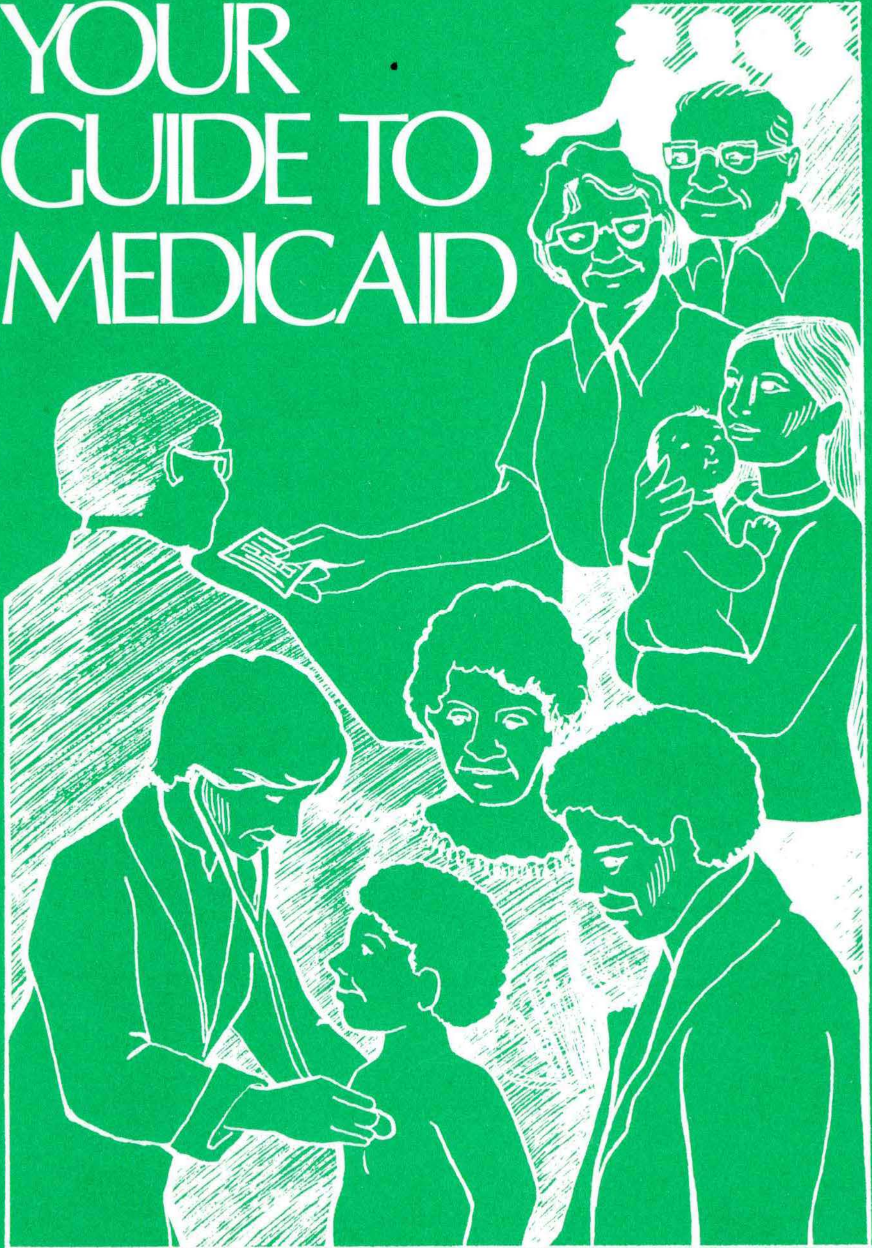
YOUR GUIDE TO MEDICAID



IOWA DEPARTMENT OF SOCIAL SERVICES

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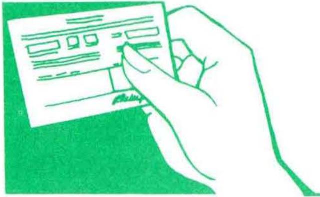
Your Guide to Medicaid

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 the program.

Your Medical Eligibility Card

As long as you are eligible for Medicaid, every month you will receive a medical 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 ever lose your card contact your local social services office and they can give you a replacement card. Do not let anyone else use your card.



Who Can Provide Services or Supplies Under Medicaid

The different types of medical and health services available through the Medicaid program are covered only if they are medically necessary. The services provided through the Medicaid program are listed in this booklet.

Under the program you have free choice of doctor, dentist, pharmacy, or other provider of service. 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 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 that you are a Medicaid recipient before he provides the service, he can bill you.

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 Social Services. Out-of-state providers must send their bills to:

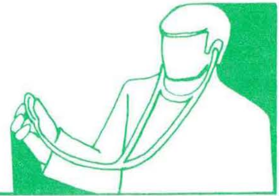
Iowa Title XIX Medical Assistance
Blue Cross and Blue Shield of Iowa
636 Grand Ave.
Des Moines, Iowa 50307

The bill must include the case name, case number, patient's name and person code available from your medical eligibility card. The bill should include a diagnosis and itemized list of services provided. If you have Medicare, your Medicare claim number also should be on the bill.

A provider of service who participates in the Medicaid program must accept the payments that the program makes to him 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 can bill you.

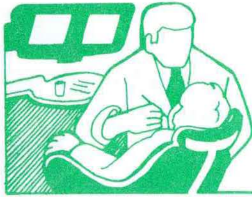
Following is a list of services that are covered and not covered under the program. We would suggest that you check this list before receiving medical care.

Physicians



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

1. 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 would be covered if it is required for employment, school or camp; in connection with the Early and Periodic Screening Program for Children; or by the Department of Social Services. All other routine physical exams are *not* covered.
2. **Abortions and sterilizations are only covered under certain conditions. You should ask your local social services office if an abortion or sterilization for you would be covered.**
3. Cosmetic surgery for the primary purpose of improving appearance is not covered.
4. Treatment of flat foot and routine foot care such as cutting or removal of corns or callouses and trimming of nails is not covered.
5. Acupuncture treatments are not covered.
6. Surgery for obesity is not covered except by prior approval of the Department of Social Services.



Dentists

Payment will be made for dental services including cleaning of the teeth, fillings, extractions, dental surgery, orthodontia and dental disease control. Some dental services require prior approval by the Department of Social Services. Your dentist knows about these and the procedure he has to follow. The following points should be kept in mind about dental care under Medicaid:

1. If the procedure is expensive, it probably requires prior approval. If your dentist doesn't get prior approval, you will have to pay for it.
2. Some dental procedures such as getting dentures and orthodontia (straightening of the teeth) 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 case is canceled.
3. Since the dentist can charge you for broken appointments, dental appointments should be kept whenever possible. 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.

Prescription Drugs

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

1. Over-the-counter drugs are not covered. This includes aspirin, laxatives, iodine and other items that you can buy without a doctor's prescription. The pharmacy can bill you for these items.
2. Some types of drugs are covered only if they are approved in advance by the Department. Your pharmacist will know what these drugs are; however, if the Department does not approve them in your case the pharmacy can bill you.

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:

1. The services of a private duty nurse are not covered.
2. A private room is not covered unless it is medically necessary for treatment of the patient's condition.
3. Services of the hospital barber or beauty shop are not covered.
4. Telephone and television are not covered.

5. 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 office.
6. Treatment in a hospital that exists solely for the treatment of mental illness is not covered. However, treatment for a psychiatric condition in a regular community general hospital **is** covered under the program.

Important: You should use the 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, clinic, home or other location. The only covered service is manual manipulation of the spine for treatment of a subluxation (misalignment of the spine) demonstrated to exist by an x-ray. If the chiropractor provides any other services, such as diathermy or laboratory tests, these will not be covered and he can bill you for them.

Optometrists

Covered services include the 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 optometrist's services are:

1. Contact lenses are covered only following cataract surgery. If you receive contact lenses under any other circumstances the optometrist can bill you.
2. **There is a maximum payment amount for frames under the program. If you want more expensive frames, you must pay the full cost of the frames yourself. Under Medicaid rules you cannot pay the optometrist the difference between what the program will pay and what the more expensive frames actually cost.**
3. Certain services provided by optometrists require prior approval by this Department. This includes a second lens correction in 12 months, tonometry (pressure test) for individuals under age 35, visual fields and subnormal visual aids. If you receive these services and the Department does not approve, the optometrist can bill you for them.
4. Sunglasses are not covered by the program.

Opticians

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

1. Sunglasses are not covered under the program. If you receive sunglasses the optician can bill you.

2. Contact lenses are covered only following cataract surgery. If you receive contact lenses under any other circumstances the optician can bill you.
3. **There is a maximum payment amount under the program for frames. If you want more expensive frames you must pay the full cost. Under the program you cannot make up the difference between what the program will pay and what the more expensive frames actually cost.**

Ambulance Service

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

1. Your condition must be such that you could be transported **only** by ambulance.
2. 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 transferred to another hospital in the same locality 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.

Examples of ambulance service that are **not** covered are the following:

- 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.
- 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.

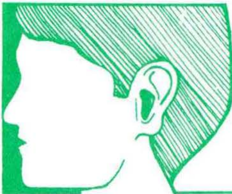
If you receive any ambulance service that is not covered as indicated above, the ambulance company can bill you.

Transportation

Medicaid covers transportation to receive necessary medical care if the specific type of care you require is not available in your community. There are cost limitations, so be sure to check with your local social services office **before** you arrange your transportation. Your transportation costs will be covered under Medicaid if you meet one of the following conditions:

1. You need the services of a physician or a hospital and there is no physician or hospital in your community;
2. You have been referred by your physician to a specialist in another community because one is not available locally; or
3. You live in a rural area and must travel to a city or town to receive necessary medical care.

Payment 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.



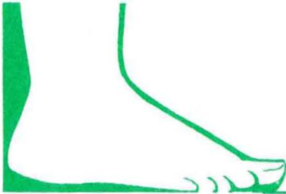
Hearing Aids

Medicaid covers examinations to establish the need for a hearing aid. When it has been determined that you can benefit by a hearing aid, payment will be made for a hearing aid, and necessary batteries, supplies and repairs. If you feel you could benefit from a hearing aid, contact your local social services office where you will be assisted with the following steps:

1. You must be examined by a physician, preferably one

who specializes in treatment of the ear, to determine that there is no physical reason a hearing aid could not be worn.

2. Next, your hearing must be tested to determine if use of an aid would improve hearing and the particular type of hearing aid that would be most beneficial in your particular case.
3. If both of the above examinations indicate that a hearing aid would be helpful, then the program can make payment for a hearing aid that meets your requirements purchased from a qualified hearing aid dealer.



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 or callouses.

Orthopedic Shoes

Orthopedic shoes are covered only if prescribed in writing by a doctor of medicine or osteopathy or a podiatrist. If you obtain special shoes without a written prescription, the shoe dealer can bill you.

Occupational Therapy, Speech Therapy

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

The services of privately practicing occupational or speech therapists are not covered under the program and if you receive such services, the therapist can bill you.

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 who 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 $100 for an individual in a calendar year. The therapist can bill you for any amount in excess of $100 per year.

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 part-time skilled nursing care, physical therapy, speech therapy, occupational therapy, part-time services of home health aides, 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 part-time skilled nursing care in your home. Full-time nursing care at home is not a covered service under the program nor is private duty nursing service in your home.

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.

No items of medical equipment are covered for a patient in a nursing home. The nursing home is expected to provide any necessary medical equipment for its patients.

Intermediate Care Facilities or Nursing Homes

The program is designed to assist with the cost of care in an intermediate care facility (nursing home) if your physician certifies that you need nursing care (care above the level of room and board but not to the degree which a hospital or skilled facility provides) and you are currently eligible for Medical Assistance. You are allowed to retain $25 per month of your income and the remainder of your income will be applied to the cost of the nursing home.

You also may be eligible for such services if your income exceeds the Medicaid financial criteria. In this case, the fact that you are residing in a medical institution may entitle you to such services and also to other Medicaid services. The local social services office is responsible for determining financial eligibility in this instance.

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 ineligible for Medical Assistance, the Department of Social Services will not pay for any care you have received. If you are eligible for Medicaid, but you are not ill enough to require nursing home care, the Department will pay for services only from the date of admission to the date the facility is informed that you are not medically eligible for such care.

Skilled Nursing Facilities

If your doctor certifies that you need the level of service provided by a skilled nursing facility (care under the 24-hour supervision of licensed nursing personnel) and you are eligible for Medicaid, the cost of care may be covered by the program.

The local social services office will decide if you are financially eligible for such services if your income exceeds the eligibility ceiling for persons not in a medical institution.

Community Mental Health Centers

Payment will be made for services of a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of a community mental health center certified as such by the Iowa Mental Health Authority. **All services must be provided under the direct personal supervision of a psychiatrist.**

Psychologists and Social Workers

These services are covered only 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. The services of privately practicing psychologists or social workers are **not** covered under the program.

Family Planning Clinics

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

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 the tests he is prescribing from a certified laboratory are covered by Medicaid.

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