Residential Care Facilities

Provider Manual

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III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. INTRODUCTION

This provider manual contains the policies and procedures of the Department of Human Services (referred to as "DHS" or "the Department") that govern participation of a residential care facility (RCF) in the State Supplementary Assistance (SSA) program.

To be eligible for SSA, a person must meet all of the following requirements:

- Be aged, blind, or disabled as determined by the Social Security Administration.
- Be a resident of Iowa.
- Receive Social Security Income (SSI) or would receive SSI except for excess income.
- Have resources of $2,000 or below for a single person or $3,000 or below for a married couple living together.

Individual eligibility for the program is determined by DHS. Facility contracts and payments are administered by the Department's Iowa Medicaid Enterprise.

Legal Basis

Title XVI of the Social Security Act, as amended by Public Law 92-603, authorizes the SSI program.

Iowa Code Chapter 249 authorizes the SSA program. DHS has adopted rules at 441 Iowa Administrative Code (IAC) Chapters 50 through 54 to administer the SSA program. Please see below to view individual chapters.

- 441 IAC Chapter 50: Application for Assistance
- 441 IAC Chapter 51: Eligibility
- 441 IAC Chapter 52: Payment
- 441 IAC Chapter 54: Facility Participation

The Department of Inspections and Appeals (DIA) has adopted the following rules at 481 Iowa Administrative Code which pertain to RCFs:

- 481 IAC Chapter 57: Standards for licensing RCFs
- 481 IAC Chapter 63: Standards for licensing of residential care facilities for the intellectually disabled
- 481 IAC Chapter 62: Standards for residential care facilities for persons with mental illness

- 481 IAC Chapter 60: Physical standards for all types of RCFs
- 481 IAC Chapter 50 and 481 IAC Chapter 56: General procedures for licensing, training, and enforcement

B. FACILITY PARTICIPATION REQUIREMENTS

1. Facility License

The facility providing care must be licensed by the Iowa Department of Inspections and Appeals (DIA) as a residential care facility (RCF) or a residential care facility for persons with an intellectual disability (RCF/ID) or a residential care facility for persons with mental illness (RCF/MI).

2. Institutional Status

No SSA payment can be made to a resident of a tax-supported facility providing residential care, unless the facility is licensed for 16 beds or less.

Tax-supported facilities include county homes and other residential care facilities that are owned or operated by an agency of the federal, state, or local government. These facilities are defined as public institutions by the Supplemental Security Income (SSI) program.

Persons residing in public institutions are not eligible for SSI unless the "institution" has less than 16 beds. Since SSA recipients must meet all SSI standards except for income, this restriction also applies to the SSA program.

3. *Application and Contract for Residential Care Facilities*, Form 470-0443

Each RCF shall complete a form 470-0443, *Application and Contract for Residential Care Facilities* in order for a provider to receive SSA payments. Use the form to:

- Spell out the conditions under which a facility may participate in the SSA program,
- Describe the responsibilities of the Department and the facility, and
- Serve as an application to participate in the cost-related system of payment for residential care within the state program.

The Department must approve this contract before any payment of SSA funds. The term of the contract is five years, subject to renewal.

Read the terms of the agreement very carefully before the application to participate is signed. By signing the application, the facility is accepting the terms of the agreement. The administrator of the facility shall sign for the

facility and the Chief of the Bureau of Long Term Service and Support (LTSS) shall sign for the Department.

4. Choice of Payment System

SSA Payments to a resident of an RCF are based on a maximum per diem rate. The maximum per diem rate is communicated to facilities through Informational Letters (ILs). ILs issued by the Department can be found here.

The RCF must accept the SSA payment established by DHS as payment in full for the RCF room and board expenses of Medicaid members.

5. Record Keeping

The facility must establish a record keeping system sufficiently complete to permit the recipient, DHS, DIA, and the Social Security Administration to make necessary inquiries and ensure continuity of care that allows for easy access.

a. Establishment of Personal Case Record

A case folder shall be maintained on each person residing in the facility. This record shall contain at least:

- The physician's statement certifying that the resident does not require nursing services,
- A fully completed form 470-0477, *RCF Admission Agreement*, (formerly PA-2365-6), signed by both the facility and the resident, and
- Proof of expenditures for a resident's "Personal Needs."

Click here to view form 470-0477 online.

See 481 IAC 57.16, 481 IAC 62.1, and 481 IAC 63.17. All entries in the resident's permanent record shall be current, dated, and signed.

b. Personal Need Allowance Managed by Facility

When the facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's funds. This accounting system is subject to audit by a DHS representative and must meet the following standards:

- The personal needs funds shall be deposited in a bank in Iowa that is insured by FDIC. The funds shall be deposited in a single checking account that has in the account name the term "Resident Trust Funds."
  - Personal needs funds shall not be comingled with trust funds from any other facility.
  - Personal needs funds shall not be comingled with facility operating funds except for facility funds deposited to cover bank charges, not to exceed $500. Bank service charges for this account are an allowable audit cost if the service cannot be obtained free of charge.
- A separate ledger sheet must be maintained for each resident.
  - When a resident is admitted to the facility, a ledger sheet must be credited with the resident's total incidental money on hand.
  - Thereafter, the ledger must be kept current on a monthly basis. The facility shall show the date, the amount given the resident, and the resident's signature.
- Each time a purchase is made through the checking account on behalf of the resident (instead of a direct cash disbursement to the resident), the expenditure item in the ledger must be supported by a signed, dated receipt. The receipt must indicate the article furnished for the resident's benefit.
- Personal funds must not be turned over to persons other than the resident's conservator or other persons selected by the resident.
- With the consent of the resident (if the resident is able and willing to give such consent), the administrator may turn over personal funds belonging to the resident to a close relative or friend to purchase a particular item. However, a signed, itemized, dated receipt shall be included in the resident's files.
- Receipts for each resident must be kept until canceled by Department auditors. The ledger and receipts for each resident must be made available for periodic audits by an accredited Department representative. Audit certification will be made by the Department's representative at the bottom of the ledger sheet; supporting receipts may then be destroyed.

The Department reserves the right to charge back to the facility any maintenance items that are charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may also be charged back to the facility.

6. Report to Department

The facility must notify the Department when:

- A person enters the facility and wishes to participate in the SSA program.
- A resident receiving SSA changes level of care.
- A resident receiving SSA is discharged from the facility.

Notify the DHS office submitting a *Case Activity Report*, form 470-0042. For form instructions see *Case Activity Report*, Form 470-0042.

If a resident's financial circumstances change in a manner that may affect SSA eligibility or benefits, the change must be reported to DHS. The DHS office then reviews eligibility factors and makes any needed change in the amount of client participation.

7. *Case Activity Report*, Form 470-0042

The *Case Activity Report* is used to ensure prompt and accurate reporting on resident activity as it occurs at the facility. Click here to view the form online. Complete the form as follows:

- When a Medicaid applicant or member enters the facility, complete Sections 1, 2, and 3. Enter the resident's first name, middle initial, and last name as they appear on the *Medical Assistance Eligibility Card*. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g. 1234567A.
- When a Medicaid applicant or member dies or is discharged from the facility, complete Sections 1, 2 and 5.
- The administrator or designee responsible for the accuracy of the information should sign in section 2.
- Within two business days of the member's death or discharge from the facility, provide the Case Activity Report to DHS. Keep a copy for the facility's records.

C. RESIDENT ELIGIBILITY

A resident's eligibility for SSA is determined by Income Maintenance (IM) workers within DHS.

1. Physician's Statement

All admissions to RCFs shall be based on a written order signed by a physician certifying the person being admitted does not require nursing services.

In order to comply with licensing rules, the facility shall assure that each resident is examined by a physician at least every 12 months to determine whether residential care continues to be appropriate.

For a resident to continue to remain eligible for SSA payments, the physician's statement certifying that the person requires residential care but does not require nursing services must be updated at least every 12 months. The certification shall be updated whenever there is a change in the recipient's physical condition that warrants a reevaluation. A copy of the new certification dated and signed by a licensed physician is sufficient to verify the continuing need.

2. *Application for Health Coverage and Help Paying Costs,* form 470-5170 or 470-5170(S)

SSA payments for residential care cannot be made until the resident has filed an Application for Health Coverage and Help Paying Costs, form 470-5170 or 470-5170(S), with DHS.

Ideally, the application should be filed by the date that the applicant wants to start receiving SSA benefits. If the application is filed more than 30 days after entering the facility, the applicant will not be able to receive benefits back to the date of entry.

The *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), is designed to enable the applicant to present DHS with the information needed to determine eligibility for SSA and Medicaid.

- Click here to view the English version of the form.
- Click here to view the Spanish version of the form.

Facilities that want to keep a supply of these forms on hand may obtain them from DHS or may order them from Iowa Prison Industries at:

(800) 332-7922.

The information shall be provided by the resident, and the resident must sign the form unless mentally or physically unable to do so. If the resident has an authorized representative, such as a guardian, conservator, or payee, that person is responsible for furnishing the information and signing the application on the resident's behalf.

This means that if the facility is the payee for the resident's benefits, the facility is responsible for completing the form and providing the required verification.

3. Application Processing

The Department's decision with respect to eligibility will be based primarily on information furnished by the applicant. The Department will notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. The applicant is likely to be asked to furnish:

- A social security number or proof of having applied for a number.
- Proof of income and resources.
- Proof of citizenship and identity for Medicaid purposes.
- Evidence of disability if the applicant is under age 65.

Failure of the applicant to supply the information or refusal to authorize the Department to secure the information from other sources shall serve as a basis for denial of assistance.

If the applicant is already receiving SSI, the Social Security Administration has already cleared most eligibility factors.

If it appears that the applicant would be eligible for SSI but is not receiving it, the applicant will be required to apply for SSI in addition to applying for SSA.

The time needed for eligibility determination may be extended when:

- There is a delay caused by the Social Security Administration's inability to establish SSI eligibility, or
- There is a delay caused by the local office's inability to establish disability or blindness, in cases where the applicant's or recipient's income exceeds SSI limits.

NOTE: When action on the application is delayed for these reasons, the Department has no responsibility for making SSA payments until eligibility is established.

If the applicant is eventually found eligible, payment shall be retroactive to the date the applicant became eligible, or 30 days before date of application, whichever is later. However, if the applicant dies before the establishment of SSI eligibility or is found ineligible as a blind or disabled person, the Department shall assume no responsibility for payment.

4. Eligibility Decision

The Department will issue a notice of decision to notify an applicant or recipient of SSA of the decisions made on the person's case. This includes when:

- An application is approved or denied.
- A recipient's client participation changes.
- Assistance is renewed because of a review or redetermination.
- A recipient transfers from one program to another.
- Assistance is canceled.

For SSA residential care, the notice will state the effective date of assistance, the amount of money the resident has to contribute toward the cost of care, and how that amount was calculated. The effective date for SSA shall be no earlier than 30 days before the date the Department received the application.

The original notice is mailed directly to the resident. When the resident has a guardian, conservator, or payee, a copy of the notice is mailed to that person. The facility will receive a copy of the notice only if the facility is payee for the resident's benefits.

If the facility is payee, the facility should take any action required and file the form in the resident's records. No action is required upon receipt of a notice of decision unless the resident or the person acting on the resident's behalf wants to appeal the Department's action. Instructions for how to request an appeal are found on the back of the form.

5. *RCF Admission Agreement*, Form 470-0477

Both the law and licensing rules governing RCFs provide that there must be a contract between the facility and each individual resident. The *RCF Admission Agreement,* form 470-0477, serves as this contract and must be present in each resident's record. Click here to view the form online. Requirements for this contract are found in Iowa Administrative Code (IAC) for the Department of Inspections and Appeals at 481 IAC 57.14.

This contract meets the licensing requirements set by the Department of Inspections and Appeals. Page 2 of the form meets the additional requirements of the SSA program.

The facility shall initiate the form before or at the time of a person's admission to the facility. Page 1 shall be completed for all residents. It must be completed and signed by an authorized representative of the facility and the resident or the resident's guardian. The law requires that the form be completed in duplicate: one copy for the facility and one copy for the resident.

The "Base Rate" amount must be inserted each time the form is completed and the correct time frame circled.

Under the SSA program, residents moving from an independent living arrangement to an RCF may retain enough of the first month's income to meet maintenance or living expenses connected with the previous living arrangement. A SSA recipient who transfers from one facility to another may have a refund from the first facility which should be shown as the amount to be paid on admission to the second facility.

In such cases, the income maintenance worker shall determine how much of the resident's income is available for the first-month client participation. Verification of the amount can be obtained from DHS.

Page 2 shall be completed for residents who receive SSA payments. The amount of the resident's personal needs allowance shall be entered.

One copy shall be retained by the facility and filed in the resident's personal file. The other copy shall be given to the resident or the resident's representative.

6. Eligibility Review

If the resident receives an SSI payment, the Social Security Administration is responsible for reviewing eligibility. If not, the DHS local office will reexamine the resident's eligibility for SSA:

- At least every 12 months, based on the information the resident submits on the *Medicaid/State Supp. Review*, form 470-5482 or 470-5482(S), and
- When there is a change in the resident's circumstances that may affect eligibility, as reported by the resident or the resident's representative by telephone or by mail. The Department issues form 470-5590, *Ten-Day Report of Change for Medicaid/Hawki*, to assist residents in making this report.

a. *Medicaid Review*, Form 470-5482 or 470-5482(S)

Medicaid Review, form 470-5482 or 470-5482(S), is designed to enable the resident to provide DHS with the information needed to determine eligibility for SSA at the time of review. The Department will mail the form to the resident when a review is due.

- Click here to view the English version of the form.
- Click here to view the Spanish version of the form.

The information shall be provided by the resident, and the resident must sign the form unless mentally or physically unable to do so. However, if the resident has an authorized representative, such as a guardian, conservator, or payee, that person is responsible for furnishing the information and signing the application on the resident's behalf.

This means that if the facility is the payee for the resident's benefits, the facility is responsible for completing the form and providing the required verification.

The completed application form shall be submitted to the local Department of Human Services office.

b. *Ten-Day Report of Change for Medicaid/Hawki*, Form 470-5590 or 470-5590(S)

The *Ten-Day Report of Change for FIP and Medicaid*, form 470-0499 or 470-0499(S), may be used by the resident or the resident's representative to report changes in eligibility factors. Failure to make a timely report may result in loss of benefits for the resident.

- Click here to view the English version of the form.
- Click here to view the Spanish version of the form.

The Department issues the form to the resident:

- Upon approval of the application,
- When requested, and
- As a replacement when the local office receives a completed form.

Keep the form until a reportable change occurs; then the resident or the resident's representative shall complete the form and send it to DHS.

When the RCF is the payee, the RCF shall complete the form for the resident. Facilities that are payees for resident's benefits are responsible for monitoring the resident's financial situation and making the required reports.

D. BASIS OF PAYMENT

SSA is a supplement to a resident's other income which assures the resident of sufficient funds to meet the cost of care in the RCF and to provide a standard allowance to meet personal needs.

The resident retains a portion of the income for personal needs. The resident pays the balance of the income to the facility to be applied to the cost of care. This amount is called "client participation." The facility is responsible for collecting those funds from the resident.

SSA payments are made directly to the resident unless the recipient has made a written request for another person (or the facility) to be the payee. This request must include an effective date, be signed and dated by the resident, and be on file in the Department's local office.

If a resident agrees to make the facility the payee for the resident's benefits, the income maintenance worker must make system entries to indicate this. A "guardian file" must be created in the Medicaid Management Information System to direct the payment.

A facility that has assumed the duties of a payee is also responsible for ensuring that the resident responds to all communications from the Department.

1. Client Participation

Client participation is the amount of the resident's own income that the resident pays to the facility. This amount is supplemented by the SSA payment to equal the total established charge for the number of days the resident was in the facility during a month.

All resident income determined to be available for client participation shall be applied to the cost of care beginning with the first month of admission.

A resident may have limited client participation in the first month, due to the resident's living expenses in the previous living arrangement. The Department determines how much of the resident's income may be protected for other obligations and how much is available for client participation.

The income protected for a person leaving an independent living arrangement never exceeds the SSI payment for a single person (or a couple) at home.

A resident transferring to an RCF from a nursing facility, a foster care facility, or another RCF shall apply any unused client participation toward the cost of care in the new facility.

Residents should contact their income maintenance worker if they have questions about their client participation or the personal needs allowance. More information regarding personal needs allowance can be found in Section 6 below.

2. Items to Be Furnished by the Facility

DIA licensing rules require that certain items be available in an RCF. The facility must provide the following items when payment is accepted from a recipient of SSA:

- Three or more meals per day, with special diet when ordered by the physician;
- Furnished living and sleeping quarters (see 481 IAC 57.30(4));
- Laundry, including linens and personal clothing as needed for the resident to present a neat appearance, to be free of odors, and to be comfortable;
- Assistance with personal care, such as grooming, washing hair, and administration of medications, exclusive of nursing care;
- General supervision; and
- Provision of activities and socialization experiences to the extent deemed adequate by DIA.

Each facility shall provide a variety of supplies and equipment to fit the needs and interest of the residents. When these items are supplied to residents, they may be included in audit costs. These shall include:

- Books (standard and large print)
- Magazines
- Newspapers
- Radio
- Television
- Bulletin boards

Also appropriate would be:

- Box games
- Game equipment
- Piano
- Song books
- Craft supplies
- Audio or video player
- Outdoor equipment

If ordered by a physician, non-legend drugs (aspirin, cough syrup, etc.) or nonprescription vitamin pills may be furnished by the facility. If the individual resident requests such items without an order by a physician, the items may be charged to the resident.

Residents may be charged for over-the-counter drugs not provided by the facility or Medicaid.

3. Eligibility Based on 31-Day Month

Eligibility is established on the basis of a 31-day month. A resident's income may be such that the resident is eligible for a SSA payment during a 31-day month, but ineligible for a payment during a month with fewer days. If so, the resident does not receive a payment during the shorter month, but remains eligible for medical coverage.

4. Days Covered

SSA payments are made for only that portion of the month when the resident is in the facility (except as specified under Reserve Bed Days Due to Hospitalization and Reserve Bed Days Due to Visits or Vacation).

Payment shall be made for the date of entry, but not for the date of discharge or death. The number of days in a month has a direct bearing on the payment. Payment shall not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the resident remains eligible for all other benefits of the program.

a. Reserve Bed Days Due to Hospitalization

Legal reference: 441 IAC 52.1(3)"e" and "f"

SSA payments may be made to hold a bed for a resident who is absent from the facility due to hospitalization. Payment will be approved for a period not to exceed 20 days of hospitalization per calendar month.

Payment can be made while the resident is in a state mental health institute under the same terms as if the resident were hospitalized. No coding is needed until a resident is discharged or ineligible.

A facility may not collect more client participation than what the SSA program would pay.

Example:

> Ms. Doe is an RCF SSA recipient whose total monthly client participation is $155.10. Ms. Doe enters the hospital on June 1 and returns to the RCF on June 26, for a total of 25 days absence.
>
> The facility will bill for 20 reserve bed days, 5 covered days, and 5 non-covered days. The facility will keep the documentation of reserve bed days for audit purposes.

b. Reserve Bed Days Due to Visits or Vacation

Legal reference: 441 IAC 52.1(3)"e" and "f"

When the resident is absent overnight due to a visit or vacation, payment is made to hold the bed for a period not to exceed 30 days during any calendar year.

EXCEPTION: Payments may be made for additional visit days if a family member or legal guardian of the resident, or the resident's physician, case manager, or Department service worker provides signed documentation to the RCF that the resident wants additional visit days and the days are for the resident's benefit.

Obtain this documentation whenever the resident is absent for more than the 30-day limit, and keep it in the resident's permanent file. If the facility does not get documentation, the facility must bill the days as non-covered days unless the resident is discharged.

DIA is responsible for ensuring that facilities have justification for SSA payment for more than 30 days.

If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a *Case Activity Report*, form 470-0042, to the Department to terminate the SSA payment.

Residents are not restricted in how they choose to use the visit days to which they are entitled. They may use their visit days all at once or distributed throughout the calendar year. However, visit or vacation days may not be used to extend a hospital stay beyond 20 days per calendar month.

5. Supplementation from Other Sources

The SSA payment, as established by the Department of Human Services, is considered payment in full for the goods and services listed under Items to Be Furnished by the Facility.

There shall be no additional charge made to the resident over and above the SSA payment. Neither shall there be any additional charge to relatives, other persons, organizations, or agencies. Local governmental agencies may provide funding to support the facility operations.

Any supplemental payment meant to cover these goods and services, regardless of source, shall be considered as income and used to reduce the SSA payment. Regional supplementation on behalf of a resident is considered a supplemental payment and is treated as such.

When a resident's other income, including the supplemental payment, reaches the point where the cost of the residential care is met, the SSA payment is canceled.

When a facility furnishes services over and above the goods and services listed under Items to Be Furnished by the Facility, the facility shall contact the regional mental health and disability management system for information about funding through regional services allocations.

6. Personal Needs Allowance

A recipient of SSA for residential care is entitled to a personal needs allowance. This amount is set aside from the resident's income before determining the amount that the resident pays the facility (known as "client participation").

The personal needs allowance is money designated for the personal use of the resident. The personal needs allowance also includes an amount to cover the average Medicare copayments for a facility resident based on the previous year.

This allowance is seen as a method of improving the quality of life for persons needing residential care. The money can serve as a way for residents to maintain control over part of their lives and environment. It may also be used for transportation to medical providers in the same community.

The resident is the person who will be spending the money and should be informed that the allowance is to cover personal needs. Personal needs include the purchase of clothing and incidentals.

Accumulated personal needs funds are counted toward the resource limit when determining eligibility for SSI or SSA.

The Department increases the personal needs allowance for residents of RCFs at the same percentage and at the same time as federal Social Security and SSI benefits are increased. These changes are communicated to facilities through Informational Letters. Click here to view a listing of informational letters.

If the resident is unable to manage the personal fund, a guardian, representative payee, or conservator should work with the resident to determine the current needs. When there is no guardian, relative, or representative payee to act on behalf of the resident, the facility may assume the responsibility of managing the personal allowance if the resident is unable to do so independently.

a. Uses of Personal Needs Allowance

Personal needs money is for the exclusive personal use of the resident. The resident may not be charged for maintenance items. These items are properly included in the facility per diem rate.

b. Disposition of Unused Personal Funds in Case of Death

When a recipient of SSA dies in an RCF, the funds remaining in this person's personal account shall be treated in the following manner:

- When an estate is opened for the deceased, the funds shall be submitted to the estate administrator. If any part of the resident's personal property is being held by another person, the facility shall advise that person of the estate being opened and shall notify the estate administrator.
- When no estate is opened, the funds shall be released to the person assuming responsibility for the resident's funeral expenses.
- When no estate is opened and there are no living heirs, the funds shall be submitted to the Department to escheat to the state.

It may be advisable for the facility operator to consult with an attorney before releasing the funds.

7. Billing Procedures

For the Department to determine the amount needed to cover a resident's care, the facility must submit a claim indicating the number of days for which payment shall be made. Billing for previous month should be submitted as soon as possible after the end of the month.

The IME processes RCF claims for payment. Facilities must submit claims electronically.

The IME provides software for electronic claims submission at no charge. To request this software, email IME Provider Services at: imeproviderservices@dhs.state.ia.us. For other questions about billing, contact IME Provider Services at (800) 338-7909.

a. Time Frames for Submitting Claims

Claims can be submitted any time during the month for the previous month. However, for residents who are in the facility all month, submit only one claim per month after the end of the month.

Payment will be made for covered dates of service when Iowa Medicaid Enterprise receives the initial claim within one year from the date of services. Claims submitted beyond the one-year limit may be paid only when they are delayed due to delays in receiving third-party payments or retroactive eligibility determinations.

b. Payment After Resident's Death

Indicate the death of a resident by entering the discharge code for death on the claim. When a resident's death is reported on the claim, the Department issues the check to cover the amount of assistance due the resident for that billing period directly to the facility.

When the resident's death occurs after the close of a billing period but before the receipt of the SSA check covering that period, immediately report the death to the Department using the *Case Activity Report*, form 470-0042. Click here to view the form online.

When the income maintenance worker reports the death through the computer system, the payee is changed to the facility. If the check has already been issued in the name of the resident, return it and submit the billing for the final month as above.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Iowa Medicaid enrolled nursing facilities and RCFs bill for services electronically as an institutional claim on a monthly basis. The IME offers free electronic billing software; PC-ACE Pro 32, available through www.edissweb.com. Click here for more information on how to obtain PC-ACE software or to view help resources.

For other questions about billing, contact IME Provider Services at (800) 338-7909.