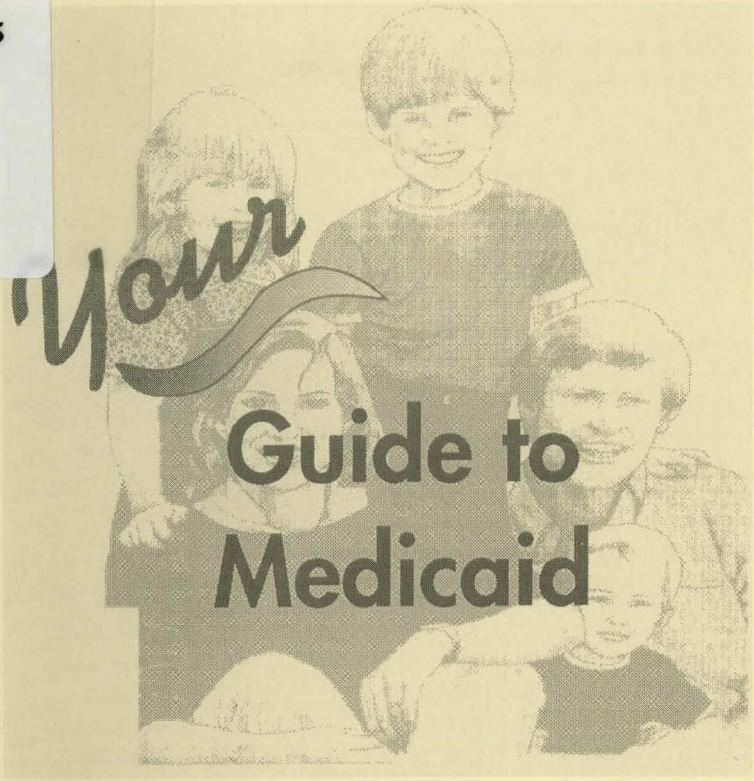
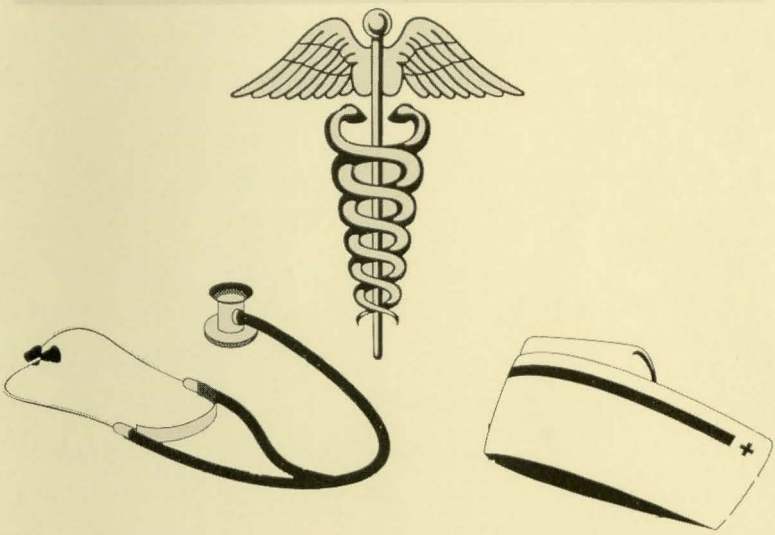


Your Guide to Medicaid



Iowa Department of Human Services

Your Guide to Medicaid
Table of Contents

Your Guide to Medicaid
Table of Contents

Your Guide to Medicaid

This guide tells you what Medicaid covers and how to use the program. Keep your guide where you can find it. Then when you need medical care you can use it to find out whether the services you need are covered by Medicaid.

Your Medical Assistance Eligibility Card

If you are eligible for Medicaid, every month you will receive a medical assistance eligibility card. The card is good only for that month. **Carry your card with you and always show it to the provider of health services every time you request care.** If you lose your card, contact your county Human Services office for a replacement. Do not let anyone else use your card.

Your Responsibilities

You must notify your county Human Services office or caseworker within 10 days of any changes in health care coverage. In addition, you must notify your medical providers of another party who may be liable to pay your medical expenses. You must report to your county office any accidents in which you are injured and require medical treatment. You must also report the receipt of settlements from lawsuits, insurance and worker's compensation claims. Failure to comply with your responsibilities can give the Department cause to deny or terminate your Medicaid eligibility.

The Department by law does not need your consent to recover payments made on your behalf or to intervene to make claim against any person or party that may be responsible for the cost of your medical expenses.

The Department will provide documents or claim forms describing the services that have been paid, if you or your attorney request them. These documents may also be provided to a third party if necessary.

Who Can Provide Services

The different types of medical and health services available through the Medicaid program are covered only if they are medically necessary. **You should use medical care wisely and prudently.** The services provided through the Medicaid program are listed in this booklet. Some Medicaid recipients have a different choice about how they receive their health care. See the section in this brochure entitled "MediPASS and HMOs: Managed Health Care Coverage for You and Your Family."

Under the program you have free choice of doctor, dentist, pharmacy or other providers of services. However, the providers of service also may choose whether or not they wish to participate in the program. Therefore, you should always show your medical assistance eligibility card and make sure the provider understands that you are a Medicaid recipient **before** the service is provided. If that particular provider of service does not participate in the program and you do not tell him or her that you are a Medicaid recipient before service is provided, you can be billed.

It is your responsibility to keep any appointments you make with providers or call to cancel or reschedule.

When you are traveling out of state and need medical care, the same limitations of service apply except that intermediate care facility (nursing home) care requires prior approval from the Iowa Department of Human Services.

A provider of service who participates in the Medicaid program must accept the payments that the program makes and make no additional charges to you for services covered under the program. Some services, however, are not covered under Medicaid, so if you receive these services the provider will bill you. You are responsible for these.

It is your responsibility to obtain only those services for which you have a medical need. When overuse or abuse of Medicaid is documented by the Department, you may be restricted from using some services.

Co-Payment

You may be required to share some of the costs of the service you receive. This sharing in the costs is called a co-payment. The provider of service will be responsible for collecting the co-payment from you. Co-payment may not be imposed on any services required by federal regulations such as physician and family planning services. Services that are not mandatory but the state has the option to cover (such as dental services and prescription drugs) may require a co-payment. Your provider can advise you if co-payment applies and the amount you must pay.

There will be no co-payment for individuals in skilled nursing facilities or nursing facilities when the facility care is covered by Medicaid, or if you are pregnant or under the age of 21, or for services provided by a health maintenance organization (HMO).

Following is a list of services that are covered and not covered under the program. Check this list before receiving medical care.

Physicians

The program covers medical and surgical services performed in the office, clinic, hospital, your own home or other locations, including diagnostic tests, X-rays and procedures that are part of your treatment. The following limitations apply:

- **Routine physical examinations are not covered.** A routine physical examination is one that is performed in the absence of any illness or injury. However, there are some exceptions. A routine physical examination will be covered if it is required for employment, school, or camp; as part of the Early and Periodic Screening Program for individuals under the age of 21; or by the Department of Human Services. Payment will also be made for a routine physical examination for a newly settled refugee who is eligible for medical assistance.

- **Abortions and sterilizations are only covered under certain conditions. You should ask your county Human Services office if an abortion or sterilization for you would be covered.**
- Cosmetic, plastic, or reconstructive surgery for the primary purpose of improving appearance or for psychiatric purposes is not covered.
- Treatment of flat foot and routine foot care such as cutting or removing of corns or calluses and trimming of nails is not covered.
- Acupuncture treatments are not covered.
- Surgery for obesity is not covered except when prior approval is granted. The physician makes the request for prior approval.

Dentists

Payment may be made for dental services including cleaning of teeth, fillings, extractions, dental surgery and dental disease control. Some dental services require prior approval. Your dentist knows about these and the procedure that must be followed. The following points should be kept in mind about dental care under Medicaid:

- If the procedure is expensive, it probably requires prior approval. If your dentist doesn't get prior approval, Medicaid may refuse to pay the bill.
- Some dental procedures, such as getting dentures, take a long time to complete. If you start dental treatment but become ineligible for Medicaid before completion, the dentist can bill you for any services provided after your Medicaid is canceled. You will be responsible for this bill.
- Since the dentist can charge you for broken appointments, dental appointments should be kept. However, if for some good reason you must cancel an appointment, the dentist should be given at least 24-hours notice. When you break an appointment without notice, the dentist can bill you. You will be responsible for paying this bill.

Prescription Drugs

The program covers insulin and drugs that by law can only be sold by a pharmacy on a physician's prescription. Also covered are medical and sickroom supplies. The program will also pay for birth control drugs and supplies. The following limitations apply to prescribed drugs:

- Some over-the-counter drugs are covered when prescribed by your physician. These include aspirin, acetaminophen and certain vitamins. The pharmacy can bill you for other over-the-counter items. You will have to pay for these.
- Some types of drugs are covered only if they are approved in advance. Your pharmacist will know what these drugs are; however, if the drugs are not approved, the pharmacy can bill you and you will have to pay for them.

Hospitals

The program covers both inpatient and outpatient hospital care. There are no specific limitations on the amount of care that will be paid for as long as that amount of hospital care is medically required. The following limitations apply to hospital care:

- The services of a private duty nurse are not covered.
- Telephone and television are not covered.
- Hospitalization to receive dental treatment is not covered unless you have a physical or mental condition that prevents the dentist from providing treatment in his or her office.
- Services received by individuals under the age of 21 and over the age of 65 in a psychiatric institution may be covered under certain conditions.
- Inpatient hospital care and payment to physicians for surgical procedures that can safely and effectively be performed on an outpatient basis are not covered.

- An emergency room charge will not be covered except for emergency services or when referred to the emergency room by your doctor. If you go to the emergency room for routine treatment, you may have to pay for it.

Important: *You should use services of the hospital emergency room only when your condition actually warrants emergency attention. Routine non-emergency medical care should be obtained from your private physician.*

Chiropractors

The program covers services of a chiropractor received in the office or home. The only covered service is manual manipulation of the spine for treatment of a subluxation (misalignment of the spine) which is confirmed by an X-ray. If the chiropractor provides any other services, these will not be covered and you can be billed. You will be responsible for the bill.

Rural Health Clinics

Services provided by a rural health clinic are covered if the clinic has been certified to participate in the Medicare and Medicaid programs. Covered services can include physician services, nurse practitioner and physician's assistant services, visiting nurse services and other ambulatory services, within the scope of the program.

Early and Periodic Screening, Diagnosis and Treatment "Care for Kids"

This program covers health screening for individuals under the age of 21 who are receiving Medicaid.

A complete screening examination includes a comprehensive health and developmental history, unclothed physical examination and measurements, vision and hearing screening, dental exam (individuals over the age of 12 months must be referred for dental care), mental health and nutritional assessment, necessary lab tests and immunizations and health education. Payment will be made for any follow-up services needed as a result of the screening. If you need assistance locating a provider, making an appointment or transportation, contact your county office.

Optometrists

Covered services include the eye examination to determine the need for glasses, purchase of glasses, necessary repairs to glasses and visual aids for subnormal vision if medically necessary. Limitations on optometrists' services are:

- Contact lenses are covered only if following cataract surgery or for documented cases of keratoconus of the cornea. If you receive contact lenses under any other circumstances, the optometrist can bill you. You will be responsible for the bill.
- **There is a maximum payment for frames and lenses under the program. If you want more expensive frames and lenses, you will have to pay the total cost.**
- Certain services provided by optometrists require prior approval. These include a second lens correction in 24 months, tonometry (pressure test) for individuals under age 35, visual fields and subnormal visual aids. If you receive these services and the service is not approved, you will have to pay for them.
- Sunglasses and photogray lenses are not covered by the program. If you receive sunglasses or photogray lenses, you will have to pay for them.

Opticians

Covered services include glasses and repairs to glasses, subnormal visual aids and certain other medically necessary special optical appliances. The following limitations apply:

- Contact lenses are covered only following cataract surgery and for documented cases of keratoconus. If you receive contact lenses under any other circumstances, you will have to pay for them.
- **There is a maximum payment amount for frames and lenses under the program. If you want more expensive frames and lenses, you will have to pay the total cost.**
- Sunglasses and photogray lenses are not covered by the program. If you receive sunglasses or photogray lenses, you will have to pay for them.

Ambulance Service

In order for ambulance service to be covered under the Medicaid program, you must meet the following conditions:

- Your condition must be such that you could be transported **only** by ambulance due to medical necessity.
- You must be transported to the **nearest** hospital with appropriate facilities, from one hospital to another, to a skilled nursing facility or licensed nursing home. If you are initially transported to a hospital with appropriate facilities and later transported to another hospital in the same town, the second trip would be covered under the program only if there is a valid medical reason (not your personal preference) for the second trip.

The following are examples of ambulance services that are **not** covered:

- Transportation from home or nursing home to a physician's office.

- Transportation from home or a nursing home to the outpatient department of a hospital unless it is established that it was an emergency or otherwise medically necessary.
- Transportation from one private home to another.
- Transportation to University Hospitals in Iowa City unless the University Hospitals is the **nearest** hospital with facilities necessary to your care.

If you receive any ambulance service that is not covered as indicated above, you will have to pay for it.

Ambulatory Surgical Centers

Services provided by an ambulatory surgical center is covered if the center has been certified to participate in the Medicare and Medicaid programs. Covered services are those furnished in connection with a medically necessary surgical procedure. These medically necessary procedures are eligible for payment under the same circumstances as physician services.

Transportation

Medicaid covers transportation to receive necessary medical care if the specific type of care you require is not available in your community. You should check with your county Human Services office **before** you arrange your transportation since there are certain conditions that must be met in order to be reimbursed by Medicaid. Your transportation costs may be covered under Medicaid if you meet the following conditions:

- You need the services of a physician or a hospital and there is no physician or hospital in your community.

or

- Your physician referred you to a specialist in another community because one is not available locally.

or

- You live in a rural area and must travel to a city or town to receive necessary medical care.

and

- There is no resource available to you through which necessary transportation might be secured free of charge.

Payments will be made **only** for transportation to the nearest institution or practitioner having appropriate facilities for your care. Payment for medical transportation is made directly from the Department to you by check and you are to pay the provider of transportation unless the provider of transportation is a Department volunteer or an agency set up for direct reimbursement.

Your county Human Services office can provide you with the necessary forms to file a transportation claim. You must submit your medical transportation claim form to the county Human Services office within three months of the date the transportation expense was incurred.

Podiatrists

Covered services primarily include surgery of the foot and certain prosthetic appliances for the foot. Services that are not covered under Medicaid include treatments for flat foot or for routine foot care such as clipping of nails, treatment of corns and calluses.

Orthopedic Shoes

Orthopedic shoes are covered only if prescribed in writing by a doctor of medicine, osteopathy or podiatry. If you obtain shoes without a written prescription, you will have to pay for them.

Occupational Therapy, Speech Therapy

These services are covered only if provided by a therapist employed by a hospital, home health agency, nursing home or physician. Under these circumstances the program would make payment to the individual or organization employing the therapist.

The services of a privately practicing occupational or speech therapist are not covered under the program and if you receive such services, you are responsible for paying for them.

Physical Therapy

The program covers physical therapy provided by a therapist employed by a hospital, home health or rehabilitation agency, nursing home or physician. Also covered are services provided by certain privately practicing physical therapists that meet special qualifications and have been certified to participate in the Medicare and Medicaid programs.

Total payments through the program for services of a privately practicing physical therapist may not exceed a specified amount in a calendar year.

Hearing Aids

Medicaid covers examinations to establish the need for a hearing aid. When it has been determined that you can benefit from a hearing aid, payment will be made for a hearing aid and necessary batteries, supplies and repairs.

- Children under 18 years of age must be examined by a physician, preferably one who specializes in treatment of the ear, who must determine that there is no physical reason why a hearing aid can not be worn. Adults 18 years of age and over are encouraged to see a physician first.

- Next, your hearing must be tested to determine if use of an aid would improve hearing and the type of hearing aid that would be most beneficial.
- If the examinations above indicate that a hearing aid would be helpful, the program can make payment for a hearing aid that meets your requirements when it is purchased from a qualified hearing aid dealer.

Home Health Agencies

Services provided by a home health agency are covered if the agency has been certified to participate in the Medicare and Medicaid programs. Covered services can include skilled nursing care, physical therapy, speech therapy, occupational therapy, home health aide services, medical social services and medical supplies and equipment provided by the home health agency. To be covered, these services must be medically necessary for the treatment of an illness or an injury.

Medicaid does not cover home care services furnished primarily to assist people in meeting personal family and domestic needs. The program covers only care provided in your home. Full-time nursing care at home is not covered. Private duty nursing services at home are not covered, except for persons under age 21, when the care is medically necessary.

Home- and Community-Based Services under Medicaid (waiver)

If you need nursing home care or care in another type of medical facility but would rather remain at home or return home if needed services could be arranged, you may be eligible for a waiver program available under Medicaid.

This program is called the Home- and Community-Based Services program. Iowa has six Home- and Community-Based Services (HCBS) waiver programs:

- AIDS/HIV waiver
- Brain Injury waiver
- Elderly waiver
- Ill and Handicapped waiver
- Mental Retardation waiver
- Physical Disabilities waiver

Contact the county office of the Iowa Department of Human Services to see if you qualify for this program.

Medical Equipment

The only types of medical equipment that are covered under the program are items of equipment, the use of which is **primarily medical** in nature. Items that have only an incidental medical use in individual cases are not covered. Some examples of items that are **not covered** include: air conditioners, dehumidifiers, blenders, massage devices and exercise equipment.

Generally items of medical equipment are not covered for a patient in a nursing home. The nursing home is expected to provide any necessary medical equipment for its patients.

Targeted Case Management

Medicaid case management services are available to Medicaid eligible persons with mental retardation, developmental disabilities, or chronic mental illness who reside outside a medical institution except that some discharge planning activities from facilities may also be provided. Case management services include the following components:

- Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements;
- Assurance that an individual comprehensive plan (ICP) is developed which addresses the consumer's total needs for services and living arrangements;
- Assistance to the consumer in obtaining the services and living arrangements identified in the ICP;
- Coordination and facilitation of decision-making among providers to ensure consistency in the implementation of the ICP;
- Monitoring of the services and living arrangements to ensure their continued appropriateness for the consumer;
- Crisis assistance to facilitate referral to the appropriate provider to resolve the crisis; and
  - Discharge planning activities for institutionalized persons For a period not to exceed 30 days prior to the estimated date of discharge and
  - For discharge activities of the case manager that do not duplicate the discharge planning activities of the institution.

Intermediate Care Facilities for the Mentally Retarded and Persons with Related Conditions (ICF/MR)

Facilities provide 24-hour care and services in a licensed and certified facility setting for persons with mental retardation or other similar conditions. Persons must require intensive active treatment and must be referred by a targeted case manager, approved by a central point of coordination and by the Iowa Foundation for Medical Care before payment is allowed. Contact the county office of the Department of Human Services for further information on this program.

Nursing Facilities or Medicare-Certified Skilled Nursing Facilities

The program is designed to assist with the cost of care in a nursing facility. The physician must certify that you need nursing care (and this decision is supported by the Iowa Foundation for Medical Care), but not to the degree which a hospital provides, and you are currently eligible for medical assistance. If you need the level of service provided by a certified skilled nursing facility, that cost of care may also be covered by the program.

You are allowed to retain part of your income for personal needs. The remainder of your income will be applied to the cost of the nursing home, unless the source of income is the Family Investment Program (FIP).

It is important to make sure you are both **medically** and **financially eligible** for care in a nursing home. If you are admitted to a nursing home and it is later determined that you are either **medically** or **financially ineligible** for Medical Assistance. Medicaid will not pay for any care you have received.

Family Planning Clinics

Covered services include counseling, medical examinations, laboratory tests, and drugs and supplies furnished by the clinic in connection with family planning.

Genetic Consultation Clinics

Genetic consultation services are payable when a genetic disorder or birth defect is suspected or confirmed and the services contribute to the treatment of the recipient or provide family planning information. These services do not include diagnostic testing procedures that are covered as physician or hospital services. Services provided by a genetic consultation clinic are covered if the clinic has been certified to participate in Medicaid.

Maternal Health Centers

Payment will be made for medical care during pregnancy including health education, nutritional counseling, social services and case management provided by nutritionists, social workers, physicians and nurse practitioners employed or under contract with a Maternal Health Center. Payment will also be made for care immediately following childbirth.

Psychologists and Social Workers

These services are covered if provided by a psychologist or social worker employed by a hospital, home health or rehabilitation agency, community mental health center or physician. In such cases the program makes payment to the individual or organization employing the psychologist or social worker. If you receive treatment from a private social worker, you will have to pay for it. The services of privately practicing social workers are not covered under the program. Qualifying psychologists in private practice may be paid for covered services.

Community Mental Health Centers

Payment may be made for services of a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of a community mental health center certified by the Department of Human Services.

Independent Laboratories

Medicaid can pay for diagnostic tests provided by independent laboratories. The laboratory must be certified by Medicare and Medicaid for the services you receive. Not all laboratories are certified and some laboratories are certified only for certain kinds of tests.

Your physician can tell you which laboratories are certified and whether Medicaid covers the tests he or she is ordering from a certified laboratory. Be sure to ask, because you will be responsible for noncovered tests.

Certified Registered Nurse Anesthetists

Payment will be made for certified registered nurse anesthetists' services in accordance with the limitations noted for physicians.

Family or Pediatric Nurse Practitioners

Payment will be made for family or pediatric nurse practitioners in accordance with the limitations noted for physicians.

Federally Qualified Health Centers

Payment will be made for federally qualified health centers services with the limitations noted for physicians and dentists.

Clinics

Payment will be made for clinic services in accordance with the limitations noted for physicians and dentists.

Area Education Agency Services

Area Education Agency services such as physical therapy, occupational therapy, speech therapy, and psychological and audiological services may be covered by Medicaid.

Birth Center Services

Covered services include prenatal, delivery and postpartum care if the center is a Medicaid provider.

Nurse-Midwife Service

Covered services include prenatal, delivery and postpartum care if the provider is a Medicaid provider.

MediPASS and HMOs: Health Care Coverage for You and Your Family

In many counties Medicaid recipients who are either Family Investment Program (FIP) eligible or FIP-related eligible are asked to select a Managed Health Care provider - either an HMO or a MediPASS doctor. Recipients who do not make a choice when asked to do so are assigned.

Managed Health Care ensures that each Medicaid recipient will have a primary care doctor. The program promotes the building of a doctor/patient relationship. This means that when you want medical services, you will have a phone number to call and a doctor and office staff who are more likely to be familiar with your medical care needs. When you require medical help, you can get that from your doctor instead of having to rely upon an impersonal emergency room or a doctor that you do not know.

Managed Health Care also makes it easier to see whether or not you and your children are getting the preventive services that you should get to stay healthy in the first place — things like shots for your children and a yearly pap and pelvic examination if you are a woman.

You will not lose any Medicaid benefits by enrolling in an HMO or with a MediPASS doctor. However, enrollment does change the way that you obtain some of your medical services. You should carefully read the information that you will be given about your choices and how to obtain Medicaid services.

Once you make a choice (or are assigned if you do not make a choice when asked to do so), you will receive additional written information. You can call a toll-free telephone line on regular workdays from 8:30 to 4:30 if you want information that you will be given about your choices and how to obtain Medicaid services.

The number is 1-800-338-9154.
The Des Moines local number is 327-5123.

You can also call this number if you have any problems after you are enrolled or if you want to change your enrollment. You may request a change if you decide that you are not happy with your choice or if your circumstances change (for example, if you move or if your doctor retires).

Iowa Plan for Behavioral Health

Most Medicaid recipients under age 65 are enrolled in the Iowa Plan for Behavioral Health (Iowa Plan); a statewide managed care for mental health services and substance abuse treatment. While you may never need mental health or substance abuse care, it is your right to know how to access these Medicaid benefits if you are enrolled with the Iowa Plan.

Information about the Iowa Plan for Behavioral Health is available by calling the Iowa Plan toll-free number: 1-800-317-3738. If you are enrolled with the Iowa Plan, the toll-free number will be printed on your Medicaid card and you will receive a packet of information about the Iowa Plan shortly after you become eligible for Medicaid. You may call the toll-free number if you have questions about mental health or substance abuse services. To access services through the Iowa Plan, you may call the toll-free number for a list of providers, or you may go directly to a provider to get care. It is important that you show your Medicaid card to the provider so that they will know that you are enrolled with the Iowa Plan. Most providers are part of the Iowa Plan program.

If your provider is not part of the Iowa Plan, they may want to join the program, or they can refer you to another provider. In case of a mental health or substance abuse emergency, you may go directly to a hospital emergency room where you can be evaluated for the appropriate care and treatment.

Use of the Medicaid Toll-Free Hotline

Included with your Medical Assistance Eligibility Card is a toll-free telephone number (**1-800-338-8366**) to help you resolve unpaid bills that you thought Medicaid should have covered. The worker who answers this hotline will take down the information about your bill and submit it to the Division of Medical Services for review and reconsideration. The Des Moines local number is:

327-5121

Before you call the Medicaid hotline, you should have the following information in front of you:

- The medical bill.
- A brief description of what services was provided.
- The Personal Identification Number listed on the Medical Assistance Eligibility Card for the person who received the services listed on the bill.

This hotline is not to be used to ask questions concerning Medicaid policy or if Medicaid covers medical procedures or equipment. Those questions should be directed to your county DHS worker or to your medical provider.

Appeals and Hearings

If you are dissatisfied with the decisions or lack of decisions by the Department, you should discuss the matter with your worker. If a satisfactory agreement cannot be reached, you have the right to file an appeal and ask for a hearing.

If a hearing is allowed, it will be an informal meeting before an administrative law judge from the Department of Inspections and Appeals in which you can present your complaint. All the facts will be reviewed to see if the decision was correct or should be changed.

You may file an appeal to ask for a hearing by **writing** to your county Department of Human Services office or by **writing** to:

Appeals Section
Iowa Department of Human Services
5th Fl Hoover State Office Building
Des Moines IA 50319-0114

If you feel the "Notice of Decision" is incorrect, you will protect your right to a hearing by filing an appeal within 30 days of the date on the notice. Discussions with your worker or other Department staff do not extend this time limit.

IOWA
DEPARTMENT OF
HUMAN SERVICES

No person shall be excluded from employment or the receipt of services or benefits by the Department or any of its vendors, Purchase-of-Service providers, or contractors because of his or her race, creed, color, gender, age, physical or mental disability, religion, national origin, or political belief.

Comm. 20 (Rev. 11/99)