PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

Medical Homes provide better healthcare quality, improve member self-management of their own care and reduce avoidable costs over time. Iowa Total Care will actively partner with providers, community organizations, and groups representing our members to increase the number of providers who are recognized as Medical Homes.

Iowa Total Care has dedicated resources to ensure its providers achieve the highest level of Medical Home recognition with a technical support model that will include:

- Readiness survey of contracted providers
- Education on the process of becoming certified
- Resources, tools, and best practices

The Secure Provider Web Portal offers tools to help support PCMH accreditation elements. These tools include:

- Online care gap notification
- Member panel roster (including Member detail information)

For more information on the Medical Home model or how to become a Medical Home, contact your Provider Relations Representative.

Integrated Health Homes

Iowa Total Care supports Integrated Health Homes (IHHs) for members any age who have Serious Mental Illmess (SMI) or Serious Emotional Disturbance (SED) with a documented Functional Impairment (FI) provided by a Team of Health Care Professionalsthat are designed to deliver whole-person, patient-centered, coordinated care. This includes members who are enrolled in the 1915(i) Habilitation Program; adults diagnosed with a Serious and Persistent Mental Illness (SPMI); and the 1915(c) Children' Mental Health Waiver for children diagnosed with Serious Emotional Disturbance (SED).

An IHH requires Iowa Medicaid Enterprise (IME) registration and ongoing compliance with IHH standards of participation as set forth in the Iowa State Plan and federal guidance.

The IHH Provider includes:

- Access to support services to remove barriers to achieving improved health status.
- Access to health education and promotion to address smoking, nutrition and physical activity.
- Assistance with transitional care and discharge planning after hospitalization or rehabilitation.
- Assistance to find community resources and support services.
- Assistance to manage medications and medical treatments.
- A single comprehensive plan of care.

Chronic Condition Health Homes

Iowa Total Care supports Chronic Condition Health Homes (CCHH) for members of any age who have two chronic health conditions, or who are at risk for developing a second condition. Chronic health conditions include: Hypertension, Chronic Pain, COPD, BMI over 25 or BMI over 85th Percentile for pediatric, Heart Disease, Diabetes, Asthma, Substance Abuse Disorder, or Mental Health Condition.

CCHH providers will be registered with the IME as a Designated Provider working collaboratively to meet the healthcare needs of participating members, helping them achieve improved outcomes with regard to their chronic medical conditions.

The CCHH Provider includes:

- A PCP to manage all health care conditions.
- A nurse to identify and achieve health and wellness goals.'
- A Health Coach to support the Health Home in meeting provider standards and delivering Health Home services to the member.
- Access to support services to remove barriers to achieving improved health status.
- Access to health education and promotion to address smoking, nutrition and physical activity.
- Assistance with transitional care and discharge planning after hospitalization or rehabilitation.
- Assistance to find community resources and support services.
- Assistance to manage medications and medical treatments.
- A single comprehensive plan of care.

Iowa Total Care will support the Integrated Health Homes and Chronic Condition Health Homes by:

- Identify providers who meet the standards of participation of an IHH and CCHH.
- Educate and support the providers in practice transformation and integrated care coordination.
- Provide training, technical assistance, expertise and oversight to the Health Homes.
- Provide oversight and technical support to Health Home providers to coordinate with primary care providers.
- Continuously assess the provider's capacity to meet integrated care coordination standards.
- Provide infrastructure and tools to coordinate behavioral health and physical health providers.
- Provide outcomes tools and measurement protocols to assess effectiveness.
- Develop self-management tools for the individuals served.
- Manage and perform data analytics and outcome measures to evaluate service effectiveness and cost- efficiency of care coordination and service delivery.
- Provide clinical guidelines and other decision support tools.
- Provide technical support and tools for the electronic exchange of health information.
- Identify, develop and maintain the enrollment process.
- Provide a repository for member data.
- Support providers to share data.
- Develop and offer learning activities.
- Perform data analysis at the member level and program-wide to inform continuous quality improvement.
- Offer Performance Measures Program which may include incentives.
- Reimburse providers.
- Provide clinical and care coordination support.

- Health Home email, IHH_ITC@iowatotalcare.com to exchange information

State-Covered Services

Some services are carved out and covered by the State's fee-for-service (FFS) program instead of Iowa Total Care. While Iowa Total Care does not cover these services, providers and specialists must provide required referrals and assist in setting up these services. These include:

- Services included in the Program of All Inclusive Care for the Elderly (PACE)
- School-based services provided by the area education or local education agencies
- Dental services provided outside a hospital setting
- State of Iowa Veterans Home services
- Money Follows the Person (MFP) grant-funded services

For details on how and where to access these services, members can call the Iowa Medicaid Enterprise Member Services Unit toll-free at **800-338-8366**, Monday through Friday from 8 a.m. to 5 p.m.

Accessibility

Iowa Total Care is committed to providing equal access to quality health care and services. In May 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by Iowa Total Care through an onsite Accessibility Site Review (ASR). Iowa Total Care's expectation, as communicated through the provider contract, is full compliance with all Federal and State disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above; the Americans with Disabilities Act; Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all Federal and State disability access laws and regulations, which remains the legal responsibility of Iowa Total Care providers.

Appointment Availability and Access Standards

Iowa Total Care follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Iowa Total Care monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Primary Care Providers	**Timeframe**
Emergency Medical Condition	Twenty-four (24) hours a day, seven (7) days a week
Urgent Medical Condition	Within twenty-four (24) hours
Non-Urgent Sick Visits (w/persistent symptoms)	Within forty-eight (48) hours
Routine Appointments	Not to exceed four (4) to six (6) weeks
Specialists	**Timeframe**
Specialty Providers – Urgent	Within twenty-four (24) hours
Specialty Providers – Routine	Within thirty (30) days
Hospitals – Emergency	Twenty-four (24) hours a day, seven (7) days a week
Behavioral Health – Non-life Threatening Emergency	Within six (6) hours, or direct member to crisis center or ER
Behavioral Health – Mobile Crisis	Within one (1) hour of presentation or request
Behavioral Health – Urgent	Within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with provider or Iowa Total Care
Behavioral Health –Persistent Symptoms	Within forty-eight (48) hours of reporting symptoms
Behavioral Health – Routine	Within three (3) weeks of the request for an appointment

Substance Use Disorder & Pregnancy	Members who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment
Intravenous Drug Use	Admitted not later than fourteen (14) days after making the request for admission, or One-hundred and twenty (120) days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than forty-eight (48) hours after such request
Labs and X-Ray Services – Non-Urgent	Not to exceed three (3) weeks
Labs and X-Ray Services – Urgent	Within forty-eight (48) hours
General Optometry – Routine	Not to exceed three (3) weeks
General Optometry – Urgent	Within forty-eight (48) hours

Covering Providers

PCPs and specialists must arrange for coverage with another provider during scheduled or unscheduled time off, preferably with another Iowa Total Care network provider. In the event of unscheduled time off, please notify Provider Services of coverage arrangements as soon as possible. The covering provider is compensated in accordance with the fee schedule in their agreement, and, if not an Iowa Total Care network provider, they will be paid as a nonparticipating provider.

Telephone Arrangements

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and, when possible, reschedule canceled and no-show appointments.

- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, noncompliant individuals, or those with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
    - After-hours telephone care for non-emergent, symptomatic issues within thirty (30) minutes.
    - Same day for non-symptomatic concerns.
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record.

Iowa Total Care will monitor appointment and after-hours availability on an ongoing basis through its Quality Management/Quality Improvement (QM/QI) Program.

24-Hour Access

Iowa Total Care PCPs and specialists are required to maintain sufficient access to facilities and personnel in order to provide covered services and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- During after-hours, a provider must have arrangements for one of the following:
    - Access to a covering practitioner.
    - An answering service.
    - Triage service.
    - A voice message that provides a second phone number that is answered.
    - Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members.

Examples of unacceptable after-hours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours.
- The provider's office telephone is answered after-hours by a recording that tells patients to leave a message.
- The provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed.
- A clinician returning after-hours calls outside thirty (30) minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialist, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.
Iowa Total Care will monitor providers' offices after-hour coverage through surveys and through mystery shopper calls conducted by Iowa Total Care Provider Network staff.

Confidentiality Requirements

Providers must comply with all federal, state, and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider and member information, whether oral or written, in any form or medium. The following information is considered confidential:

All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The privacy rule calls this information Protected Health Information (PHI). “Individually identifiable health information,” including demographic data, is information that relates to:

- The individual’s past, present or future physical or mental health or condition.
- The provision of healthcare to the individual.
- The past, present, or future payment for the provision of healthcare to the individual.
- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- Many common identifiers (e.g. name, address, birth date, social security number).

The privacy rule excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the family educational rights and privacy act, 20 u.s.c. § 1232g.

Provider offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Iowa Total Care.
Release of data to third parties requires advance written approval from the Department of Human Services, except for releases of information for the purpose of individual care and coordination among Providers, releases authorized by members or releases required by court order, subpoena, or law.

Member Privacy Rights

Iowa Total Care privacy policy assures that all members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Iowa Total Care’s privacy policy conforms with 45 c.f.r. (code of federal regulations): relevant sections of HIPAA that provide member privacy rights and place restrictions on uses and disclosures of PHI (§164.520, 522, 524, 526, and 528).

Iowa Total Care’s policy also assists our personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

Use and Disclosure Guidelines
Iowa Total Care is required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations
A privacy request may be subject to specific limitations or restrictions as required by law. Iowa Total Care may deny a privacy request under any of the following conditions:

- Iowa Total Care does not maintain the records containing the PHI.
- The requester is not the member and we're unable to verify his/her identity or authority to act as the member's authorized representative.
- The documents requested are not part of the designated record set (e.g., credentialing information).
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the member or another person.
- Iowa Total Care is not required by law to honor the particular request (e.g., accounting for certain disclosures).
- Accommodating the request would place excessive demands on us or our time and resources, and is not contrary to HIPAA.

CULTURAL COMPETENCY

Iowa Total Care views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, and diverse populations. It accommodates the patient's culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Iowa Total Care is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care.
As part of Iowa Total Care's Cultural Competency Program, providers must:

- Inform members of their right to access free, quality medical interpreters and signers, accessible transportation and TDD/TTY services
- Facilitate member access to Cultural and Linguistic services
- Document member requests for language services and/or refusal of professional language services in the medical record
- Participate in cultural competency education and training at least annually
- Provide medical care with consideration of the members' primary language, race, ethnicity and culture
- Ensure that office staff routinely interacting with members have been given the opportunity, and have participated in, cultural competency training
- Ensure that treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on health care
- Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

Iowa Total Care considers this mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered service or availability of a facility

- Providing an Iowa Total Care member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times)

Iowa Total Care provides Cultural Competency related educational opportunities for providers on the Provider tab on the Iowa Total Care website. Providers are also encouraged to participate in training provided by other organizations. For additional information regarding resources and trainings, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: https://cccm.thinkculturalhealth.hhs.gov/

- Think Cultural Health's website includes classes, guides and tools to assist you in providing culturally competent care. The website is: http://www.thinkculturalhealth.hhs.gov/

- The Health Care Literacy website which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-tookit/index.html

Interpreter Services

Interpreter services are available at no cost to Iowa Total Care members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if linguistic needs are not met.
Providers may not request or require an individual with limited English proficiency to provide his or her own interpreter. Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. Providers may not rely on an adult or minor child accompanying an individual with limited English proficiency to interpreter or facilitate communication or on a minor child to interpreter or facilitate communication. A minor child or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. An accompanying adult may be used to interpret or facilitate communication when the individual with limited English proficiency specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances. Providers are encouraged to document in the member's medical record any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

To obtain language services, members and providers must contact the Iowa Total Care Member Services Department at **833-404-1061** or TTY 711. Members requiring in-person interpretation services are advised to contact Members Services 48 hours before the appointment. Please note, the member must be present, if the provider is requesting telephonic interpretation services or requesting an in-person interpreter.

Americans with Disabilities Act

Provider Accessibility Initiative (PAI) is committed to providing equal access to quality health care and services that are physically and programmatically accessible for members living with disabilities and their companions. “Physical access” also known as “architectural access” refers to persons with a disability, ability to access buildings, structures, and the environment. “Programmatic access” refers to persons with a disability, ability to access goods, services, activities, and equipment. The goal of PAI is to increase percentage of practitioner locations within our network that meet minimum federal and state disability access standards.
PAI covers people with physical, mental, cognitive, or intellectual limitations such as difficulty walking, balancing, climbing, seeing, hearing, reading, understanding, or remembering.
As Iowa Total Care moves closer to full inclusion of people with disabilities through policy and practice integration, provider directory accessibility information display, and architecture barrier removal, it is important to understand that disability is just one aspect of a person’s full complex life and each person should be seen as an individual, not a disability. The key to creating an acceptable environment for providing health for people living with disabilities is to treat each individual with respect and equality.

- Do not be overly friendly or condescending toward individuals with disabilities
- Use appropriate greetings, such as shaking hands
- Challenge derogatory language and jokes
- Take ownership for making everyone feel welcome and accepted

When providing assistance:

- First, ask if help is needed
- Be sure to understand what is needed and offer only what is needed
- Don’t take over; just help
- Speak directly to the person rather than through someone else, such as a sign language interpreter
- Don’t be afraid to make a mistake.
    - Made a mistake? Apologize, correct, learn, and move on
- Use common sense and a positive attitude
- Always think of the person first
- Be generous with yourself
- Unsure of what to do or say? Ask!

Important Points to Remember: Word Choice

- Avoid words with negative connotations like “handicapped”, “afflicted”, “crippled”, “victim”, “sufferer”, etc.

- Do not refer to individuals by their disability. A person is not a condition
- Emphasize “person first” terminology:
    - Handicapped — A PERSON with a disability
    - Deaf — A PERSON who is deaf
    - Mute — A PERSON without speech
    - Confined/Wheelchair-Bound — A PERSON who uses a wheelchair

- If you happen to not have a disability at this time in your life, that DOES NOT make you “normal” or “able-bodied”. It makes you “non-disabled”.

Iowa Total Care strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and

- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services

The term "disability" means, with respect to an individual -
A physical or mental condition that limits a person’s movement, senses, or activities. These limitations may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. Disability is any substantial limitation of a person’s life activities and may be present from birth or may occur during a person’s lifetime. Any individual meeting any of these conditions is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

Programmatic access to healthcare means that policies and practices that are part of the delivery of healthcare do not hinder the ability of members with disabilities to receive the same quality of care as other persons.

Policies for Communication and Access to Information:

1. Provisions for intake forms to be completed by persons who are blind or with a low visual disability with the same confidentiality afforded other members
    a. Use of large print forms, electronic or online web-based forms, or in-person staff assistance in a private location
2. Provision for a presence of sign language interpreters to enable full communication with deaf or hard of hearing members who use sign language
    a. Professionalism and confidentiality require healthcare providers to take responsibility for the communication
3. Provision for making auditory information (E.G. automated messages) available via alternative means
    a. Written communication or secure web-based methods may be used as possible substitutes
4. Provision for communicating with deaf or hard of hearing members by telephone

    a. Use of telephone relay services (TRS), a TDD, or use of secure electronic means

Policies for Scheduling and Waiting:

1. Policies that allow scheduling additional time for the duration of appointments for members with disabilities who may require it
    a. Members may require more time than the standard because of multiple complexities. More time may be needed to conduct the examination or for communication through an interpreter as well as other communication issues.
2. Policies to enable members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival
    a. Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious
3. Policies to allow flexibility in appointment times for members who use paratransit
    a. Members may arrive late at appointments because of delays or other problems with paratransit scheduling or reliability
4. Policies to enable compliance with federal law that guarantees access to provider offices for people with disabilities who use service animals
    a. Members with service animals expect the animal to accompany them into the waiting and examination rooms. This is protected under the Americans with Disabilities Act. This policy statement simply prepares staff to respond accordingly.

Policies for Conducting the Examination

1. Training of healthcare providers in operation of accessible equipment
    a. Staff must know how to operate accessible equipment, such as adjustable height exam tables and scales so they can be regularly and easily utilized.

Policies for Follow-up or Referral

1. Current or potential members including people with disabilities should only be referred to another provider for established medical reasons or specialized expertise.
    a. Referral results in a delay of treatment and subject members to additional time, expense, and reduces member choice of providers.
2. Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which members are referred.
    a. Members may be unable to comply with medical referrals if referred location is not accessible and/or not prepared to provide the recommended service

General Requirements

General prohibitions against discrimination.

- No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability;

- Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

- Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

- Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

- Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

- Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

- Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

- Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Iowa Total Care, or opportunity enjoyed by others receiving the aid, benefit, or service.

- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

- That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;

- That have the purpose or effect of defeating or

- substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or

- That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.

- A public entity may not, in determining the site or location of a facility, make selections --
- That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
- That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
- Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
- A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
- Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.
- Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
- A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the

provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

- A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

Mandatory Reporting of Suspected Child and Dependent Adult Abuse

Iowa Total Care providers who are mandatory reporters under Iowa law have a responsibility to report known or suspected child or dependent adult abuse in accordance with all applicable laws.

If you suspect a child under the age of 18 is abused or neglected, call the Child Abuse Hotline at **800-362-2178**. More information is available at www.dhs.iowa.gov/child-abuse.
To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call **800-362-2128**. More information is available at www.dhs.iowa.gov/DependentAdultProtectiveServices/Families.

Advance Directives

Iowa Total Care providers are required to provide adult members with written information about the members' right to have an Advance Directive as defined in 42 C.F.R. 489.100. An Advance Directive is a legal document, such as a living will or Durable Power of Attorney, where a member may provide directions or express preferences concerning their medical care and/or may appoint someone to act on their behalf. Members can use Advance Directives when the member is unable to make or communicate decisions about their medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes the member to be unable to actively make a decision about their medical care.

Iowa Total Care is committed to ensuring that members are aware of and are able to avail themselves with information regarding their right to execute Advance Directives. Iowa Total Care is equally committed to ensuring its providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding Advance Directives.
Iowa Total Care will provide and ensure that providers are sharing written information with all adult members receiving medical care with respect to their rights under all applicable laws so members may make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.

Advance Directives are addressed by a provider with the member:

- When a member visits the provider’s office.
- At a hospital at the time of a member’s admission as an inpatient.
- At a skilled nursing facility at the time of a member’s admission.
- Prior to or on the first visit when a member begins receiving care with a home health agency.
- At the time a member begins hospice care.

Neither Iowa Total Care nor providers will condition the authorization or provision of care or otherwise discriminate against a member based on whether or not the member has executed an Advance Directive. Iowa Total Care will facilitate communications between a member or member's authorized representative and the member's provider if the need is identified to ensure they are involved in decisions to withhold resuscitative services, or to forego or withdraw life-sustaining treatment.

Iowa Total Care is aligned with the HEDIS Care of Older Adults measure, which includes annual review of advanced care planning, medication review, functional status, and pain assessment. Iowa Total Care will annually assess and document the Advance Directive status in the Care Management systems for members who receive Long Term Services and Support. Providers must document that a member received information on Advance Directives that informed them of their right to execute and have one in the member's permanent medical record.
Iowa Total Care recommends the following:

- The first point of contact for the member in the PCP's office should ask if the member has executed an Advance Directive and the member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Advance Directive to the PCP's office and document this request in the member's medical record.
- An Advance Directive should be a part of the member's medical record and include mental health directives.

If an Advance Directive exists, the provider should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the Advance Directive and if available) and with the referring provider, if applicable. Any such discussion should be documented in the medical record.

Iowa Total Care requires contracted providers to maintain written policies and procedures regarding Advance Directives and provide staff education related to it.
Members can file a grievance regarding noncompliance with Advance Directive requirements with Iowa Total Care and/or with the Iowa DHS. Iowa Total Care provides information about Advance Directives to members in the Member Handbook, including the member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or healthcare power of attorney, and general instructions.

Primary Care Provider (PCP)

The Primary Care Provider (PCP) is a specific provider operating under the scope of his or her licensure, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating, and monitoring other medical care; rehabilitative service; and maintaining continuity of care on behalf of a member. PCPs are the cornerstone of Iowa Total Care's service delivery model. The PCP serves as the "Medical Home" for the member. The Medical Home concept consists of establishing a member/provider relationship, supports continuity of care,

and patient safety. This leads to elimination of redundant services, cost- effective care, and better health outcomes.

Iowa Total Care offers a robust network of PCPs to ensure every member has access to a Medical Home within the required travel distance standard (one within 30 minutes or 30 miles of each member's home where available).

Iowa Total Care requires PCPs and specialists to conduct reasonable outreach whenever a member misses an appointment and to document this in the member's medical record. An effort will be considered reasonable if it includes three (3) attempts to contact the member. Attempts may include, but are not limited to: written attempts, telephone calls, and home visits. At least (1) one such attempt must be a follow-up telephone call.

Provider Types That May Serve as PCPs

A PCP is a medical practitioner in our network and may be a:

- Family Practitioner
- General Practitioner
- Internist
- Pediatrician
- Advanced Registered Nurse Practitioner (ARNP)
- Obstetrician or Gynecologist (OB/GYN)
- Physician Assistant

Member Panel Capacity

All PCPs reserve the right to determine the number of members they accept into their panel. Iowa Total Care **does not guarantee** any provider will receive a certain number of members. The PCP to member ratio shall not exceed 1,500 members per PCP.

PCPs interested in exceeding the member limit should contact their Provider Relations Representative to discuss providing satisfactory evidence of added capacity by use of physician extenders and/or extended office hours to accommodate additional members.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Iowa Total Care Provider Services toll-free at **833-404-1061**. A PCP shall not refuse to treat members as long as they have not reached their requested panel size.

Providers shall notify Iowa Total Care in writing at least forty-five (45) days in advance of their inability to accept additional Medicaid members under Iowa Total Care agreements. In no event shall any established patient who becomes an Iowa Total Care member be considered a new patient.

PCP Assignment

Iowa Total Care members have the freedom to choose a PCP from our comprehensive provider network. Within seven (7) days of enrollment, Iowa Total Care will send new members a letter

encouraging them to select a PCP. For those members who have not selected a PCP during enrollment or within ten (10) calendar days of enrollment, Iowa Total Care will use a PCP auto-assignment algorithm to assign an initial PCP. Members reserve the right to change their PCP at any time. PCPs may be updated by calling our Member Services toll free at **833-404-1061**.

The algorithm assigns members to a PCP according to the following criteria:

1. Member's geographic location.
2. Member's previous PCP, if known.
3. Other family members' PCPs, if known.
4. Special healthcare needs, including pregnancy, if known.
5. Special language and cultural considerations, if known.

PCP Responsibilities

Iowa Total Care will monitor PCP actions for compliance with the following responsibilities:

- Providing primary and preventive care and acting as the member's advocate.
- Providing, recommending, and arranging for care.
- Complying with all Federal and State disability access laws and regulations and providing physical and programmatic access to members with disabilities.
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds DHS data specifications.
- Ensuring and maintaining continuity of each member's healthcare, including behavioral health and long term care services.
- When needed, effectively communicating with the member by using (free of charge to the member):
    - Sign language interpreters for those who are deaf or hard of hearing.
    - Oral interpreters for those individuals with (LEP) Limited English Proficiency.
- Maintaining a current medical record for the member, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.
- Arranging for Behavioral Health Services.
- Allowing Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as Healthcare Effectiveness Data and Information Set (HEDIS) and other contractual, regulatory, or other programs.
- Ensuring the member receives appropriate prevention services for the member's age group. – added bullet point
- Referring a member for Behavioral Services based on the following indicators:

- Suicidal/homicidal ideation or behavior;
- At-risk of hospitalization due to a Behavioral Health condition;
- Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;
- Trauma victims;
- Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;
- Request by member or authorized representative for Behavioral Health services;
- Clinical status that suggests the need for Behavioral Health services;
- Identified psychosocial stressors and precipitants;
- Treatment compliance complicated by behavioral characteristics;
- Behavioral and psychiatric factors influencing medical condition;
- Victims or perpetrators of abuse and/or neglect, and members suspected of being subject to abuse and/or neglect;
- Non-medical management of substance abuse;
- Follow-up to medical detoxification;
- An initial PCP contact or routine physical examination that indicates a substance abuse problem;
- A prenatal visit that indicates substance abuse problems;
- Positive response to questions that indicates substance abuse, observation of clinical indicators, or laboratory values that indicate substance abuse;
- A pattern of inappropriate use of medical, surgical, trauma, or emergency room services that could be related to substance abuse or other Behavioral Health conditions; and/or the persistence of serious functional impairment

Specialist Responsibilities

Iowa Total Care encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the member's care and ensure the referred specialist is a participating provider within the Iowa Total Care network and that the PCP is aware of the additional service request. The specialist may order diagnostic tests without PCP involvement.

Female members will have direct access to an in-network OB/GYN, or other women's health specialist for routine OB/GYN services regardless of whether their PCP (general practitioner,

family practitioner, or internist) provides such women's health services, including routine gynecological exams.

Emergency admissions will require notification to Iowa Total Care's Medical Management department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require prior authorization from Iowa Total Care.

The specialist must:

- Maintain contact with the PCP.
- Comply with all Federal and State disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Obtain prior authorization from the Iowa Total Care Medical Management department if needed before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five (5) business days.
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care.
- Maintain the confidentiality of medical information.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.

Iowa Total Care requires PCPs and specialists to conduct reasonable outreach whenever a member misses an appointment and to document this in the member's medical record. Such an effort shall be deemed to be reasonable if it includes three attempts to contact the member. Such attempts may include, but are not limited to: written attempts, telephone calls, and home visits. At least one such attempt must be a follow-up telephone call.

Hospital Responsibilities

Iowa Total Care utilizes a network of hospitals to provide services to Iowa Total Care members. Hospital Services Providers must be qualified to provide services under Medicaid. All services must
be provided in accordance with applicable State and Federal laws and regulations and adhere to the requirements set forth in the participating provider agreement.

Hospitals must:

- Notify the PCP immediately or at most no later than the close of the next business day after the member's Emergency Room (ER) visit.

- Comply with all Federal and State disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify the Iowa Total Care Medical Management department by sending an electronic file of the ER admission within twenty-four (24) hours or the next business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, Date of Service (DOS), and member's phone number.
- Notify the Iowa Total Care Medical Management department of all admissions within one (1) business day.
- Notify the Iowa Total Care Medical Management department of all newborn deliveries within two (2) business days of the delivery.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.

Voluntarily Leaving the Network

Providers must give Iowa Total Care notice of voluntary termination following the terms in their participating agreement. For a termination to be considered valid, providers are required to send written notice 180 days prior to a voluntary termination via certified mail (return receipt requested) or overnight courier to:

Iowa Total Care
Attn: Network Management
1080 Jordan Creek Parkway
West Des Moines, IA 50266

In addition, Providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to Iowa Total Care or the member.

Iowa Total Care will notify affected members in writing of a provider's termination, within fifteen (15) calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely.

COVERED BENEFITS AND LIMITATIONS

Iowa Total Care network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Manual, please contact Provider Services toll-free at 833-404-1061.

Iowa Total Care covers, at a minimum, those core benefits and services which includes Fee-for-Service (FFS) services covered under the Iowa Medicaid program specified in our agreement with the State of Iowa Department Human Services as set forth below:

Services	IA Health Link	Iowa Health & Wellness Plan (IHAWP)	Hawki
Preventive Services			
Affordable Care Act (ACA) preventive services	Covered	Covered	Covered
Routine check-ups	Covered	Covered; limitations may apply.	Covered
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Covered up to age 21.	Covered up to age 21.	Not covered
Immunizations	Covered	Covered; limitations may apply.	Covered; limitations may apply.
Professional Office Services			
Primary Care Provider	Covered	Covered	Covered
Office visit	Covered	Covered	Covered
Allergy testing	Covered	Covered	Covered
Professional Office Services			
Allergy serum and Injections	Covered	Covered	Covered
Certified nurse midwife Services	Covered	Covered	Covered
Chiropractor	Covered; limitations may apply.	Covered; limitations may apply.	Covered; limitations may apply.
Contraceptive devices	Covered	Covered	Covered
Family planning and family planning related services	Covered	Covered	Covered

Services	IA Health Link	Iowa Health & Wellness Plan (IHAWP)	Hawki
Gynecological exam	Covered	Covered; limited to one visit per year	Covered
Injections	Covered; limitations may apply.	Covered; limitations may apply.	Covered; limitations may apply.
Laboratory tests	Covered	Covered	Covered
Child care medical services	Covered up to age 21 under EPSDT.	Not covered	Not covered
Newborn child - office visits	Covered	Covered	Covered
Podiatry	Covered; routine foot care is not covered unless it is part of a Member's overall treatment related to certain health care conditions.	Covered; routine foot care is not covered unless it is part of a Member's overall treatment related to certain health care conditions.	Covered
Routine eye exam *One routine vision exam per calendar year.*	Covered	Covered	Covered
Routine hearing exam *One routine hearing exam per calendar year.*	Covered	Covered	Covered
Specialist office visit	Covered; PCP referral may be required.	Covered; PCP referral may be required.	Covered; PCP referral may be required.
Inpatient Hospital Services			
Preapproval of inpatient admissions	Covered; Required for non- emergent admissions.	Covered; Required for non-emergent admissions.	Covered; Required for non-emergent admissions.
Room and board	Covered	Covered	Covered
Inpatient Physician services	Covered; includes anesthesia.	Covered; includes anesthesia.	Covered

Services	IA Health Link	Iowa Health & Wellness Plan (IHAWP)	Hawki
Inpatient supplies	Covered	Covered	Covered
Inpatient surgery	Covered	Covered	Covered
Bariatric surgery for morbid obesity	Covered	Not covered	Covered; limitations may apply.
Breast construction, following breast cancer and mastectomy	Covered	Covered	Covered; limitations apply.
Organ/bone marrow transplants	Covered; limitations apply.	Covered; limitations apply.	Covered; limitations apply.
Outpatient Hospital Services			
Abortions	Covered; Certain circumstances must apply. Contact Member Services. Prior Authorization required.	Covered; Certain circumstances must apply. Contact Member Services. Prior Authorization required.	Covered; certain circumstances must apply. Contact Member Services. Prior Authorization required.
Ambulatory surgical center	Covered; includes anesthesia.	Covered; includes anesthesia.	Covered; includes anesthesia.
Chemotherapy	Covered	Covered	Covered
Dialysis	Covered	Covered	Covered
Outpatient diagnostic lab, radiology	Covered	Covered	Covered

Emergency Care			
Ambulance	Covered	Covered	Covered
Urgent care center	Covered	Covered	Covered
Hospital emergency room	Covered	Covered; $8.00 per visit for non-emergent medical services.	Covered; emergency services for non-emergent conditions are subject to a $25 copay if the family pays a premium for the Hawki program.
Non-Emergency Medical Transportation (NEMT)	Covered	Not covered	Not covered
Behavioral Health Services			
Assertive Community Treatment (ACT)	Covered	Covered when the member has been determined to be medically exempt pursuant to 441 IAC subrule 74.12(3)	Not covered
Behavioral Health Intervention Services (BHIS), including applied behavior analysis	Covered	Covered; residential treatment is covered when the member has been determined to be medically exempt pursuant to 441 IAC subrule 74.12(3)	Not covered
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, and residential substance use treatment.)	Covered (MCO Members only.)	Covered IHWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Not covered

Services	IA Health Link	Iowa Health & Wellness Plan (IHAWP)	Hawki
Inpatient mental health and substance abuse treatment	Covered	Covered; limitations may apply. IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Covered
Office visit	Covered	Covered IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Covered
Outpatient mental health and substance abuse	Covered	Covered IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Covered
Psychiatric Medical Institutions for Children (PMIC)	Covered	Covered for 19 to 20 year olds. Limitations may apply. IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Not covered

Services	IA Health Link	Iowa Health & Wellness Plan (IHAWP)	Hawki
Crisis Response and Subacute Mental Health Services	Covered	Covered IHAWP members who are **medically exempt** may access all available behavioral health and SUD treatment services including residential services.	Covered
Outpatient Therapy Services			
Cardiac rehabilitation	Covered	Covered	Covered
Occupational therapy	Covered	Limited to 60 visits per year.	Covered
Oxygen therapy	Covered	Limited to 60 visits in a 12-month period.	Covered
Physical therapy	Covered	Limited to 60 visits per year.	Covered
Pulmonary therapy	Covered	Limited to 60 visits per year.	Covered
Respiratory therapy	Covered	Limited to 60 visits per year.	Covered
Speech therapy	Covered	Limited to 60 visits per year.	Covered
Radiology Services			
Mammography	Covered	Covered	Covered
Routine radiology screening and diagnostic services	Covered	Covered	Covered
Sleep study testing	Covered	Covered; sleep apnea diagnostic services only.	Covered

Services	IA Health Link	Iowa Health & Wellness Plan (IHAWP)	Hawki
Laboratory Services			
Colorectal cancer screening	Covered	Covered	Covered
Diagnostic genetic testing	Covered	Covered	Covered
Pap smears	Covered	Covered	Covered
Pathology tests	Covered	Covered	Covered
Routine laboratory screening and diagnostic services	Covered	Covered	Covered
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) testing	Covered	Covered	Covered
Durable Medical Equipment (DME)			
Medical equipment and supplies	Covered	Covered	Covered
Diabetes equipment and supplies	Covered	Covered; limitations may apply.	Covered
Eye glasses	Covered; limitations may apply	Covered for ages 19 to 20, limitations may apply.	Covered; limitations may apply.
Hearing aids	Covered	Covered for ages 19 to 20, limitations may apply.	Covered; limitations may apply.
Orthotics	Covered; limitations may apply.	Not covered	Covered; limitations may apply and Prior Authorization required.

Services	IA Health Link	Iowa Health & Wellness Plan (IHAWP)	Hawki
Long Term Services Supports (LTSS) – Community Based			
Care Management HCBS Waiver and HCBS Habilitation populations only	Covered	Not covered	Not covered
Section 1915(c) Home-And Community-Based Services (HCBS)	Covered	Not covered	Not covered
Section 1915(i) Habilitation Services	Covered	Covered medically exempt only.	Not covered
Community-based Neurobehavioral Rehabilitation Services	Covered	Covered medically exempt only.	Not covered
Long Term Services and Support (LTSS) – Institutional			
ICF/ID (Intermediate Care Facility for Individuals with Intellectual Disabilities)	Covered; limitations apply.	Not covered	Not covered
ICF/MC (Intermediate Care Facility for Individuals with Medical Complexity) Care Facility for indivdiuals	Covered; limitations apply.	Not covered	Not covered
Nursing Facility (NF)	Covered	Not covered	Not covered
Nursing Facility for the Mentally Ill (NF/MI)	Covered	Not covered	Not covered
Skilled Nursing Facility (SNF)	Covered	Covered; limitations apply, limited to 120 day stays.	Not covered
Skilled Nursing Facility Out of State (Skilled preapproval)	Covered; limitations apply.	Not covered	Not covered

Services	IA Health Link	Iowa Health & Wellness Plan	Hawki
Hospice			
Hospice	Covered	Covered; limitations apply.	Covered
Health Homes			
Chronic Condition Health Homes	Covered	Covered medically exempt only.	Not covered
Integrated Health Homes	Covered	Covered.medically exempt only.	Not covered
Private duty nursing/Personal cares per EPSDT authority	Covered up to age 21 under EPSDT.	Covered up to age 21 under EPSDT.	Not covered
Vision Services			
Exams (every 12 months): Additional coverage for exams are covered following eye surgeries or for monitoring of certain medical conditions may be covered.	Covered	Covered	Covered
Eyewear	Covered: Eyeglasses (frames and lenses) are covered as follows: Under 1 year of age: 3 pair every 12 months. Age 1-3: 4 pair every 12 months. Age 4-7: 1 pair every 12 months. Age 8 and over: 1 pair every 24 months.	Eyeglasses (frames and lenses) are covered as follows; Age 19-20: 1 pair every 24 months.	$100 each year toward frames and contact lenses.

Services	IA Health Link	Iowa Health & Wellness Plan	Hawki
Repairs Under 21: Coverage for lost or damaged glasses. Over 21: Lost or damaged glasses beyond repair are covered once every 12 months.	Covered	Age 19-20: Coverage for lost or damaged glasses.	Not covered
For Coverage Questions call Envolve Vision at 1-833-564-1205.			

Urgent Care Services

Iowa Total Care defines Urgent Care as the existence of conditions due to an illness or injury which are not life threatening but require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention. 441 Iowa Administrative Code (IAC) 88.1.

If a member is unsure as to whether or not their situation is an emergency, they may contact their PCP or Iowa Total Care's 24 hour Nurse Advice Hotline during regular or after business hours and on weekends; however, this is not a requirement to access these services.

Emergency Care Services

Emergency Care Services must be accessible 24 hours a day, seven days a week. They are provided in a hospital or comparable facility in order to stabilize the member and determine the severity of the condition and the appropriate treatment of acute symptoms.

Members may access emergency services at any time without Prior Authorization from Iowa Total Care.

Emergency services are covered by Iowa Total Care when provided by a qualified provider, including out-of-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Iowa Total Care. Iowa Total Care will not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition; or
2. A representative from the Plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, Iowa Total Care requires notification for hospital admission or Prior Authorization for follow-up care, as noted elsewhere in this manual.

Emergency Care Co-payments

An eight dollar ($8) copayment for Iowa Health and Wellness Plan members and a twenty five dollar ($25) copayment for Hawki members will be applied for use of a hospital Emergency Room (ER) to treat non-emergent conditions. A copayment shall not be imposed on on Hawki Members who do not pay a premium.

Before providing non-emergency services and imposing copayments , the hospital providing care must:

- Conduct an appropriate medical screening to determine that the member does not need emergency services.
- Inform the member of the amount of his or her copayment for non-emergency services provided in the hospital ER.
- Provide the member with the name and location of an available and accessible alternative non-emergency services provider.
- Determine that the alternative provider can provide services to the member in a timely manner with a lesser or no copayment
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

If the member has been advised of the available alternative provider and of the amount of the copayment, and chooses to continue to receive treatment for a non-emergency condition at the hospital ER, the hospital will assess the copayment. Emergency services rendered for emergent conditions are exempt from any copayment.

NETWORK DEVELOPMENT AND MAINTENANCE

Iowa Total Care maintains a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with DHS' access and availability requirements.

Iowa Total Care offers a network of PCPs to ensure every member has access to a Medical Home within the required travel distance standards.

In the event Iowa Total Care's network is unable to provide medically necessary services required under the contract, Iowa Total Care will ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to Prior Authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for a Iowa Total Care member, please contact our Medical Management team at **833-404-1061** and we will identify a provider to make the necessary referral.

Tertiary Care

Iowa Total Care offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical subspecialists available twenty-four (24) hours per day in the geographical service area. In the event Iowa Total Care's network is unable to provide the necessary tertiary care services required, Iowa Total Care will ensure timely and adequate coverage of these services through an out-of-network provider who is enrolled with the Iowa Medicaid Enterprise (IME) until a network provider is contracted and will ensure coordination with respect to Prior Authorization and payment issues in these circumstances.

INTEGRATED HEALTH SERVICES

Overview

Iowa Total Care Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). After normal business hours, our 24/7 nurse advice hotline staff is available to answer questions about Prior Authorization.

Integrated Health Services include the areas of utilization management, care management, population management, and quality review. Clinical services are overseen by the Iowa Total Care Medical Director. The Vice President of Medical Management (VPMM) has responsibility for direct supervision and operation of the department. To reach the Medical Director or VPMM, contact Medical Management toll-free at **833-404-1061**.

Integrated Care

Iowa Total Care uses a multi-disciplinary Integrated Care Team (ICT) to offer and coordinate care. Our staff coordinates care with all the necessary individuals on the member's care team, including the member's primary and specialty providers, other care team members, and those identified as having a significant role in the member's life, as appropriate.

Our goal is to help each and every Iowa Total Care member achieve the highest possible levels of wellness, functional capacity, and quality of life, while demonstrating positive clinical results. Integrated care is an integral part of the range of services we provide to all members. We

continually strive to achieve optimal health status through member engagement and behavioral change motivation using a comprehensive approach that includes:

- Strong support for the integration of both physical and behavioral health services.
- Assisting members in achieving optimum health, functional capability, and quality of life.
- Empowering members through assistance with referrals and access to available benefits and resources.
- Working collaboratively with members, family and significant others, providers, and community organizations to assist members using a holistic approach to care.
- Maximizing benefits and resources through oversight and cost-effective utilization management.
- Rapid and thorough identification and assessment; especially members with special health care needs.
- A team approach that includes staff with expertise and skills that span departments and services.
- Information technologies that support care coordination within plan staff and among a member's providers and caregivers.
- Multifaceted approach to engage members in self-care and improve outcomes.
- Continuous quality improvement processes that assess the effectiveness of integrated care and identify areas for enhancement to fully meet member priorities.
- Assessment of member's risk factors and needs.
- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members understand treatment recommendations.
- Active coordination of care for members with coexisting behavioral and physical health conditions, residential, social, and other support services where needed.
- Development of an integrated plan of care.
- Referrals and assistance to community resources and/or behavioral health providers.

The model emphasizes direct member contact (i.e., telephonic outreach; face-to-face meetings; and written educational materials). In some circumstances, face-to-face education is preferred because it more effectively engages members, allows staff to provide information that can address member questions in real time and better meets member needs. Participating members also receive preventive care and screening reminders, invitations to community events, and can call any time regarding health care and psychosocial questions or needs.

Medically Necessary

Medically necessary is defined differently for certain services in the Iowa Administrative Code (IAC) * and are specific to each individual. This means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

Medically necessary services:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition or disability.
- Will assist the member in achieving or maintaining maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities are appropriate for members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker and the PCP, as well as any other providers, programs, and agencies that have evaluated the member.

All such determinations must be made by qualified and trained healthcare providers.

* PD Nursing and Personal Care 441 IAC 78.9(10) / Behavioral Health Intervention Services (BHIS) 441 IAC 78.12(6) / Child Care Medical Services 441 IAC 78.57(5)

Care Management Program

Iowa Total Care will assign a specific Care Manager to each member who, when determined by assessment, would benefit from such services. A member may be assigned to Care Coordination, Care Management, or Disease Management, as applicable. Services provided under varying levels of Care Management may include:

- Development and implementation of a Person-Centered Care Plan (PCCP).
- Monitoring of the PCCP to determine if it is meeting the member's identified needs.
- Assessment of need for assignment to an Integrated Health Home/ Chronic Condition Health Home.
- Referring and connecting member to an appropriate Health Home when identified.
- Targeted Health Education Annual Comprehensive Health Risk Assessment to determine if the PCCP is appropriate or if a higher or lower level of Care Management is needed.

Health Risk Screening (HRS)/Annual Re-assessments

Upon Enrollment, Iowa Total Care will conduct a Health Risk Assessment (HRA) using a tool approved by the Department of Human Services to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or needs for Service Coordination. Any member whose screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a Comprehensive Health Risk Assessment (CHRA).

The HRA must be completed within the first ninety (90) days of enrollment, and may be conducted by phone, electronically, by mail, or in person.

For reassessments, within the twelve (12) months after initial outreach or completed initial Health Risk Screening, Iowa Total Care will follow-up and conduct a reassessment to obtain new, additional, or updated changes in status over the course of the year. The HRS outreach is achieved by phone, electronically, by mail, or in person.

Comprehensive Health Risk Assessment (CHRA)

The CHRA will be scheduled within thirty (30) days of identification of potential need for Care Management. Reassessment will occur at a minimum of every twelve (12) months thereafter unless there is a change in condition or significant health event or requested by the member/caregiver. This CHRA is approved by the Iowa Department of Human Services and is used to help identify supports and services the member may need. All support and services needs are reviewed and agreed upon by the member and their identified caregiver/support. All documentation is uploaded in Iowa Total Care's clinical documentation system, which supports the development of the PCCP. All PCCPs will require agreement and signature by the member or their designated representative, as well as all providers that are part of the member's PCCP (unless the member requests to not share the PCCP with a provider(s)).

Care Managers will consult with the member's PCP, specialists, behavioral health providers, other providers and Interdisciplinary Team (IDT) experts, as needed when developing the PCCP.

The Care Management team is available to help all providers manage their Iowa Total Care members. Listed below are programs and components of special services that are available and can be accessed through the Care Management team. If you have an Iowa Total Care patient and feel he/she could benefit from the addition of a Care Management team member please let us know.

Programs and components are:

- Link the member to a Medical Home
- Educate members about self-management of their condition
- Ensure member awareness of and compliance with medications
- Connect the member to needed supports
- Transition of Care Program
- ER Diversion Program
- Whole-Person Care Coordination
- Discharge planning/coordination

To contact a Care Manager call our toll-free number at **833-404-106**1.

High- Risk Pregnancy Program

The Maternity Team will implement our *Start Smart for Your Baby*® Program (Start Smart), which incorporates care management and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age.

The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members, and providing care management to high and moderate risk members through the postpartum period. A nurse care manager with obstetrical experience will serve as lead Care Manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life as needed based on their specific condition or diagnosis.

The Maternity Team has provider oversight, whose primary responsibility is advising the team on overcoming obstacles, helping identify high-risk members, and recommending interventions. These providers will give input to Iowa Total Care Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

Example

Iowa Total Care offers a premature delivery prevention program by supporting the use of 17-P. When a provider determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is submitted to the Iowa Total Care CM who will check for eligibility.

The CM will arrange for 17-P to be administered via a home health agency in the member's home, or in the practitioner's office as part of the member's medical benefit. The nurse manager will contact the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing provider during the entire treatment period. The Maternity Team works in collaboration with local PCPs, FQHCs, Health Homes, and local Health Departments to support this program with the goal of improved maternity/neonate care in Iowa.

Contact the Iowa Total Care Management department for enrollment in the obstetrical program.

Notice of Pregnancy Program

In an effort to increase member Notice of Pregnancy (NOP) communication and reduce the recurrence of Preterm births, Iowa Total Care is launching a Pregnancy Provider Incentive Program effective January 1, 2020.

NOP forms are located on the Iowa Total Care Provider Portal and Iowa Total Care Provider Website. You may submit NOP forms through the Iowa Total Care Provider Portal (Provider.iowatotalcare.com) or by Fax 833-257-8323.

Submitted forms must be accurate and complete, i.e., member name, date of birth, member ID, full name of provider, gestation, initial OB visit date, Provider's Tax ID Number (TIN) and all pregnancy information (as able). Duplicate NOP forms will not qualify for multiple incentives.

MemberConnections® - Community Health Services Program

Iowa Total Care's outreach program is designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable.

The program components are integrated as a part of our Care Management program in order to link Iowa Total Care and the community we serve. The program recruits staff from the communities served to establish grassroots support and awareness of Iowa Total Care within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to Community Health Services through numerous sources. Members who call the Iowa Total Care Member Service department may be referred for more personalized discussion on the topic they are inquiring about. CMs may identify members who would benefit from one of the many Community Health Services program components, and complete a referral request. Providers may request Community Health Services referrals directly to the Community Health Services Representative or their assigned CM. Community groups may request that a Community Health Services Representative visit their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Care Coordination – Coaching

Community Health Services Representatives are available to work with members towards targeted health education; advocate, coach and foster the development of independent health skills, support in addressing any social service and concrete barriers that the member faces when working to achieve whole health and wellness. The Community Health Services Representative collaborates closely with the provider, nurse care manager, team nurse manager, and other members of the interdisciplinary care team. The Community Health Services Representative works with the member in the community settings, such as their home, community centers, and more, to provide culturally fit health education and assistance. They are available whenever a need or request from a CM, member, and provider is made, or when a member is recommended for a specific coaching program based on health status.

Navigation and Other Assistance

General assistance and navigation support may be provided to members and requested by CM, member, or provider as needed. Topics covered during these in-person visits include overview of covered benefits, how to schedule an appointment with the PCP; the importance of preventive

healthcare, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and reliable phone access through our Connections Plus®. Connections Plus is a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan CM, PCP, specialty provider, 24/7 nurse advice hotline, 911, or other members of their healthcare team. Community Health Services Representatives may also ensure the member knows how to contact the health plan for assistance. Social needs may be addressed during these visits to ensure holistic care and removal of barriers to accessing the health care system. Community Health Services Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

Building Community Capacity

Community Health Services Representatives are available to present to group settings during events initiated by State entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about, overview of services offered by Iowa Total Care, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers, Iowa Total Care, and health education. Targeted community events include our Adopt-a School program where a representative will actively promote healthy lifestyle activities related to disease prevention and health promotion by visiting schools of the communities served. Community baby showers promote health education and awareness for healthy pregnancies and healthy babies. Health Fairs to enable easy access to providers, other health -care services and more.

To contact the Community Health Services Team call our toll-free number at **833-404-1061**.

Members with Mental Health and Substance (Alcohol and Drug) Use Disorders

Iowa Total Care uses an intensive Care Management (CM) Program to address the unique needs of members related to Mental Health and Substance Use Disorders (SUD), including frequent co-morbid and co-occurring conditions, which require an integrated approach to all aspects of care coordination and treatment. The program incorporates interventions such as structured post-discharge telephonic or in-person contact; assessing satisfaction with outpatient providers; careful attention to compliance with prescribed medications as well as potential impact of each medication on all Physical Health (PH) and Behavioral Health (BH) conditions.

The following programs will be initiated for members identified with needs related to Mental Health and SUD as indicated:

- Integrated Health Homes
- Intensive Care Coordination
- Utilize Community Health Workers to engage members
- Transition of Care from different care settings/levels
- Chronic Condition Health Homes

The Care Manager will complete an assessment to confirm member needs related to Mental Health and/or SUD, assessing medical, BH, social, and other needs. Within thirty (30) calendar days of identification, or sooner as dictated by member needs, a Care Coordinator Manager will outreach to members identified to complete a comprehensive assessment, develop a care plan, and provide other needed assistance. Other outreach processes and initiatives will include:

- Partnering with community care managers and peer supports to outreach to members with Serious Mental Illness (SMI), SUD, and other BH needs.
- Identifying agencies serving the homeless population and coordinate with those agencies on initiatives geared toward identifying and connecting difficult- to -reach members with supportive resources and stable housing.
- Building relationships with local hospitals so they notify Iowa Total Care when our members visit the ER.
- Education and enrollment of eligible members into an IHH as applicable.

In an effort to support the HH, staff will use comprehensive assessments to identify members who could benefit from a Health Home and educate eligible members on available services, including member's choice to opt in or out of the Health Home program. For members who choose to enroll in a Health Home, the CC will coordinate with the member's chosen Health Home provider to ensure continuity of care. Once the member is enrolled in the Health Home program, our CC will work with the Health Home staff and/or other members of the community-based team to promote recovery through a care plan, which is developed in collaboration with the member. The care plan can include: treatment referrals; self-management tools to help the member understand triggers; and, use of local support groups and resources. Care plans will also include coordination with the Health Home provider, other involved providers (including OB/GYNs, behavioral health providers, PCPs and specialists), as well as family and community supports as desired by the member or authorized representative.

New provider orientation and our Iowa Total Care Provider Portal contains information on behavioral health and co-occurring conditions, as well as our requirements and processes for screening, referring and coordinating care for individuals with these disorders. We will provide PCPs with screening tools for mental health issues and SUD, and provide training on their use.

Referrals for Care Management of members with needs related to Mental Health and/or SUD can be made via the Iowa Total Care Provider Portal or by calling Iowa Total Care toll-free at **833-404-1061** and completing a referral telephonically.

24 Hour Nurse Advice Line

Our members have many questions about their health, their PCP, and access to emergency care. Therefore, we offer a Nurse Advice Line to help members proactively manage their health needs and decide on the most appropriate care. We provide this service to support your practice and offer our members access to a registered nurse at any time — day or night. The toll-free telephone number is **833-404-1061.**

The Nurse Advice Line is always open and always available for members. Staffed by Registered Nurses (RNs), they often answer basic health questions, but are also available to triage more complex health issues using nationally recognized protocols. Nurses will refer members with chronic problems, such as asthma or diabetes, to our Care Management or Member Service departments for follow-up assistance, education, and encouragement to improve their health. Members can call the Nurse Advice Line to request information about providers and services available in their community after hours, when the Iowa Total Care Member Service department is closed. The staff is proficient in both English and Spanish and can provide additional translation services if necessary.

LONG TERM SERVICES AND SUPPORTS (LTSS)

Iowa Total Care coverage includes services for members who require services and supports at a level that is provided in facility-based settings such as a nursing home or an intermediate care facility. This is referred to as Long-Term Care (LTC). When the same type of care is provided to members in their home and/or community (Home and Community Based Services or HCBS), in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID), or in a Nursing Facility or Skilled Nursing Facility it is called Long Term Services and Supports (LTSS).

The provider is responsible for supervising, coordinating, and providing all services authorized for their member in accordance with the member's Person-Centered Service Plan. In addition, the provider is responsible for: ensuring the receipt of an authorization for all services approved as part of the member's Person-Centered Service Plan; maintaining continuity of each member's care; and maintaining the member's medical record. This includes documentation of all services provided by the provider and the member or responsible party's signature for receipt of covered services.

Role of the Community Based Case Manager (CBCM)

The CBCM's primary function is to assist the team in identifying needs, facilitate access to LTSS and other services, and monitor the member's health, safety, and services access. The CBCM is responsible to lead the Person-Centered Service Plan (PCSP) process and oversee the implementation of the member's PCSP. The CBCM will ensure there is a Level of Care (LOC) assessment completed at least every 365 days and the CBCM at a minimum will hold a comprehensive PCSP meeting every 365 days. The CBCM will identify, coordinate, and assist the member in gaining access to all needed services, including: covered and non-covered services; medical, social, housing, educational, and other necessary services and supports. The CBCM is responsible for locating and coordinating traditional Medicaid providers, specialists, or other entities essential for service delivery. This includes seamless coordination between physical, behavioral, and support services. CBCMs work with the member and Interdiciplinary team to coordinate evaluations and reassessments, identify strengths and needs, create the member's person-centered goals through the PCSP process, and contact the member monthly and provider(s) at least quarterly to monitor progress on goals, health, and safety. The CBCM will work

with the member to complete activities necessary to maintain LTSS eligibility. The CBCM will offer options, such as choices of traditional Medicaid Waiver providers, the availability of the Consumer Choices Option (CCO), and other LTSS services that may meet the member's needs. To contact a CBCM, call Iowa Total Care at **833-404-1061**.

Provider's Role in Service Planning and Care Coordination

The service provider will work with CBCM and member's team to address necessary services and supports and participate in the PCSP process to ensure members' needs are addressed. Providers are expected to follow the PCSP as written by the case manager and approved by the member's service planning team. Traditional Medicaid Providers, as well as CCO employees should follow documentation standards as outlined in Iowa Administrative Code. Providers must report major incidents to ITC using this link https://www.iowatotalcare.com/providers/resources/forms-resources.html and report to the case manager as outlined in Iowa Administrative Code.

Service Request Process for LTSS

LTSS services require approval and Prior Authorization by Iowa Total Care. The PCSP is the request for prior authorization for LTSS services. The PCSP is completed by the case manager and sent to Utilization Management for review. After a decision has been made, a Notice of Action will be mailed to the member and provider. In the case of an adverse action a reduction, termination or denial of services, appeal rights will be included in the notification letter.

PCSPs are reviewed with members during regularly scheduled face–to-face visits at least every 3 months and at the time of re-assessment. If a member experiences a significant change in condition, has a change in level of needed support, or if the member requests a change in service(s) or provider, there may be a need to amend the PCSP. An amendment can be requested at any time to ensure the member's needs are met.

All services are subject to benefit coverage, limitations, and exclusions, as described in applicable State rules and regulations. Iowa Total Care providers are contractually prohibited from holding any Iowa Total Care member financially liable for any service administratively denied by Iowa Total Care. Continuity of care coverage begins on the member's effective date of enrollment for any existing services, and remains in effect until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented.

LTSS Provider Responsibilities

LTSS providers are required to adhere to the following responsibilities:

- Provide Iowa Total Care members with a professionally recognized level of care and efficiency consistent with community standards, the health plan's clinical and non-clinical guidelines, and within the practice of the provider's professional license.
- Abide by the terms of the Participating Provider Agreement.

- Comply with all plan policies, procedures, rules and regulations, including those found in this manual.
- Maintain confidential medical records consistent with Iowa Total Care's medical records standards, medical record- keeping guidelines, IAC 79.3 sections (1), (2) and (3), and applicable HIPAA regulations.
- Maintain a facility that promotes enrollee safety.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Participate in Iowa Total Care's quality improvement program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of the provider's profession.
- Notify the plan if you are undergoing an investigation, or agree to written orders by the state licensing agency.
- Notify the plan if there is a change of status with member eligibility.
- Ensure you have staff coverage to maintain service delivery to members.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.
- Continue to provide services to members whose services are being transitioned to another provider. Providers should continue provision of HCBS, in accordance with the member's plan of care, until the member has been transitioned to a new provider, which may exceed thirty (30) days from the date of the notice.

UTILIZATION MANAGEMENT

The Iowa Total Care Utilization Management Program (UMP) is designed to ensure members receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members, age categories, and range of diagnoses. It provides for aggregate and individual analysis and feedback of providers and plan performance in providing access to care, the quality of care provided to members, and utilization of services. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, maternity care, and ancillary care.

Iowa Total Care UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and that meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of care and/or population management for members at risk for significant health costs or ongoing care.
- Development of an infrastructure to ensure members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self-management.
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals.

Medically Necessary

Medically Necessary 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 it:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition or disability.
- Will assist the member in achieving or maintaining maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities are appropriate for members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker, and the PCP, as well as any other providers, programs, and agencies that have evaluated the member. All such determinations must be made by qualified and trained healthcare providers.

Prior Authorizations

Failure to obtain the required Prior Authorization for a service may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions, as described in applicable plan coverage guidelines. All out-of-network services require Prior Authorization except for family planning, Emergency Room, post-stabilization services and table top X-rays.

Iowa Total Care providers are contractually prohibited from holding any Iowa Total Care member financially liable for any service administratively denied by Iowa Total Care for payment due to the provider's failure to obtain timely Prior Authorization.

Services That Require Prior Authorization

This list is not all inclusive. Visit www.iowatotalcare.com and use the Prior-Authorization Check tool to determine if a service requires Prior Authorization and to easily submit a request for Prior Authorization or referral.

Ancillary Services

- Cochlear Implant
- Durable Medical Equipment (DME) includes: medical supplies; enteral and parenteral pumps; wound vacs; bone growth stimulator; customized equipment (based on DME, orthotics, and prosthetics listing)
- Fixed Wing non-emergency air transport
- Hearing Aid Devices
- Home health- care (including infusions, home health aide, private duty)
- Hospice services - other than inpatient facility
- Hyperbaric oxygen treatment (outpatient)
- Implantable devices (infusion pumps, intraocular implant/shunt, neuromuscular stimulator, spinal stimulator for pain management, testicular/penile prosthesis, vagas nerve stimulator)
- Orthotics and Prosthetics (based on DME, orthotics, and prosthetics listing)

Behavioral Health

- Autism Spectrum Disorders and Habilitative Services diagnosis and treatment (CBH)
- Behavioral Health: inpatient and substance abuse admissions; Partial Hospital Program (PHP); intensive outpatient program (IOP); outpatient electroconvulsive therapy (ECT); and Community Based Mental Health Services for youth and adults.

Home and Community- Based Waiver Services

Also see the Service Request Process for LTSS in the Long Term Services and Supports section of this manual.

- Adult Day Care
- Assistive Devices
- Assisted Living
- Behavioral Programming
- Case Management Services (for all members utilizing IHH services including Habilitation and Children's Mental Health Waiver members)
- Case Management (for those that are receiving both 1915(i) and 1915(c) waiver services and not enrolled in an IHH)
- Chore
- Consumer Choices Option (CCO)

- Consumer Directed Attendant Care (CDAC)
- Counseling
- Day Habilitation
- Emergency Response
- Environmental Modifications and Adaptive Devices
- Family and Community Support
- Family Counseling and Training
- Home -Based Habilitation
- Home Delivered Meals
- Home Health Aide
- Homemaker
- Home/Vehicle Modifications (HVM)
- In-Home Family Therapy
- Interim Medical Monitoring and Treatment (IMMT)
- Mental Health Outreach
- Nursing
- Nutritional Counseling
- Prevocational Services and Habilitation
- Respite: Individualized, Group, Specialized
- Senior Companion
- Supported Community Living (SCL)
- Specialized Medical Equipment
- Supported Community Living: Residential-Based (RBSCL) for Children
- Supported Employment (SE)
- Transportation

Facility Services

- Elective/planned hospitalizations (Notification at least five (5) business days prior to the scheduled date of admission)
- Emergency Admissions and/or Observation Stay (Notification within (one) 1 business day of admission)
- Mental Health Institution (MHI)
- Observation Services (inpatient)
- Skilled Nursing Facility
- Intermediate Care Facility (ICF/ID) (Concurrent review Authorization required for State-approved stays)
- Nursing Home – permanent full-time resident (Concurrent review Authorization required for State- approved stays)
- Psychiatric Medical Institution for Children (PMIC)

Pharmaceuticals

- Specialty Pharmaceuticals as per Prior Authorization list
- Selected Injectable therapy/biopharmaceuticals (e.g., Synagis, Growth Hormone), as per Prior Authorization list
- Enteral/Parenteral Formulas (pumps and supplies - see DME)

Practitioner Services

- Chiropractic
- Infertility Treatment
- Transplants (surgery itself)

Radiology and Laboratory Services

- Genetic/Molecular Diagnostic Testing
- MR-guided Focused Ultrasound (MRgFUS) to treat uterine fibroid
- Quantitative Drug Screening

Surgery & Procedures

- Ablative Techniques for treating Barrett's Esophagus and for treating primary and metastatic liver malignancies
- Bariatric Surgery
- Capsule Endoscopy
- General Anesthesia with a Dental diagnosis
- Hyperhydrosis treatment
- Joint Replacement - outpatient and inpatient joint replacement procedures in addition to total hip and/or knee
- Lung Volume Reduction Surgery
- Maze procedure (for treatment of atrial fibrillation)
- Muscle Flap Procedure
- Orthognathic Surgery (treatment of maxillofacial jaw functional impairment)
- Pain Management Services
- Potentially Cosmetic or Plastic surgery e.g. : blepharoplasty; blepharoptosis repair; brow lift; breast surgery or reconstruction other than post mastectomy; cranial/facial/jaw procedures; nasal/sinus surgery; panniculectomy; and lipectomy/diastasis recti repair; vein procedures
- Potentially Experimental Treatment/Clinical Trials
- Sleep Apnea Procedures and Surgeries
- Sleep Studies
- Spinal Surgery
- Surgeries/procedures performed in outpatient facilities or ambulatory Surgery Centers e.g.: arthroscopy; gender reassignment; joint replacement; obstructive sleep apnea surgery; potentially cosmetic or plastic surgery; TMJ; transcatheter; uterine; artery embolization; vein procedures; and others listed
- Tonsillectomies

- Uvulopalatopharyngoplasty (UPP)
- Ventriculectomy, cardiomyoplasty
- Wearable Cardioverter-Defibrillators

Therapy Services (PT, OT, ST)

- Physical Therapy (excluding initial evaluation)
- Occupational Therapy (excluding initial evaluation)
- Speech Therapy (excluding initial evaluation)

Requesting a Prior Authorization

- The preferred method for submitting Prior Authorizations is through our Secure Provider Web Portal at www.iowatotalcare.com. The provider must be a registered user on the Secure Provider Web Portal. If the provider is not a registered user and needs assistance or training on submitting Prior Authorizations there, the provider should contact their assigned Provider Relations Representative.
- Other methods for submitting Prior Authorization requests are as follows:
    - Call the Medical Management Department toll-free at **833-404-1061**. Medical Management's normal business hours are Monday – Friday 8 a.m. to 5 p.m. CST. Voicemails left after hours will be responded to on the next business day.
    - Fax Prior Authorization requests on the Prior Authorization fax forms posted at: www.iowatotalcare.com. Faxes will not be monitored after hours and will be responded to on the next business day.

Timeframes for Prior Authorization Requests and Notifications

Prior Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for Prior Authorization and notification.

Any Prior Authorization request that is faxed or sent via the Secure Provider Web Portal after normal business hours (8 a.m. – 5 p.m., Monday – Friday, excluding holidays) will be processed the next business day.

Failure to obtain Prior Authorization may result in claim denials.

Service Type	Timeframe
Scheduled Admissions	Prior Authorization required five (5)business days prior to the scheduled admission date
Elective Outpatient Services	Prior Authorization required five (5)business days prior to the elective outpatient admission date
Emergent Inpatient Admissions	Notification within twenty-four (24) hours to include clinical rationale for admission.
Observation	Notification within one (1) business day
Emergency Room and Post Stabilization, Urgent Care and Crisis Intervention	Notification within two (2) business day
Newborn Delivery	Notification within two (2) business days.
Neonatal Intensive Care Unit (NICU) Admissions	Notification within twenty-four (24) - hours to include clinical rationale for admission.

Prior Authorization Determination Timelines

Iowa Total Care medical Prior Authorization decisions are made as expeditiously as the member's health condition requires, but shall not exceed the timeframes listed below.

Type	Timeframe
Expedited Pre-Service/Urgent	Seventy-two (72) hours
Standard Pre-Service/Non-Urgent	Within fourteen (14) calendar days
Concurrent review	Seventy-two (72) hours
Urgent concurrent review	Twenty-four (24) hours

Clinical Information

Iowa Total Care clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to Federal and State regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Iowa Total Care is entitled to request and receive protected

health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Information necessary for Authorization of covered services may include, but, is not limited to:

- Member's name, member ID number.
- Provider's name and telephone number.
- Facility name, if the request is for inpatient admission or outpatient facility services.
- Provider location if the request is for an ambulatory or office procedure.
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date).
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed).
- Admission date or proposed surgery date, if the request is for a surgical procedure.
- Discharge plans.
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to Iowa Total Care within two (2) business days or before discharge.

If additional clinical information is required, an Iowa Total Care representative will notify the requestor of the specific information needed to complete the Authorization process.

Clinical Decisions

Iowa Total Care affirms that utilization management decision- making is based on appropriateness of care and service and the existence of coverage. Iowa Total Care does not reward providers or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct Utilization Management (UM) activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Iowa Total Care Medical Director, is responsible for making UM decisions in accordance with the member's plan of covered benefits and established PC criteria. Failure to obtain Prior Authorization for services that require plan approval may result in payment denials.

Review Criteria

Iowa Total Care has adopted utilization review criteria developed by McKesson InterQual®, the American Society of Addiction Medicine (ASAM), and the State of Iowa DHS, as indicated, to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. All criteria are utilized as screening guides and are not intended to be a substitute for provider judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

LTSS including all HCBS services will be authorized in the context of member specific needs identified through a person- centered assessment and any member encounters in order to determine the appropriate type, scope, and volume of services to be authorized for each member. The needs of members are unique, and in the instance of complex health- care needs that require additional input, a member's community base care manager will collaborate with the ITC chief medical officer as well as identified members of the care team to determine the services necessary to best support a member's needs to ensure successful, member- driven, outcomes.

Peer to Peer Review

Providers may obtain the criteria used to make a specific adverse determination by contacting Medical Management toll-free at **833-404-1061**. At the time of notification of an adverse decision, requesting practitioner/facility will be offered the opportunity to schedule a conversation to discuss any adverse decisions with a physician or other appropriate reviewer. The Medical Director may be contacted through Provider Services by calling **833-404-1061** and asking for a peer review with the Medical Director. A Case Manager may also coordinate communication between the Medical Director and requesting provider.

Appealing an Adverse Benefit Determination

Members, their authorized legal representatives, or a provider, with the member's written consent, may request an appeal related to an adverse benefit determination. Instructions for how to file an appeal are provided in the Grievances and Appeal Processes section of this manual and are included in all denial letters.

Second Opinion

Members or a healthcare professional, with the member's consent, may request and receive a second opinion from a qualified professional within the Iowa Total Care network. If there is not an appropriate provider to render the second opinion within the network, the member may

obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network providers require Prior Authorization by Iowa Total Care when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

Iowa Total Care evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the Iowa Total Care population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, contact Medical Management toll-free at **833-404-1061**.

Notification of Pregnancy

Members that become pregnant while covered by Iowa Total Care may remain an Iowa Total Care member during their pregnancy. The managing physician should notify the Iowa Total Care prenatal team by completing the Notification of Pregnancy (NOP) form available at www.iowatotalcare.com within five (5) days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Care Management section for information related to our *Start Smart for Your Baby*® program and our 17-P program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Concurrent Review nurses conduct concurrent review for inpatient admissions through onsite or telephonic methods with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The Concurrent Review nurse will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within seventy-two (72) hours of receipt of clinical information. For a length of stay extension request, clinical information must be submitted by 3 p.m. CST on the day review is due. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review. However, the hospital must notify Iowa Total Care within two (2) business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which Prior Authorization and/or timely notification to Iowa Total Care was not obtained due to extenuating circumstances (e.g. member was unconscious at presentation; member did not have their Medicaid ID card; or otherwise indicated Medicaid coverage; services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within thirty (30) calendar days following receipt of request, not to exceed ninety (90) calendar days from the date of service.

Speech Therapy and Rehabilitation Services

Iowa Total Care offers our members access to all covered, medically necessary outpatient physical, occupational and speech therapy services.

Prior Authorization is required for outpatient occupational, physical or speech therapy services and should be submitted to Iowa Total Care as described in Procedures for Requesting a Prior Authorization section of this Manual.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Iowa Total Care is using National Imaging Associates (NIA) to provide Prior Authorization services and utilization of advanced diagnostic imaging. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior Authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA
- PET Scans
- Nuclear Radiology

Key Provisions

- Emergency Room, observation and inpatient imaging procedures do not require Prior Authorization.
- It is the responsibility of the ordering provider to obtain Prior Authorization.
- Providers rendering the above services should verify that the necessary Prior Authorization has been obtained. Failure to do so may result in claim non-payment.

To reach NIA and obtain Prior Authorization, call our toll-free number at **833-404-1061** and follow the prompt for radiology Prior Authorizations. NIA also provides an interactive website which may be used to obtain online Prior Authorizations. Visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Iowa Total Care, in collaboration with NIA Magellan, will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

Under this program, Prior Authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment, and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, NIA Magellan addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

NIA Magellan has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. NIA Magellan also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient.
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed.
- Quality assessment of imaging providers to ensure the highest technical and professional standards.

How the Program Works

In addition to the other procedures that currently require Prior Authorization for members, Prior Authorization will be required for the following cardiac procedures:

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

- Stress Echocardiography

The following services do not require Prior Authorization through NIA Magellan:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach NIA Magellan and obtain Prior Authorization, call our toll-free number at **833-404-1061** and follow the prompt for Radiology and Cardiac Prior Authorizations. NIA Magellan also provides an interactive website, which may be used to obtain online Prior Authorizations. Visit RadMD.com for more information.

CLINICAL PRACTICE GUIDELINES

Iowa Total Care's clinical and quality programs are founded on evidence-based prevention and clinical practice guidelines. Whenever possible, Iowa Total Care adopts guidelines that are published by nationally recognized organizations, government agencies, state-wide collaboratives, and/or consensus guidelines from healthcare professionals in the applicable field. Iowa Total Care providers are expected to follow these guidelines.

Medical policies serve as one set of guidelines for determining what medical services, procedures, devices and drugs may be considered medically necessary. Iowa Total Care uses the following guidelines to make medical necessity decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

- Federal law,
- State law/guidelines,
- Iowa Total Care-specific clinical policy, and
- Centene clinical policy.

Centene's clinical policies reflect current scientific research and evidence-based clinical standards. They are maintained by a Clinical Policy Committee that ensures the clinical policies provide a guide to medical necessity, are reviewed and approved by appropriately qualitied physicians, and are available to all Centene Health plans. If no specific clinical policy has been adopted by Iowa Total Care or Centene, then InterQual® criteria are used to evaluate whether a medical procedure or equipment is medically necessary. InterQual® is a nationally-recognized clinical decision support tool that is produced using a rigorous development process based on the principles of evidence-based medicine.

Additional resources used by Iowa Total Care clinical and quality programs include the following representative samples of nationally-recognized guidelines.

- American Cancer Society Guidelines for the Early Detection of Cancer (Revised May 2018)

- Institute for Clinical Systems Improvement Health Care Guideline: Adult Acute and Subacute Low Back Pain Diagnosis Algorithm (Revised March 2018)
- CDC Advisory Committee on Immunization Practices Recommended Immunization Schedules: Adult and Child
- The National Comprehensive Cancer Network® (NCCN®) Guidelines
- The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder
- Hayes Evidence Analysis
- IBM Micromedex®
- For links to the most current version of the clinical policies used by Iowa Total Care, visit our website at www.iowatotalcare.com. A paper copy of the individual Centene Clinical Policies listed is available by calling Provider Services toll-free at **833-404-1061**.

Pharmacy

Iowa Total Care provides pharmacy benefits through its Pharmacy Benefit Manager, Envolve Pharmacy Solutions.

Iowa Total Care adheres to the state of Iowa Preferred Drug List (PDL) to determine medications covered under the Iowa Total Care Pharmacy Benefit, as well as medications that may require Prior Authorization (PA). Please visit the Iowa Total Care website at www.iowatotalcare.com for a link to the State's current PDL and PA criteria.

Some members may have copayment or cost share when utilizing their prescription benefits. Refer to the Iowa Total Care Member ID card for information or call Iowa Total Care at **833-404-1061**.

Who Receives Pharmacy Benefits Through Iowa Total Care

Iowa Total Care administers the Medicaid pharmacy benefit. Medicaid benefits are always paid "last". That is, if a member has another insurance plan in addition to Iowa Total Care, that other insurance plan will be primary. If the primary plan is a commercial insurer, Medicaid benefits may cover the remaining portion (copay) after the primary insurance has paid. Medicaid will not cover the remaining portion if the service is not a covered pharmacy benefit (such as for drugs to treat infertility or erectile dysfunction).

If a member has both Medicaid and Medicare, they are dual-eligible. Dual eligible members have their pharmacy benefit through Medicare Part D Plans, and because they qualify for Medicaid, they automatically qualify for the "extra help" feature that is available to low income Medicare recipients. The terms of their coverage (which drugs are covered, days' supply offered, etc.) is determined by the Medicare Part D Plan. Dual eligible members do not have pharmacy benefits administered through Iowa Total Care.

Preferred Drug List (PDL)

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

require Prior Authorization. Visit the Iowa Total Care website at www.iowatotalcare.com for a link to the state's current PDL and criteria.

The Preferred Drug List does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the independent professional judgment of a provider or pharmacist.
- Relieve the provider or pharmacist of any obligation to the member or others.

The State of Iowa PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a notation throughout the PDL.

In addition to the State of Iowa PDL, a voluntary list known as the Recommended Drug List (RDL) is available on the posted State of Iowa PDL. Recommended drug means a drug placed on a voluntary list designed to inform prescribers of cost-effective alternatives and, if used, will result in a cost savings to the Medicaid program. The drug does not require a Prior Authorization unless noted.

Working With the Pharmacy Benefit Manager (PBM)

Iowa Total Care works with Envolve Pharmacy Solutions to administer pharmacy benefits, including the Prior Authorization process. Certain drugs require Prior Authorization to be approved for payment by Iowa Total Care.

These include:

- Non-preferred medications, notated with an 'N' on the Preferred Drug List
- Some State of Iowa preferred drugs, notated with a 'P' and/or code '11' in the comments column on the Preferred Drug List.

Pharmacy Prior Authorization

The State of Iowa PDL includes a broad spectrum of brand name and generic drugs. Prescribers are encouraged to prescribe from the State of Iowa PDL for their patients who are members of Iowa Total Care. Some drugs will require PA (Prior Authorization).

All reviews are performed using the PA criteria established by the State of Iowa Drug Utilization Review (DUR) Commission. Once approved, Envolve Pharmacy Solutions notifies the prescriber by fax. If the clinical information provided does not meet the medical necessity and/or Prior Authorization guidelines for the requested medication, Iowa Total Care will notify the member and the prescriber of medication alternatives, when applicable, in addition to providing information for the appeal process.

Drug Prior Authorization requests can be submitted to Envolve Pharmacy Solutions through phone or fax. To ensure timeliness of our members' pharmacy needs, Iowa Total Care has a strict twenty four (24) hour turnaround time requirement to process these requests.

Phone

The Envolve Pharmacy Solutions Authorization (PA) help desk is staffed with PA triage specialists Monday through Friday, 9 a.m. to 8 p.m. (CST). Prescribers may call Envolve Pharmacy Solutions to initiate a PA by calling **866-399-0928**.

During regular business hours, licensed clinical pharmacists and pharmacy technicians are available to answer questions and assist providers. For assistance outside of regular business hours, providers can call the Nurse Advice Line at **833-404-1061.**

FAX

Iowa Total Care/Envolve Pharmacy Solutions authorization request forms can be found on iowatotalcare.com. Prescribers can locate the forms under the pharmacy section under the provider heading. Upon completing the form, fax it to Envolve Pharmacy Solutions at **877-386-4695**. Once approved, Envolve Pharmacy Solutions will notify prescriber by fax.

When medical necessity criteria is not met based on the clinical information submitted, the prescriber will be notified of the reason by fax. The notification will include PDL alternatives, if applicable.

If a prior authorization is denied, a member may request an appeal. A member can call us at 1-833-404-1061 (TTY: 771). If a member calls, they must also ask us in writing at:

Iowa Total Care
ATTN: Appeals
1080 Jordan Creek Parkway, Suite 100 South
West Des Moines, IA 50266

A member may also have a provider make an appeal on their behalf, if the member tells us in writing. More information on the appeal process can be found on page 82 of this manual.

Pharmacy Claim Submission

For Envolve Pharmacy Solutions Pharmacy Paper Claim submissions, send correspondence to:

Attn: Envolve Pharmacy Solutions
Pharmacy Claim Submission
5 River Park Place East, Suite 210
Fresno, CA 93720

Compounds

Compounded prescriptions must be submitted online and each ingredient must have an active and valid National Drug Code (NDC). Compounded medications may be subject to Prior Authorization based on ingredients submitted. Compounds that have a commercially available product are not reimbursable.

Pharmacy Copayments

Some Iowa Total Care members will have a $1.00 copay for prescription medications. Copayments depend on the member's plan. There are members who are exempt from copays such as pregnant women and children under 19 years of age.

72- Hour Emergency Supply of Medications

Federal law allows dispensing of a 72-hour supply of medication in an emergency situation. Iowa Total Care will allow a 72-hour supply of medication to any patient awaiting a PA determination, unless PA criteria does not allow. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication (unless PA criteria does not allow), whether or not the PA request is ultimately approved or denied. The pharmacy will contact the Envolve Pharmacy Solutions Pharmacy Help Desk at toll-free **844-792-2436** for a prescription override to submit the 72 -hour medication. The pharmacy help desk call center is available twenty-four (24) hours a day, seven (7) days a week.

Some behavioral health medications may allow for seven (7)-days' supply. Refer to State of Iowa PDL for information.

Newly Approved Products

New FDA approved drugs will be evaluated by the Pharmacy and Therapeutics (P&T) Committee at the next scheduled meeting. They will require a Prior Authorization before the P&T Committee review. If Iowa Total Care does not grant prior authorization, the member and prescriber will be notified and given information regarding the appeal process.

Step Therapy

Some medications listed on the State of Iowa PDL may require specific medications to be used before the member can receive the requested medication. If Iowa Total Care has a record that the required medication met the Step Therapy criteria, the medications are automatically covered. If Iowa Total Care does not have a record that the specific medication was tried, the member or prescriber may be required to provide additional information. If Iowa Total Care does not grant authorization, the member and prescriber will be notified and provided information regarding the appeal process.

Benefit Exclusions

The following drug categories are not part of the Iowa Total Care benefit and are not covered:

- Fertility- enhancing drugs.
- Anorexia, weight -loss or weight -gain drugs.
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective.
- Drugs and other agents used for cosmetic purposes or for hair growth.
- Erectile dysfunction drugs prescribed to treat impotence.

So called DESI (Drug Efficacy Study Implementation) drug products are not covered as part of the Medicaid pharmacy benefit, because they are not recognized as being safe and effective (by the FDA), and there is not a compelling justification for their use.

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum 31- day supply. Some contraceptives can be filled up to a 90- days supply. Dispensing outside the Quantity Limit (QL) or Age Limit (AL) requires prior authorization. Iowa Total Care may limit how much of a medication a member can get at one time.

If the prescriber recommends a member receive a higher quantity limit due to a medical reason, the prescriber can submit for prior authorization. . If Iowa Total Care does not grant a PA approval, the member and prescriber will be notified and provided with information regarding the appeal process.

Some medications on the State of Iowa PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns, as well as current medically accepted quality standards of care as supported by clinical literature. There is always consideration for an exception during the PA review for medically necessary treatments.

Over-the-Counter Medications (OTC)

The pharmacy program covers approved OTC medications listed in the State of Iowa PDL. Some OTC medications may require prior authorizations. All OTC medications must be written on a valid prescription by a licensed physician in order to be reimbursed. Refer to the State of Iowa PDL for a list of covered OTC products using the link provided on the Iowa Total Care website, www.iowatotalcare.com.

PROVIDER RELATIONS AND SERVICES

Provider Relations

Iowa Total Care's Provider Relations is committed to supporting providers as they care for our members. Through provider orientation, ongoing training and support of daily business operations, we will strive to be your partners in good care. Upon credentialing approval and contracting, each provider will be assigned a Provider Relations Representative. The Provider Relations Representative will contact the provider to schedule an orientation.

Reasons to Contact a Provider Relations Representative

- Report any changes to your practice (locations, NPI, TIN numbers).
- Initiate credentialing of a new practitioner.
- Schedule an in-service training for new staff.
- Conduct ongoing education for existing staff.
- Obtain clarification of policies and procedures.
- Obtain clarification of a provider contract.
- Request fee- schedule information.
- Obtain member roster.
- Obtaining Provider Profiles.
- Learn to use electronic solutions on web authorizations, claims submissions and member eligibility.
- Open/close patient panel.

Provider Services

Iowa Total Care Provider Services team is available to assist providers toll free at **833-404-1061** Monday through Friday 7:30 a.m. to 6:00 p.m. CST. Closed on State holidays.

CREDENTIALING AND RE-CREDENTIALING

Iowa Total Care maintains a high quality healthcare delivery system, and our credentialing and re-credentialing processes help us achieve this by validating the professional competency and conduct of our providers.

The process includes verifying the provider's enrollment with the Iowa Medicaid Enterprise, their licensure, board certification, education, and the identification of adverse actions, including malpractice or negligence claims, through checks with applicable state and federal agencies and the National Practitioner Data Bank.

Iowa Total Care requires re-credentialing every three years (3) to maintain up-to-date provider professional information. Providers are also required to notify Iowa Total Care of any changes to

their credentialing information in a timely manner. This information is essential for Iowa Total Care's members, who depend on the accuracy of the provider directory.

Which Providers Must Be Credentialed?

The following providers are required to be credentialed:

Medical Practitioners

- Medical Doctors
- Chiropractors
- Osteopathic Doctors
- Podiatrists
- Nurse Practitioners
- Physician Assistants
- Other Medical Practitioners

Behavioral Health Practitioners

- Psychiatrists and other Physicians
- Addiction Medicine Specialists
- Doctoral or Master's Level Psychologists
- Master's Level Clinical Social Workers
- Master's Level Clinical Nurse Specialists or Psychiatric Nurse Practitioners
- Other Behavioral Healthcare Specialists

Facility and Other Providers

- Hospitals, home health agencies, skilled nursing facilities, FQHCs, RHCs, laboratory testing/diagnostic facilities, rehabilitation centers, durable medical equipment providers, and freestanding surgical centers.
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.
- Other atypical long term services and supports (LTSS) providers, including home and community-based services (HCBS) and long term care (LTC) institutional-based services providers.

Information Provided at Credentialing

All new providers and those adding providers to their practice must be enrolled through the Iowa Medicaid Enterprise and submit, at a **minimum,** the following information when applying for participation in Iowa Total Care's network:

- Completed, signed and dated Iowa State Universal Practitioner Credentialing Application no older than one hundred and twenty (120) days *or*
- Authorize Iowa Total Care to access applicant's information on file with the Council for Affordable Quality Health Care (CAQH) at www.CAQH.org .

- Current malpractice insurance coverage detailed on the credentialing application; *or* a copy of provider's current malpractice insurance policy face-sheet that includes expiration dates, amounts of coverage and provider's name; *or* evidence of compliance with applicable Iowa regulations regarding malpractice coverage; *or* alternative coverage.
- Copy of current Drug Enforcement Administration (DEA) registration Certificate, if applicable.
- Copy of current Iowa Controlled Substance registration certificate, if applicable.
- Hospital admitting privileges or arrangements for the following practitioner types: MD, DO, DPM, CMW, NP, and PA.
- Completed and signed W-9 form...
- Curriculum vitae listing, at a minimum, a five-year work history (not required if work history is completed on the application).
- Proof of highest level of education: copy of certificate or letter certifying formal post-graduate training.
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable.

All providers (hospital, facility, group, clinic or ancillary provider) must be enrolled through the Iowa Medicaid Enterprise and submit the following:

- Completed, signed, and dated Iowa Total Care Facility Application with the attachments requested that is no older than 365 calendar days.
- Copy of State Operational License.
- Copy of Accreditation Certificates by a nationally recognized accrediting body, (e.g.: TJC/JCAHO), if applicable.
    - If not accredited, a copy of the provider's most recent state or CMS survey, including response to any corrective actions, and response from surveyor recognizing corrective action taken by provider.
- Completed and signed W-9 form.
- Other applicable State/Federal Licensures (e.g.: such as CLIA, DEA, Pharmacy, or Department of Health).
- Roster (in an approved Iowa Total Care format) or CAQH data form for each practitioner employed by the provider.
- Current malpractice and/or general liability insurance coverage detailed on the credentialing application; or a copy of their current malpractice insurance policy face-sheet that includes expiration dates, amounts of coverage and provider's name; or evidence of compliance with applicable Iowa regulations regarding malpractice coverage; or alternate coverage.

All HCBS providers must be enrolled through the Iowa Medicaid Enterprise and submit the following:

- Completed, signed, and dated Iowa Total Care HCBS Waiver Provider Application
- For Consumer Directed Attendant Care (CDAC) Agency only: Completed Iowa Total Care Provider Attestation Statement.
- Copy of Certificate and/or Licensures, as applicable.

- Other applicable State/Federal Licensures (e.g. CLIA, DEA, Pharmacy, or Department of Health).
- Completed and signed W-9 form.
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage) that meets the minimum required amount set by the State of Iowa, as applicable to the services each HCBS waiver provider is contracting to provide.

Credentialing Process

When Iowa Total Care receives an application or re-credentials, we verify the following information:

- Provider's enrollment with the Iowa Medicaid Enterprise.

- Current licensure through the appropriate licensing agency.
- Board certification, or residency training, or medical education.
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions.
- Hospital privileges in good standing.
- Federal and State sanctions and exclusions, including the following sources:
    a. Office of Inspector General (OIG)
    b. The System for Award Management (SAM)
    c. Medicare Opt-Out Listing
    d. Iowa List of Excluded Individuals/Entities

Once the provider's credentialing application is reviewed for completeness, the Iowa Total Care Credentialing Committee makes a final decision at its next regularly scheduled meeting.

Credentialing Committee

The Credentialing Committee establishes and adopts criteria for provider participation in Iowa Total Care's network. The committee also oversees all credentialing procedures, including provider participation, denial and termination. Iowa Total Care ensures that the credentialing of all providers applying to our network is completed as follows: 85 percent within thirty (30) days; 98 percent within forty-five (45) days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the decision regarding their application.

Providers must be credentialed prior to accepting or treating members, unless Prior Authorization has been obtained to treat the member as an out-of-network provider. PCPs cannot accept member assignments until they are fully credentialed.

Site visits are performed at provider offices within sixty (60) days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the provider's site visit score is less

than 80 percent, the provider may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices, and safety procedures.

Committee meetings are held no less than ten times per year and more often as deemed necessary.

Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Re-Credentialing Process

To comply with accreditation standards, Iowa Total Care re-credentials all providers at least every three years from the date of the initial credentialing decision to identify any changes in the provider's licensure, sanctions, certification, competence, or health status that may affect their ability to perform services.

In between credentialing cycles, Iowa Total Care conducts ongoing monthly monitoring activities on all network providers. This includes an inquiry to the appropriate state licensing agency to identify newly disciplined providers or those with a change in their licensure status. This helps make certain that providers are maintaining a current, active, unrestricted license to practice between credentialing cycles. Additionally, Iowa Total Care reviews monthly reports from the OIG, SAM, and Medicare Opt Out to identify network providers who are newly sanctioned or excluded from participation in Federal and State programs.

Loss of Network Participation

A provider's agreement may be terminated at any time if Iowa Total Care's Credentialing Committee determines the provider no longer meets credentialing requirements.

Upon notification from regulatory agencies or State licensing boards that a provider is suspended or terminated from participation in Medicaid or Medicare Programs, Iowa Total Care will immediately act to terminate the provider from participation in its network. Terminations for loss of licensure and criminal convictions will coincide with the effective date of the action.

Right to Review and Correct Information

All providers participating within the Iowa Total Care network have the right to review information obtained by the health plan that was used to evaluate the providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, malpractice insurance carriers, and State licensing agencies. This does not allow a provider to examine peer review-protected information, such as references, personal recommendations, or other information.

If a provider identifies any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process

differ from that submitted by the provider, the provider has the right to correct any erroneous information submitted by another party. To request release of such information, a provider must submit a written request to Iowa Total Care's Credentialing Department at:

Iowa Total Care Credentialing Manager
7700 Forsyth Boulevard
St. Louis, MO 63105

Upon receipt of this information, the provider has fourteen (14) days to provide a written explanation detailing the error or the difference in information. The Iowa Total Care Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

Right To Be Informed of Application Status

Providers who have submitted an application to join Iowa Total Care's network have the right to be informed of the status of their application upon request. To obtain status, contact your Provider Network Specialist or call the Provider Services line toll-free at 833-404-1061.

Right To Appeal Adverse Credentialing Decisions

Iowa Total Care may decline an applicant's participation for reasons such as quality of care or liability claims issues. In such cases, the provider has the right to request reconsideration in writing within fourteen (14 days) of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration. The Credentialing Committee will review the reconsideration request at its next regularly scheduled meeting, but no later than sixty (60 day) s from the receipt of the additional documentation. Iowa Total Care will send a written response to the provider within two weeks of the final decision.

The applicant will be sent a written response to his/ her request within two (2) weeks of the final decision. A written request for appeal should be sent to:

Credentialing Manager
7700 Forsyth Blvd.
St. Louis, MO 63105

MEMBER AND PROVIDER RIGHTS AND RESPONSIBILITIES

Member Rights

Iowa Total Care expects providers to respect and honor members' rights, including the right to:

- Receive information about Iowa Total Care, its services, and its providers.

- Be treated with respect and with due consideration for his or her dignity and privacy, including but not limited to the right to fully participate in the community and to work, live, and learn to the fullest extent possible.
- Receive information on available treatment options and alternatives that are presented in a manner that the member is able to understand.
- Participate in decisions about their healthcare. This includes the right to refuse treatment.
- Get care right away for an Emergency Medical Condition.
- Decide about their health care and to give permission before the start of diagnosis, treatment, or surgery.
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected.
- Have the personal information in medical records kept private.
- Report any complaint or grievance about a provider or their medical care.
- File an appeal of an action that reduces or denies services based on medical criteria.
- Express a concern or appeal to the Ombudsman's office.
- Receive interpretation services.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Not be discriminated against due to race, color, national origin, health status, or the need for healthcare services.
- Request a second opinion.
- Be notified at the time of enrollment and annually of dis-enrollment rights.
- Make an Advance Directive and to file a complaint with the Iowa DHS if they feel it is not followed.
- Choose a provider who gives care whenever possible and appropriate.
- Receive accessible healthcare services equivalent in amount, duration, and scope to those provided under Medicaid FFS and sufficient in amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished.
- Receive appropriate services not denied or reduced solely because of diagnosis, type of illness or medical condition.
- Freedom to exercise the rights described herein, without any adverse effect on treatment by the Iowa Department of Human Services, Iowa Total Care, its providers, or contractors.

- Receive all written member information from Iowa Total Care:
    - At no cost to the member.
    - In the prevalent non-English languages of members in the service area.
    - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- Oral interpretation services free of charge for all non-English languages, not just those identified as “prevalent” and help getting the services.
- Get help from both Iowa Department of Human Services and its Enrollment Broker in understanding the requirements and benefits of Iowa Total Care.

Member Responsibilities

Members have certain responsibilities to:

- Inform Iowa Department of Human Services of changes in family size.
- Inform Iowa Department of Human Services if the member moves out of the Region, out-of-state or have other address changes.
- Inform Iowa Total Care if the member obtains or has health coverage under another policy, other third party, or if there are changes to that coverage.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.
- Take actions toward improving their own health, their responsibilities and any other information deemed essential by Iowa Total Care.
- Keep appointments and follow-up appointments.
- Access preventive care services.
- Receive Information on any of cost-sharing responsibilities.
- Learn about Iowa Total Care coverage provisions, rules and restrictions.
- Choose a PCP.
- Treat providers and staff with dignity and respect.
- Inform Iowa Total Care of the loss or theft of a member ID card.
- Present member ID card(s) when using healthcare services.
- Call or contact Iowa Total Care to obtain information and have questions clarified.
- Provide providers with accurate and complete medical information.
- Follow prescribed treatment of care recommended by a provider or let them know

the reason(s) treatment cannot be followed, as soon as possible.

- Ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives and make care decisions after weighing all factors.
- Understand health problems and participate in developing mutually agreed upon treatment goals with their provider to the highest degree possible.
- Make their PCP aware of all other providers who are treating them. This is to ensure communication and coordination in care. This also includes Behavioral Health Providers.
- Follow the grievance process established by Iowa Total Care (and as outlined in the Member Handbook) if there is a disagreement with a provider.

Provider Rights

Iowa Total Care providers have the right to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments.
    - Provide information regarding the nature of treatment options.
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered.
    - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment, as well as the benefits of such treatment options.
- Be treated by their patients and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have their patients act in a way that supports the care given to other patients and does not interfere with their operations.
- Expect other network providers to act as partners in members' treatment plans.
- File a dispute with Iowa Total Care for payment issues and/or utilization management, or a general complaint with Iowa Total Care and/or a member.
- File a grievance or an appeal with Iowa Total Care on behalf of a member, with the member's written consent.
- Have access to information about Iowa Total Care Quality Management/Quality Improvement (QM/QI) programs, including program goals, processes, and outcomes

that relate to member care and services.

- Contact Iowa Total Care Provider Services with any questions, comments, or problems.
- Collaborate with other healthcare professionals who are involved in the care of members.
- Not be discriminated against by Iowa Total Care based solely on any characteristic protected under State or Federal non-discriminate laws. Iowa Total Care does not, and has never had a policy of terminating a provider who:
    - Advocated on behalf of a member
    - Filed a complaint against us
    - Appealed a decision of ours
- Not be discriminated against by Iowa Total Care in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This does not require Iowa Total Care to contract with providers beyond the number necessary to meet the needs of members, preclude Iowa Total Care from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Iowa Total Care from establishing measures that are designed to maintain quality of services and control costs, or consistency with responsibilities to members.
- Not be discriminated against for: serving high-risk populations or specializing in the treatment of costly conditions; filing a grievance on behalf of and with the written consent of an enrollee, or helping an enrollee to file a grievance; protesting a plan decision, policy, or practice the healthcare provider believes interferes with their ability to provide medically necessary and appropriate healthcare.
- Not be discriminated against based on any of the following: race/ethnicity, color, national origin, gender, age, lifestyle, disability, religion, sexual orientation, specialty/licensure type, geographic location, patient type in which the practitioner specializes, financial status, or on the basis of the provider's association with any member of the aforementioned protected classes.

Provider Responsibilities

Iowa Total Care providers have the responsibility to:

- Treat members with fairness, dignity, and respect.
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- Maintain the confidentiality of members' personal health information, including

medical records and histories, and adhere to State and Federal laws and regulations regarding confidentiality.

- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restriction on the use and disclosure of their personal health information.
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records, and be able to request that they be amended or corrected as specified in 45 CFR §164.524 and §164.526.
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Respect members' Advance Directives and include these documents in the members' medical record.
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- Follow all State and Federal laws and regulations related to patient care and patient rights.
- Participate in Iowa Total Care data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- Review clinical practice guidelines distributed by Iowa Total Care.
- Comply with Iowa Total Care Medical Management program as outlined in this manual.
- Disclose overpayments or improper payments to Iowa Total Care.
- Not deny services to a member due to inability to pay the copayment if the household income is at or below 100% Federal Poverty Level.

- Reimburse copayments to members who have been incorrectly overcharged.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Iowa Total Care information regarding other insurance coverage.
- Notify Iowa Total Care in writing if the provider is leaving or closing a practice.
- Update their enrollment information/status with the Iowa Medicaid program if there is any change in their location, licensure or certification, or status via the Iowa Medicaid's Provider Web Portal.
- Contact Iowa Total Care to verify member eligibility or coverage for services, if appropriate.
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems they may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Office hours of operation offered to Medicaid members will be no less than those offered to commercial members.
- Not be excluded, penalized, or terminated from participating with Iowa Total Care for having developed or accumulated a substantial number of patients in Iowa Total Care with high-cost medical conditions.
- Coordinate and cooperate with other service providers who serve Medicaid members, such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, and school- based programs as appropriate.
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- Disclose to Iowa Total Care, on an annual basis, any Physician Incentive Plan (PIP) or risk arrangements the Provider or Provider Group may have with providers either within its group practice or other providers not associated with the group practice, even if there is no substantial financial risk between Iowa Total Care and the provider or provider group.
- Provide services in accordance with applicable State and Federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement.
- Allow Iowa Total Care direct access (not via vendor) to medical records for the

purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.

- Review and follow clinical practice guidelines distributed by Iowa Total Care.
    - Document medical chart with up to three outreach attempts by phone to members who have not completed an office visit in the past twelve (12) months or more.
    - Have been discharged from an inpatient-stay within the last twenty-four (24) hours since notification.
    - Have a gap-in-care overdue by thirty (30) or more days.
- Develop report based on Iowa Total Care specification to submit monthly clinical data feed from the Electronic Medical Record (EMR) system within one (1) year of enrolling in the Iowa Total Care Provider Network.
- Comply with Iowa Risk Adjustment programs that rely on complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines.
- Providers must allow for and process voluntary payroll deductions of fringe benefits or wage supplements for any employee who requests it, in accordance with the Wage Payments and Collection Law (43 P.S. §§ 260.2a and 260.3).
- Report all suspected physical and/or sexual abuse and neglect.
- Report communicable disease to Iowa Total Care.:
    - Iowa Total Care must work with DHS State and District Office epidemiologists in partnership with the designated county or municipal health department staffs to appropriately communicate reportable conditions.

MEMBER GRIEVANCE AND APPEALS PROCESSES

A member, a member's authorized representative, or a member's provider (with written consent from the member), may file an appeal or grievance either verbally or in writing.

Iowa Total Care gives members reasonable assistance in completing all forms and taking other procedural steps of the appeal and grievance process, including, but not limited to, providing translation services, communication in alternative languages, toll-free numbers with TTY/TDD, and interpreter capability.

Grievances

Grievances are defined as any expression of dissatisfaction about any matter other than an adverse benefit determination provided to Iowa Total Care by a member and their authorized representative. Examples of these type of complaints include, but are not limited to:

- Unclear and inaccurate information from staff
- Quality of care or services provided to a member
- Rudeness of a provider or employee
- Failure to respect a member's rights
- Harmful administrative processes or operations
- Disagreements with the decision to extend an appeal timeframe

Iowa Total Care wants to resolve member concerns. We will not hold it against the member if they file a grievance. We will not treat members differently.

How To File a Grievance

A member may file a grievance at any time by doing one of the following:

- Call Member Services toll-free at **833- 404-1061** (TDD/TTY: 711).
- Send a fax to **833- 809-3868**.
- Send an email to AppealsGrievances@IowaTotalCare.com
- Deliver to us in person or by mail at:

  Iowa Total Care
  ATTN: Grievances

  1080 Jordan Creek Parkway

  Suite 100 South

  West Des Moines, IA 50266

Be sure to include:

- Member first and last name
- Member Medicaid ID number
- Member address and telephone number

- Member's complaint about why they are unhappy
- What the member would like to have happen to resolve the complaint Iowa Total Care will send a letter within three (3) business days to acknowledge receipt of the grievance.

If another person files a grievance for a member, Iowa Total Care must have written permission from the member for that person to act on the member's behalf unless that person is the member's legal authorized representative. No one can act on a member's behalf without written permission.

If filing a grievance on behalf of a member, you will need to provide an Authorized Representative Designation Form, signed by the member, to Iowa Total Care. To obtain this form, contact Member Services or find it on the Iowa Total Care website at (www.iowatotalcare.com). You or the member can return it by mail or fax. Members can also call Member Services for assistance.

A member may have additional information supporting their grievance. If so, please send it along with the grievance so we can add it to our information. Members may ask to receive copies free of charge of any documentation Iowa Total Care uses to make the decision about the member's grievance.

Iowa Total Care will work to resolve the grievance as expeditiously as the member's condition warrants and will send a resolution notice within thirty (30) calendar days of the receipt of the grievance.

Appeals

An appeal is a request for Iowa Total Care to review an adverse benefit determination made by Iowa Total Care. Members may appeal a service that has been denied, limited, reduced or terminated.

Appeals may be filed by a member (parent or guardian of a minor member) or authorized representative with the written consent of the member to act on their behalf. Appeals may be filed verbally or in writing. Verbal appeals must be followed by a written, signed appeal.

When Iowa Total Care issues a "Notice of Adverse Benefit Determination" to the member, the member may file an appeal within sixty (60) calendar days from the date on the Notice.

Members can request copies of any documentation Iowa Total Care used to make the decision about their care or appeal. Members can also request a copy of their member records. These copies will be free of charge. We will not hold it against a member if he/she files an appeal. We will not treat members differently in any way.

How To File an Appeal

Members may file an appeal by doing one of the following:

- Call Member Services toll-free at **833- 404-1061** (TDD/TTY: 711).
- Send it electronically by fax to **833- 809-3868**.
- Send an email to AppealsGrievances@IowaTotalCare.com
- Deliver In person or by mail at:

Iowa Total Care
ATTN: Appeals
1080 Jordan Creek Parkway
Suite 100 South
West Des Moines, IA 50266

After we receive a member's call, written, or electronic appeal, we will send a letter within three (3) business days of receipt of the appeal acknowledging the appeal has been received. If the

appeal was received orally, we must receive a written appeal that is signed by the member or the member's authorized representative to complete the appeal.

Iowa Total Care will send an appeal resolution letter within thirty (30) calendar days of receipt of an appeal request. Iowa Total Care wants to resolve appeal concerns quickly, and will resolve member appeals within thirty (30) calendar days of filing with us. If we cannot resolve the member's appeal in thirty (30) calendar days, we may extend the timeframe by up to fourteen (14) calendar days to gather more information to assist in our decision. If Iowa Total Care needs more than thirty (30) calendar days to resolve the appeal, with approval of the State, Iowa Total Care will notify the member in writing of the reason for the delay within two (2) calendar days. Members may also request an extension. To request an extension, call Member Services toll-free at **833-404-1061** (TDD/TTY: 711). The Authorized Representative Designation Form must be sent in with the appeal and must be received within 60 days from the date of the Adverse Benefit Determination notice.

If a member needs help filing an appeal, call Member Services at **833- 404-1061**(TDD/TTY: 711). We have representatives to help members Monday through Friday, 7:30 a.m. to 6:00 p.m. CST.

Continuation of Benefits During the Appeal Process

Members may request services continue while Iowa Total Care reviews their appeal and during the State Fair Hearing process, if it is not resolved at the first appeal level. Members must request to continue services within ten (10) days of the effective date on the Adverse Benefit Determination notice.

IMPORTANT: If the final resolution of the appeal or State Fair Hearing is adverse to the member, that is, upholds Iowa Total Cares adverse benefit determination, Iowa Total Care may recover the cost of services furnished to the member while the appeal and State Fair Hearing was pending to the extent that they were provided during the appeal and State Fair Hearing process.

Expedited Appeal Decisions

If the member's health or function is at immediate risk, an expedited appeal may be requested. A request may be submitted verbally and does not require a written request or member consent. Expedited appeals will be reviewed as soon as the member's condition warrants and no later than within seventy-two (72) hours of our receiving the request. To request an expedited appeal, call Iowa Total Care at **833- 404-1061**(TDD/TTY: 711). Iowa Total Care will make reasonable efforts to verbally notify the requestor and the member of the expedited appeal decision.

State Fair Hearings

If a member is not satisfied with an Iowa Total Care appeal decision, they have the right to request a State Fair Hearing. Members must exhaust Iowa Total Care's internal appeal process before they can file a request for a State Fair Hearing. Members have one hundred and twenty (120) calendar days from the date on the appeal decision notice to request a State Fair Hearing. Members may request their services to continue during the State Fair Hearing process.

The member or their authorized representative can ask the Iowa Department of Human Services for a State Fair Hearing. Requests for a State Fair Hearing can be submitted in person, online, by telephone or in writing.

To file online visit: http://dhs.iowa.gov/node/966/ To file in writing submit requests to:

Department of Human Services
Appeals Section, 5th Floor
1305 E. Walnut
Des Moines, IA 50319-0114

If you need help filing a State Fair Hearing request or want to file by telephone, contact the DHS Appeals Section at **515 281-3094**.

PROVIDER COMPLAINTS

Complaint Process

Iowa Total Care maintains written policies and procedures for the filing of provider complaints. A provider has the right to file a complaint with us. Provider complaints will be resolved within thirty (30) calendar days. If the provider complaint is not resolved within thirty (30) calendar days, we shall request a fourteen (14) calendar day extension from the provider. If the provider requests the extension, the extension will be approved by us.

Providers may file a complaint regarding ITC policies, procedures, or any aspect of ITC administrative functions. Complaints are spoken or written expressions of dissatisfaction.

Iowa Total Care wants to resolve provider concerns. We will not hold it against the provider if he/she files a complaint. We will not treat providers differently.

How To File a Complaint

Providers can file a complaint in any way that works best for them. They can:

- Call Provider Services at **833-404-1061**(TDD/TTY: 711)
- Send a fax to **833-208 1397**
- Deliver in person or by mail:

Iowa Total Care
ATTN: Complaints
1080 Jordan Creek Parkway
West Des Moines, IA 50266

FRAUD, WASTE, AND ABUSE

Iowa Total Care takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with State and Federal laws.

Fraud means the intentional deception or misrepresentation an individual or entity makes knowing that that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes “reckless disregard” of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

Waste means the incorrect submission of claims due to factors such as uneducated office staff, coding illiteracy, staff turnover, or keying errors. Wasteful billing can typically be resolved after the provider or subcontractor and office staff is educated on proper billing requirements and/or claim submission.

Abuse: means practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the health plan. It includes billing for services that are not covered or medically necessary or that fail to meet professionally recognized standards for health- care. Abuse also includes enrollee and provider practices that result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive.

Iowa Total Care, successfully operates a Special Investigations Unit (SIU), with dedicated staff that reside in Iowa. This unit routinely inspects claims submitted to assure that Iowa Total Care is paying appropriately for covered services. Iowa Total Care performs front- and back- end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, review the Billing Manual located on our website. Iowa Total Care also performs retrospective audits which, in some cases may result in taking actions against providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include, but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Referral to the Iowa Program Integrity Unit
- Referral to the Medicaid Fraud Control Unit
- Onsite investigations
- Corrective action plan
- Any other remedies available to rectify the issue

Iowa Total Care instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- U.S. Criminal Codes

Iowa Total Care requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all Iowa Total Care members. Examples of such violations include: bribery; false claims; conspiracy to commit fraud; theft or embezzlement;, false statements; mail fraud; health care fraud; obstruction of a State and/or Federal health- care fraud investigation; money laundering; failure to provide medically necessary services; marketing schemes; prescription forging or altering; physician illegal remuneration schemes; compensation for prescription drug switching; prescribing drugs that are not medically necessary; theft of the prescriber's DEA number or prescription pad; identity theft; or members' medication fraud.

Training is available via our company website at: www.iowatotalcare.com. that providers can download in PDF format. We also include FWA training in our Provider Orientation packets. To report any fraud, waste and/or abuse concerns call the Fraud and Abuse Line at **866-685-8664**.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Iowa Total Care auditors request medical records for a defined review period. Providers have two (2) weeks to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Iowa Total Care will recover all amounts paid for the services in question.

Iowa Total Care auditors review cases for common FWA practices, including:

- Unbundling of codes.
- Up-coding services.
- Add-on codes billed without primary CPT.
- Diagnosis and/or procedure code not consistent with the member's age/gender.
- Use of exclusion codes.
- Excessive use of units.
- Misuse of benefits.
- Claims for services not rendered.

Iowa Total Care auditors consider State and Federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like-specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Iowa Total Care will seek recovery of all overpayments. Depending on the number of services provided during the review period, Iowa Total Care may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard contractors, CMS Recovery Audit contractors, and Medicaid Fraud Control units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

Suspected Inappropriate Billing

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, call our anonymous and confidential FWA hotline at **866-685-8664**. Iowa Total Care takes all reports of potential fraud, waste, and/or abuse very seriously and investigates all reported issues.

Due to the evolving nature of fraudulent, wasteful, and abusive billing, Iowa Total Care may enhance the FWA program at any time. These enhancements may include, but are not limited to creating, customizing or modifying claim edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Fraud, Waste and Abuse Reporting

Providers may voluntarily disclose any suspected fraud, waste and/or abuse by using the reporting tool on the DHS website:

https://dhs.iowa.gov/ime/members/report-fraud-abuse

QUALITY MANAGEMENT

Iowa Total Care's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Management/Quality Improvement (QM/QI) program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs.

This system provides a continuous cycle for assessing and analyzing the quality of care and service among plan initiatives including: primary, secondary, and tertiary care; preventive health, acute and/or chronic care; over- and under-utilization; continuity and coordination of care; patient

safety; and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. The system allows for systemic analysis and re-measurement of barriers to care, the quality of care, and utilization of services over time.

Iowa Total Care recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health outcomes for our members.

Where the member's condition is not likely to improve, Iowa Total Care will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions.

Whenever possible, the Iowa Total Care QM/QI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of members.

Program Structure

The Iowa Total Care Board of Directors (BoD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BoD oversees the QM/QI Program and has established various committees and ad hoc committees to monitor and support the QM/QI Program.

The Quality Improvement Committee (QIC) is a senior management committee with Iowa Total Care network physician representation that is directly accountable to the BoD. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through: a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and, resolution of process problems; the identification of opportunities to improve member outcomes; and, the education of members, providers and staff regarding the quality and medical management programs.

The following committees report directly to the Quality Management Committee (QIC):

- Medical Management Committee (MMC)
- Pharmacy and Therapeutics Committee (P&T)
- Credentialing Committee (CC)
- Performance Improvement Team
- Joint Operations Committee
- Cultural Competency Committee
- HEDIS Steering Committee
- Peer Review Committee (ad hoc Committee)

In addition to the committees reporting to the QIC, Iowa Total Care has sub-committees and workgroups that report to the above committees including, but not limited to:

- Grievance and Appeals Committee
- Provider Advisory Committee
- Member Advisory Committee
- Stakeholder Advisory Board
- Community Advisory Committee
- Ad hoc committees may also include *regional level* committees for Member Advisory and/or Community Advisory based on distribution of membership.

Provider Involvement

Iowa Total Care recognizes the integral role provider involvement plays in the success of its QM/QI program. Provider involvement in various levels of the process is highly encouraged through provider representation and participation on the Quality Committees. Iowa Total Care encourages PCP, specialty, OB/GYN, pharmacy, LTSS and Behavioral Health representation on key Quality Committees, including, but not limited to: QIC; UMC; P&T; CC; Provider and Member Advisory; Stakeholder Advisory Board; and select ad hoc committees.

Quality Management/Quality Improvement (QM/QI) Program Scope

The scope of the QM/QI program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Iowa Total Care members. Iowa Total Care's QM/QI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including: preventive care; primary care; specialty care; acute care; short-term care; ancillary services; and operations.

Goals

Iowa Total Care's primary QM/QI program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

The Iowa Total Care QM/QI program monitors the following:

- Acute and chronic care coordination
- Behavioral Health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member grievances and appeals
- Member experience

- Medical Management, including population health management
- Member safety
- Primary Care provider changes
- Pharmacy
- PCP after-hours telephone accessibility
- Provider appointment availability
- Provider complaint system
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including over- and under-utilization

Patient Safety and Quality of Care

Patient Safety is a key focus of Iowa Total Care's QM/QI program. Monitoring and promoting member safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is: any alleged act or behavior that may be detrimental to the quality or safety of patient care; is not compliant with evidence-based standard practices of care; or that signals a potential sentinel event, up to and including death of a member.

Iowa Total Care employees (including Medical Management, Member Services, Provider Services, Appeal Coordinators, etc.), panel providers, facilities or ancillary providers, members or member representatives, medical directors or the BoD may advise the Quality Management (QM) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee (ad hoc Committee) as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

Iowa Total Care QIC reviews and adopts an annual QM/QI Program and Work Plan aligned with Iowa Total Care vision and goals and appropriate industry standards. The QM Department implements quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving member health outcomes, quality of access to care and services.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each performance improvement initiative is also designed to allow Iowa Total Care to monitor improvement over time. Quality performance measures have been identified based on the potential to improve health care for Iowa Total Care members. The measures are HEDIS measures, integrated behavioral health care, along with identified State metrics. Performance is measured against established benchmarks and progress to performance goals.

Annually, Iowa Total Care develops a QM/QI Work Plan for the upcoming year. The QM/QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service). It also includes timelines for completion and reporting to the QIC and requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QM/QI Work Plan.

Iowa Total Care communicates activities and outcomes of its QM/QI Program to both members and providers through avenues such as the member newsletter, provider newsletter, and the Iowa Total Care web portal at www.iowatotalcare.com.

At any time, Iowa Total Care providers may request additional information on the Health Plan programs, including a description of the QM/QI Program and a report on Iowa Total Care progress in meeting the QAPI Program Goals, by contacting the QI Department.

For any questions relative to Quality of Care or CIRs, please contact us at QOCCIR@IowaTotalCare.com and fax **833- 205-1251**.

Feedback on Provider Specific Performance

As part of the quality improvement process, performance data at an individual provider, practice or site level is reviewed and evaluated. This performance data may be used for quality improvement activities, including use by Iowa Total Care quality committees. This review of provider- specific performance data may include, but is not limited to:

- Site evaluation results, including: medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
- Preventive care, including: wellness exams, immunizations, prenatal care, lead screening, cervical cancer screening, breast cancer screening, and other age-appropriate screenings for detection of chronic diseases or conditions.
- Member appeal and grievance data.
- Utilization management data, including ER visits/1000 and bed days/1000 reports.
- Critical Incident reporting, sentinel events and adverse outcome.
- Compliance with clinical practice guidelines.
- Pharmacy data, including use of generics or specific drugs.

As part of its motivational incentive strategies, Iowa Total Care systematically profiles the quality of care delivered by high-volume PCPs to improve provider compliance with preventive health and clinical practice guidelines and clinical performance indicators. The profiling system is developed with network providers to ensure the process has value to providers, members, and Iowa Total Care, and may include a financial component

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Iowa Department of Human Services.

As both Iowa and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important; not only to the health plan, but to the individual provider. Iowa purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Provider specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for provider incentive programs, such as "Pay for Performance." These programs reward providers based on scoring of such quality indicators used in HEDIS.

How HEDIS Rates ARE Calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claims submitted to the health plan. Measures calculated using administrative data may include: annual mammogram; annual chlamydia screening; appropriate treatment of asthma; antidepressant medication management; access to PCP services; and utilization of acute and mental health services.

Hybrid rates consist of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate procedure and diagnosis codes can reduce the necessity of Medical Record Reviews (MRR). See Iowa Total Care website and HEDIS brochure for more information on reducing HEDIS medical record reviews and improving HEDIS scores. Measures typically requiring medical record review include: diabetic HbA1c, eye exam and nephropathy; controlling high blood pressure; cervical cancer screening; prenatal care; and, postpartum care.

When Medical Record Reviews (MRR) Occur for HEDIS?

MRR audits for HEDIS are usually conducted February through May each year. Iowa Total Care QM representatives, or a national MRR vendor contracted to conduct the HEDIS MRR on Iowa Total Care's behalf, may contact you if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Iowa Total Care which allows them to collect PHI on our behalf.

How to Improve HEDIS Scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill or report by encounter submission for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as, Body Mass Index (BMI) calculations, eye exam results, and blood pressure readings.

For questions, comments, or concerns related to the annual HEDIS project or the MRRs, contact the Quality Improvement Department toll-free **844-738-5019**.

MEDICAL RECORDS REVIEW (MRR)

Iowa Total Care providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Iowa Total Care to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records must be kept in a secure location.

Iowa Total Care requires providers to maintain all records for members for at least ten (10) years. See the Member Rights section of this manual for policies on member access to medical records. Iowa Total Care may conduct medical record reviews for the purposes including, but not limited to; utilization review; quality management; medical claim review; and member grievance/appeal investigation. Providers must meet 80% of the requirements for medical record keeping; elements scoring below 80% are considered deficient and in need of improvement. Iowa Total Care will work with any provider who scores less than 80% to develop an action plan for improvement. MRR results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re-credentialing.

Required Information

Medical records mean the complete, comprehensive member records including, but not limited to: X -rays; laboratory tests; results; examinations; and notes; accessible at the site of the

member's participating PCP or provider; that document all medical services received by the member. Services include inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable State rules and regulations, and signed by the provider rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data (e.g., employer, home telephone number, spouse, next –of-kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An appropriate history of immunizations is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Iowa Total Care's practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting appeal is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.

- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere. Including family-planning services, preventive services and treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- Appropriate notations concerning use of tobacco, alcohol and substance use; for members seen three or more times substance abuse history should be queried.
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an Advance Directive has been offered to adults 18 years of age and older. Additionally the LTSS Comprehensive Medical and Service Record should contain:
- Medication Record and Person-Centered Service Plan (PCSP/IPoC), where applicable.
- Provider Acknowledgement of PCSP.

Nursing Facility records will also include:

- Substantiation of Pre-Admission Screening and Resident Review (PASRR).Documentation of specialized services delivery.
- Evidence of education regarding Patient Rights and Responsibilities.
- Acknowledgement that the member was informed of any patient pay liability.
- Documentation of financial eligibility including audit of personal assets and authentication of known personal care accounts.
- Other processes identified by either Iowa Total Care or the Department of Human Services.

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a member's authorized representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need –to- know basis.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant

Business Associate Agreement with Iowa Total Care which allows them to collect PHI on our behalf.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Iowa Total Care members. If the member or member's authorized representative is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, this should also be noted in the medical record.

Who Conducts Medical Record Reviews (MRR) for HEDIS

Iowa Total Care may contract with an independent national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted from February through May each year. At that time, if any member medical records are selected for review, the provider will receive a call and/or letter from a medical record review representative. Prompt cooperation with the representative is greatly needed and appreciated.