



IOWA MEDICAID COVID-19 PROVIDER TOOLKIT

Updated December 30, 2020



TABLE OF CONTENTS

MEDICAID FLEXIBILITIES REQUESTS	3
BLANKET WAIVERS	8
GRANTS FOR ICF/ID, PMIC, AND NF PROVIDERS	9
COVID-19 RELIEF RATE (CRR) PAYMENTS	10
GRANTS FOR HCBS, SUD, AND MH PROVIDERS	16
RETAINER PAYMENTS	17
TELEHEALTH	24
HOME DELIVERED MEALS	34
PREMIUMS SUSPENDED	36
SOCIAL SECURITY INCOME (SSI)/UNEMPLOYMENT	37
BEHAVIORAL HEALTH SERVICES (BHIS)	38
HOME- AND COMMUNITY-BASED SERVICES (HCBS)	39
CONSUMER CHOICES OPTION (CCO)	48
HEALTH HOMES	51
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)	54
LONG TERM CARE	55
NON-EMERGENCY MEDICAL TRANSPORTATION	56
OPERATIONS	57
BILLING / REIMBURSEMENT	65
MANAGED CARE ORGANIZATIONS (MCO) RESOURCES	66

MEDICAID FLEXIBILITIES REQUESTS

The Department has made the following requests to the Centers for Medicare and Medicaid Services (CMS) to continue serving Medicaid members during the COVID-19 emergency. The Department will implement requests as needed

CHIP/HAWKI AGE-OUT

Implemented: [March 13, 2020](#)

- ▶ Continued eligibility for Children's Health Insurance Program (CHIP) enrollees who turn 19 years old during the national emergency and who are otherwise ineligible for Medicaid due to income above 133% of the federal poverty level (FPL).

CHIP/HAWKI ELIGIBILITY

Implemented: [March 13, 2020](#)

- ▶ Extend eligibility to CHIP members beyond their certification period.
- ▶ Provide CHIP members additional time to submit renewal or verification materials.

CONTINUOUS ELIGIBILITY

Implemented: [March 13, 2020](#)

- ▶ Establish up to 12-months of continuous eligibility for all Medicaid enrollees age 19 and over (already in place for those under age 19).

COST SHARING SUSPENDED

Implemented: [March 13, 2020](#)

Suspend cost-sharing for all members and suspend premiums for:

- ▶ Medicaid for Employed People With Disabilities (MEPD)
- ▶ Iowa Health and Wellness Plan (IHAWP)
- ▶ Dental Wellness Plan (DWP)
- ▶ Healthy and Well Kids in Iowa (Hawki)
- ▶ Client participation is not suspended.

COVERAGE FOR UNINSURED

Status: [In Development](#)

- ▶ Cover COVID-19 testing and related visits for uninsured individuals during the emergency, as allowed under the recently passed Families First Coronavirus Response Act.

HOME DELIVERED MEALS

Implemented: [March 13, 2020](#)

- ▶ Provide home delivered meals, subject to prior authorization, for Medicaid enrollees who are not enrolled in a 1915(c) waiver and are homebound due to the national emergency.
- ▶ Provide home delivered meals for all 1915(c) enrollees who are homebound due to the national emergency.

HOSPITAL PRESUMPTIVE ELIGIBILITY

Status: [Reviewing metrics daily and implementation will occur if needed.](#)

- ▶ Allow hospitals to conduct presumptive eligibility for all Medicaid eligibility groups until the national emergency declaration is lifted.

HOSPITAL 24-HOUR NURSING FLEXIBILITY

Status: Reviewing metrics daily and implementation will occur if needed.

- ▶ Waive the 24-hour nursing requirement, which will permit a nurse to cover more than one ward in the event of staffing shortages caused by the national emergency.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) FLEXIBILITIES

Status: Reviewing metrics daily and implementation will occur if needed.

- ▶ Waive the requirement for direct care residential living unit staff, which will allow changes to direct care staff numbers, if necessary, due to the national emergency.
- ▶ Waive the continuous active treatment program requirement, which will allow the health and safety needs of residents to be met if sufficient staff are unavailable to implement continuous active treatment due to the national emergency.
- ▶ Waive the preventive care and dental services requirement, which will allow for flexibility if the timeliness requirements cannot be met due to the national emergency.
- ▶ Waive the housing of similar ages, developmental levels and social needs requirement, which will allow for movement and housing based on availability of sufficient staffing and potential health issues of clients.

LONG TERM SERVICES AND SUPPORTS (LTSS)

Status: Reviewing metrics daily and implementation will occur if needed.

- ▶ Extend minimum data set authorizations for nursing facility and skilled nursing facility residents

NON-EMERGENCY AMBULANCE SUPPLIERS

Status: Reviewing metrics daily and implementation will occur if needed.

- ▶ Temporarily allow non-emergency ambulance suppliers.

PUBLIC NOTICE REQUIREMENTS

Implemented: March 13, 2020

- ▶ Waive requirement to seek public comment prior to CMS submission.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

Status: Reviewing metrics daily and implementation will occur if needed.

- ▶ Waive the PASRR, which will allow a nursing home to continue admission of an individual who has not had an assessment completed if there is a workforce disruption or hospitals reduce or limit outside contact in their facilities.

PROVIDER ENROLLMENT

Implemented: March 13, 2020

- ▶ Waive payment of application fee to temporarily enroll a provider
- ▶ Waive site visits to temporarily enroll a provider
- ▶ Permit providers located out-of-state/territory to provide care to an emergency State's Medicaid enrollee and be reimbursed for that service
- ▶ Streamline provider enrollment requirements when enrolling providers
- ▶ Postpone deadlines for revalidation of providers who are located in the state or otherwise directly impacted by the emergency
- ▶ Waive requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have equivalent licensing in another state

- ▶ Waive conditions of participation or conditions for coverage for existing providers for facilities for providing services in alternative settings, including using an unlicensed facility, if the provider's licensed facility has been evacuated
- ▶ Temporarily delay or suspend onsite re-certification and revisit surveys, and enforcement actions, and allow additional time for facilities to submit plans of correction.

REPORTING AND OVERSIGHT

Implemented: March 13, 2020

- ▶ Modify deadlines for OASIS and Minimum Data Set (MDS) assessments and transmission
- ▶ Suspend 2-week aide supervision requirement by a registered nurse for home health agencies
- ▶ Suspend supervision of hospice aides by a registered nurse every 14 days' requirement for hospice agencies

RESIDENCY

Implemented: March 13, 2020

- ▶ Consider beneficiaries evacuated from the state temporarily absent and maintain enrollment in their home state (for home state where disaster occurred or public health emergency exists)

TELEHEALTH

Implemented: March 13, 2020

- ▶ Allow telehealth for any Medicaid service for which it is appropriate, regardless of member location.

TRIBAL NOTICE REQUIREMENTS

Implemented: March 13, 2020

- ▶ Waive requirement to consult with tribes prior to CMS submission; tribes will still be informed of submissions as soon as the State is able to do so.

ADDITIONAL SERVICES

Implemented: March 13, 2020

- ▶ Home delivered meals (as noted above)
- ▶ Companion services
 - Includes the alternative for companion services to replace habilitation services, supported community living, and consumer directed attendant care services that are unavailable if there is a shortage of providers or providers are not able to deliver goal directed service due to the COVID-19 emergency.
- ▶ Homemaker services
- ▶ Allow self-direction of the 3 added services

ALLOW CASE MANAGEMENT COMPANIES TO PROVIDE DIRECT SERVICES IN ORDER TO ADDRESS POTENTIAL PERSONNEL CRISIS.

Implemented: March 13, 2020

EXCEED SERVICE LIMITATIONS

Implemented: March 13, 2020

- ▶ Remove the annual cost limit for respite services on the Intellectual Disabilities Waiver.

HOME- AND COMMUNITY-BASED SERVICES (HCBS) REGULATIONS

Implemented: March 13, 2020

- ▶ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

OUT-OF-STATE BACKGROUND CHECKS

Implemented: March 13, 2020

- ▶ Temporarily waive out-of-state background checks for Consumer Directed Attendant Care (CDAC) providers. The State will continue to conduct Iowa background checks during the emergency.

PARENTS AND FAMILY MEMBERS

Implemented: March 13, 2020

- ▶ Allow parents and family members to provide direct services.
 - Services allowed include: home based habilitation services, supported community living, consumer directed attendant care, and meals

PROCESSES

Implemented: March 13, 2020

- ▶ Allow an extension for reassessments and reevaluations for up to one year past the due date.
- ▶ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- ▶ Adjust prior approval/authorization elements approved in waiver.
- ▶ Adjust assessment requirements.
- ▶ Add an electronic method of signing off on required documents such as the person-centered service plan.

RETAINER PAYMENTS

Status: Reviewing metrics daily and implementation will occur if needed.

- ▶ Option for State to make retainer payments when a member is unable to receive normally authorized and scheduled services due to hospitalization, short term facility stay, isolation, or closure of a service line for any of the services listed below of no more than 30 days related to the COVID-19 emergency:
 - Adult Day Care
 - Consumer Directed Attendant Care
 - Day Habilitation
 - Prevocational Services
 - Supported Employment.

SETTINGS FOR HCBS EXPANDED, IF NECESSARY AND APPROPRIATE

Status: Reviewing metrics daily and implementation will occur if needed.

- ▶ Allow services to be provided in ICF/ID or other facility settings
- ▶ Allow direct care provider's homes to be authorized settings – subject to IME approval through an exception to policy request after all other options have been exhausted
- ▶ Allow direct care providers to move into member's homes – subject to IME approval through an exception to policy request after all other options have been exhausted

- ▶ Lift the existing limitation on five person homes to no longer designate an upper limit; providers allowed to consolidate members into homes, with this allowance limited by the home's capacity.

TELEHEALTH FOR TYPICALLY FACE-TO-FACE PROCESSES

Implemented: March 13, 2020

- ▶ Level of care and need based assessment evaluations and reevaluations
- ▶ Service plan reviews
- ▶ Interim service plan changes based on member's change in needs
- ▶ Quarterly face to face case manager contacts

PROVISION OF SERVICES IN ALTERNATIVE SETTINGS

Implemented: March 13, 2020

- ▶ Allow for the provision of services in alternative settings when a licensed facility or standard medical setting is unavailable due to the COVID-19 emergency
- ▶ Subject to approval from the IME

BLANKET WAIVERS

ANNOUNCED BY CMS, APPLICABLE TO ALL STATES WITHOUT NEED TO SPECIFICALLY WAIVE

- ▶ **SKILLED NURSING FACILITY (SNF):** provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.
- ▶ **CRITICAL ACCESS HOSPITALS:** CMS is waiving the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours.
- ▶ **HOUSING ACUTE CARE PATIENTS IN EXCLUDED DISTINCT PART UNITS:** CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient.
- ▶ **DURABLE MEDICAL EQUIPMENT:** Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required.
- ▶ **CARE FOR EXCLUDED INPATIENT PSYCHIATRIC UNIT PATIENTS AND INPATIENT REHABILITATION UNIT PATIENTS IN THE ACUTE CARE UNIT OF A HOSPITAL:** CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient psychiatric units and excluded distinct part inpatient rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part to an acute care bed and unit.
CMS is also waiving requirements to allow inpatient rehabilitation facilities (IRFs) to exclude patients from the hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such.
- ▶ **SUPPORTING CARE FOR PATIENTS IN LONG-TERM CARE ACUTE HOSPITALS (LTCHS):** CMS is allowing a long-term care hospital (LTCH) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.
- ▶ **HOME HEALTH AGENCIES:** Provides relief to Home Health Agencies on the timeframes related to OASIS Transmission.

or Copy this link: <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>

GRANTS FOR ICF/ID, PMIC, AND NF PROVIDERS

Refer to [Informational Letter No. 2194-MC-FFS-CVD](#) for more details regarding the Department's distribution of grants to Medicaid enrolled Community-Based Intermediate Care Facilities for the Intellectually Disabled (ICF/ID), Psychiatric Mental Institutions for Children (PMIC), and Nursing Facilities (NF) (including NF for the Mentally Ill) to help offset impacts of the ongoing COVID-19 pandemic. This money was provided to the State under the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.

THE ELECTRONIC ATTESTATION FOR ACCEPTING THE GRANT FUNDS REQUIRES THE SUBMISSION OF A MINORITY IMPACT STATEMENT, HOW DO YOU TO SUBMIT THE ATTESTATION AND THE STATEMENT?

Providers should complete and submit the online attestation and then complete the Minority Impact Statement and email it to IMEProviderServices@dhs.state.ia.us. Unfortunately, there isn't a way to attach the Minority Impact Statement to the online attestation.

WHEN WILL THE IME DISTRIBUTE THE GRANTS?

The Department plans to distribute grants starting December 7, 2020. Facilities should expect to receive payment within one week.

DO I HAVE TO COMPLETE AN APPLICATION TO RECEIVE A GRANT?

No. The Department is giving grants to all eligible providers. However, in order to keep the grant, the facility will need to complete an electronic attestation online.

HOW MANY YEARS DO THE RECORDS NEED TO BE KEPT?

Providers should keep records for seven years, as listed in the Terms and Conditions.

ARE PROVIDERS WHO HAVE BEEN IN RECEIPT OF PAYCHECK PROTECTION PROGRAM (PPP) MONIES ELIGIBLE FOR THE CARES ACT GRANTS?

Providers are bound by the terms of that grant as well as the CARES Act COVID Relief Fund Terms and Conditions. Providers should refer to the Small Business Administration and/or U.S. Treasury for additional information.

COVID-19 RELIEF RATE (CRR) ADD-ON PAYMENTS

Refer to [Informational Letter No. 2146-MC-FFS-CVD](#) for more details regarding CRR payments to Medicaid certified skilled nursing facilities (SNF) and nursing facilities (NF) during the federal public health emergency (PHE).

SINCE PROVIDERS ARE LOOKING AT RETROACTIVE ISSUES, WHAT DOCUMENTATION WILL BE SUFFICIENT TO DEMONSTRATE THE ISOLATION/ QUARANTINE AND THE NECESSITY OF THE QUARANTINE/ISOLATION?

Providers will need to ensure sufficient documentation in the resident's medical records to substantiate the payment. Cost reporting guidance will be issued at a future date.

WILL THERE BE A DIFFERENT BILLING STANDARD MOVING FORWARD?

Standards will remain the same for past and future billing. For claims that have already been paid, the provider will need to resubmit the claim with the disaster related condition code added to the claim form to reflect the dates of service that the Medicaid resident was being treated for COVID-19.

WHAT IS THE DIFFERENCE BETWEEN QUARANTINE AND ISOLATION?

Providers must continue to follow the recommendations from the Centers for Disease Control and Prevention (CDC), Iowa Department of Public Health (IDPH) and Iowa Department of Inspections and Appeals (DIA) to ensure infection control and resident safety is met. Residents are considered to be in isolation status when admitted to the nursing facility from the hospital or community with symptoms of COVID-19 and are awaiting COVID-19 test results, reside in the nursing facility with new onset of COVID-19 symptoms and awaiting COVID-19 test results, or they have tested positive for COVID-19. Quarantine covers residents newly admitted to the facility from the hospital or community that do not have COVID-19 symptoms, but are awaiting COVID-19 test results, or residents that have been exposed to COVID-19 that do not have COVID-19 symptoms and are awaiting COVID-19 test results. CRR payments will not be available to all guidelines set forth by IDPH and DIA. [Please refer to the CRR Add-On Payment Matrix](#) for more information.

DOES THE CRR PAYMENT POLICY ALIGN WITH THE IDPH DIRECTIVES RELATED TO QUARANTINE/ISOLATION?

Not all of the directives from IDPH will qualify for the CRR payment. Please refer to the [CRR Add-On Payment Matrix](#) for more information. Providers must continue to follow the recommendations from the CDC, IDPH, and DIA to ensure infection control and resident safety is met.

WHAT ABOUT RESIDENTS WHO ARE TAKING LONGER TO MEET THE RECOVERY TIME?

Documentation, including additional positive tests, must support the medical necessity for any outliers.

WHAT ABOUT RESIDENTS THAT SHIFT FROM QUARANTINE TO ISOLATION, OR FOR DIALYSIS, AND ARE ON AN INDEFINITE QUARANTINE DUE TO THEIR REPEATED TRIPS OUTSIDE THE BUILDING?

Residents that require continuous quarantine due to repeated trips outside of the building are not eligible for the CRR payment. Providers must continue to follow the recommendations from the CDC, IDPH and DIA to ensure infection control and resident safety is met.

CAN PROVIDERS ONLY BE PAID A CRR PAYMENT FOR INPATIENTS IN A SNF IF THEY HAVE A COVID-19 POSITIVE DIAGNOSIS?

CRR payments are available for Medicaid residents discharging from a hospital to the NF, or newly admitted to the NF that are awaiting test results, or have symptoms of COVID-19, and are in isolation. In addition, payments are available for Medicaid residents who have tested positive for COVID-19, or have symptoms of COVID-19 and are awaiting test results who have been moved to a specified isolation unit. Please refer to the [CRR Add-On Payment Matrix](#) for more information..

IF A MEDICAID RECIPIENT RESIDENT IS COVID-19 POSITIVE, AND IS BEING COVERED UNDER MEDICARE PART A BENEFITS, WOULD THEY BE ELIGIBLE FOR THE CRR PAYMENT?

The primary payer source must be Medicaid, including Fee-for-Service (FFS), managed care, or Program of All-Inclusive Care for the Elderly (PACE).

ARE RESIDENTS WHO ARE DISCHARGING FROM A HOSPITAL TO THE NF ELIGIBLE? DOES THIS INCLUDE ALL ADMISSIONS TO THE ELIGIBLE FACILITY THAT AREN'T BEING COVERED UNDER MEDICARE PART A?

Medicaid recipient residents that are admitted to the NF that are not covered by Medicare Part A and have a positive COVID-19 test, or have symptoms of COVID-19 and are awaiting COVID-19 test results are eligible for the CRR payment.

ARE RESIDENTS WHO HAVE PENDING TEST RESULTS FOR COVID-19 ELIGIBLE, REGARDLESS OF THE REASON THAT THE RESIDENT WAS TESTED FOR COVID-19?

NF residents that have pending COVID-19 test results AND signs or symptoms of COVID-19 are eligible for the CRR payment as long as the facility meets the criteria of an isolation unit and the resident meets the criteria as described in the CRR IL and matrix. CRR payments are not available for baseline testing.

WHAT IS COUNTED AS DAY ONE OF THE CRR PAYMENT? FROM THE DAY THAT THE TEST WAS CONDUCTED TO THE DAY THAT THE RESULTS ARE RECEIVED BY THE FACILITY?

The eligibility date for the CRR payment is the date the Medicaid resident was placed in the isolation unit at the facility due to a positive test or showing signs or symptoms of COVID-19. The start date of the CRR payment is the date the positive test was administered. CRR payments are not available for baseline testing.

WHAT IS THE DEFINITION OF AN ISOLATION UNIT?

An isolation unit is dedicated space in the facility with dedicated staff for cohorting and managing care for residents who are symptomatic and awaiting COVID-19 test results or have tested positive for COVID-19.

IF THE RESIDENT TESTED POSITIVE FOR COVID-19 AND DID NOT HAVE SKILLED BENEFITS, HOW MANY DAYS CAN WE BILL THE MCO FOR THE CRR PAYMENT?

CRR payments are only available for the 10 consecutive calendar days that the Medicaid resident is being treated for COVID-19, regardless of the level of care. If additional time for treatment is needed, there must be a positive test every 10 days.

IF THE PROVIDER HAS TESTED MCO RESIDENTS AND ARE WAITING FOR RESULTS, CAN THEY BILL THE CRR PAYMENT UNTIL NEGATIVE RESULTS ARE RECEIVED?

The eligibility date for the CRR payment is the date the Medicaid resident was placed in an isolation unit at the facility due to a positive test or showing signs or symptoms of COVID-19. If the resident tests positive while in quarantine, the payment would begin from the date of the positive test.

IF A PROVIDER HAS A NEW ADMISSION THAT THEY ISOLATE PER CDC GUIDELINES, CAN THEY BILL THE CRR PAYMENT?

Residents that are quarantined upon admission that do not have a pending COVID-19 test and signs and symptoms of COVID-19 are not eligible for the CRR payment.

WILL NFS NEED TO INCREASE THE CHARGE ON THE UB FOR THE MCOS TO EXCEED THE MEDICAID RATE PLUS THE CRR PAYMENT?

No, there is no increase to the daily per diem for a Medicaid resident's stay. The CRR is an additional payment that the facility can bill using the "disaster related" code due to the additional expenses incurred while treating COVID-19 residents.

IT APPEARS THAT THE INFORMATIONAL LETTER CONTRADICTS ITSELF STATING- CRR PAYMENTS ARE MADE TO ELIGIBLE FACILITIES FOR ENROLLEES RESIDING IN A DESIGNATED ISOLATION UNIT OR COVID-19 DESIGNATED FACILITY WHO: A. ARE DISCHARGING FROM A HOSPITAL TO THE NURSING FACILITY; OR B. ARE PENDING TEST RESULTS FOR COVID-19; OR C. HAVE A POSITIVE COVID-19 DIAGNOSIS. ... THE CRR PAYMENT IS \$300 PER DAY PER MEDICAID MEMBER WHO ARE COVID-19 POSITIVE. WHICH IS ACCURATE?

IL 2146 defines how a facility qualifies for a payment and how a Medicaid member qualifies for a payment. Providers must continue to follow the recommendations from the CDC, IDPH and DIA to ensure infection control and resident safety is met.

MANY RESIDENTS ARE COVERED BY MEDICARE FOR THE SKILLED STAY, WHAT IF THE MEDICAID RATE PLUS THE CRR ADD-ON IS GREATER THAN THE MEDICARE RATE. CAN WE BILL MEDICAID FOR THE DIFFERENCE?

If Medicare is the primary payer source the facility is not eligible for the CRR payment, even if the resident is dual eligible.

WHEN DOES THE CRR ADD-ON STOP? THE SECOND NEGATIVE TEST RESULT?

Payment would be discontinued after 10 consecutive calendar days unless there is another positive test. The payment may end prior to 10 consecutive days if negative test results are received prior to the last day of the CRR payment. Follow [CDC guidelines](#) regarding isolation.

HOW DOES A PROVIDER DETERMINE WHAT QUARANTINED FOR COVID-19 MEANS? INTERNAL EXPOSURE? EXTERNAL ADMISSION IN ISOLATION PER CDC GUIDELINES? UNTIL THERE HAS BEEN TWO NEGATIVE TESTS FOR A CURRENT RESIDENT?

Medicaid residents would be quarantined due to at least one of the following: new admission from the hospital or community and asymptomatic, or asymptomatic with a pending COVID-19 due to exposure. Residents that are in quarantine are not eligible for the CRR payment. Facilities are expected to continue to follow the guidelines set forth by the IDPH and DIA.

WHAT DOCUMENTATION WILL BE EXPECTED TO SUPPORT BOTH THE COVID-19 POSITIVE AND THE QUARANTINED RESIDENTS?

Providers will need to ensure sufficient documentation in the resident's medical records to substantiate the payment. Cost reporting guidance will be issued at a future date. Residents that are in quarantine are not eligible for the CRR payment.

DOES A PROVIDER QUALIFY FOR THE CRR PAYMENT IF THEY HAVE A HOSPICE MEDICAID RESIDENT WHO TESTS POSITIVE FOR COVID-19?

If the Medicaid resident is in Hospice care moved to isolation due to testing positive for COVID-19 or being symptomatic and awaiting pending test results, they would qualify for the additional CRR payment while being treated for COVID-19.

BECAUSE PACE PAYS FOR BOTH MEDICARE AND MEDICAID SERVICE, WHEN SHOULD PACE PAY FOR THE CRR ADD-ON?

CRR payments are for Medicaid services only.

REGARDING PACE: DOES THE NF SEND STANDARD CLAIMS (UB-04 OR CMS-1500 FORM AS APPROPRIATE) TO IME FOR VERIFICATION OF INCREMENTAL SERVICES RENDERED? AND, IF APPROVED, HOW DOES IME NOTIFY PACE OF THE EXPENSES, WHO IS COVERED AND FOR WHAT TIME PERIODS?

The NF continues to bill PACE providers as normal. PACE will then pay the NF stay plus the CRR payment related to the COVID-19 days during the stay. Facilities should continue to bill on the forms they use and use the disaster related modifiers and condition codes to identify the COVID-19 related. The IME will not pay the claims for the CRR payments for PACE participants. PACE should be billed directly for CRR payments for their assigned participants.

REGARDING PACE: HOW AND WHEN WOULD PACE RECEIVE FUNDS FOR APPROVED EXPENSES?

The CRR funds are included in the PACE capitation rates. There will not be additional payments issued to PACE organizations for the CRR payments.

DOES PACE PAY A FLAT \$300/DAY BACK TO THE NF, OR DO THEY PAY BASED ON ACTUAL COSTS AND ADJUDICATE BASED ON MEDICARE FEE SCHEDULES PER THEIR CONTRACT? IF CLAIMS ARE SENT TO PACE, WOULD THEY NEED THE STANDARD CLAIM FORMS IN ORDER TO PROCESS APPROPRIATELY?

PACE is responsible to pay the CRR payment of \$300 per day for Medicaid resident that meets the criteria for COVID-19. If the claim has already been paid, the facility will need to resubmit the claim with the disaster modifier/condition code for the days that the CRR payment would apply.

IF A SKILLED CARE STAY IS REQUIRED BECAUSE OF A POSITIVE COVID-19 TEST, DOES THAT THEN INCREASE THE REIMBURSEMENT TO FULLY COVER THE COST OF THIS STAY?

Daily per diems remain the same. The CRR is an additional payment the facility may be eligible for per Medicaid resident that meets the COVID-19 criteria.

ARE THE PACE PROGRAMS FULLY LIABLE FOR THE COVID-19 RELATED EXPENSES AND THAT IME WILL NOT PROVIDE INCREMENTAL FUNDING FOR THIS?

The CRR payment is included in the capitation fees paid to the PACE program. The PACE organization will be responsible to pay the CRR payment in addition to the daily per diem for a PACE residents facility stay.

WHAT TYPE OF CLAIM FORM IS REQUIRED FOR THE CRR ADD-ON AND DOES IT HAVE MEDICARE BASED CONDITION CODES?

Providers can continue to bill on the same forms, the UB-04 or the CMS-1500.

WHAT CODES WOULD BE BILLED ON A CLAIM FORM TO SIGNIFY THAT THIS IS THE CLAIM FOR THE \$300 PER DAY?

The “disaster condition” code should be indicated for the dates of service that qualify for the CRR payments.

DOES THE REIMBURSEMENT START WITH A POSITIVE DIAGNOSIS OF COVID-19 AS A PRIMARY DIAGNOSIS, A SECONDARY DIAGNOSIS, OR EITHER?

Medicaid residents discharging from a hospital to the NF or newly admitted to the NF that have a positive COVID-19 test or have symptoms of COVID-19, and are placed in isolation while awaiting pending test results are eligible for the CRR payments. In addition, Medicaid residents that reside in the NF that are showing symptoms of COVID-19 and are in isolation while awaiting test results are also eligible for the CRR payment.

WHEN A RESIDENT IS TESTED AND CONFIRMED NEGATIVE, IS THAT THE DAY THAT THE ADDITIONAL \$300 WILL NO LONGER BE PAID? IF NOT, HOW WILL THIS BE DETERMINED?

Payment would be discontinued after 10 consecutive calendar days unless there is another positive test. The payment may end prior to the 10 consecutive days if negative test results are received prior to the last day of the CRR payment.

HOW WILL PROVIDERS BE ABLE TO VALIDATE THAT A SNF HAS A DESIGNATED ISOLATION UNIT OR IS ENTIRELY DESIGNATED FOR TREATMENT OF COVID-19? AND, HOW WILL PROVIDERS KNOW WHEN THIS IS NO LONGER APPLICABLE TO INDIVIDUAL SNFS?

Every facility is responsible for having an infection control plan in place which should include the ability to isolate residents that are suspected of or have a positive COVID-19 test.

THE IL SAYS THE NF “WILL BE REQUIRED TO RE-SUBMIT CLAIMS THAT HAVE PREVIOUSLY BEEN PAID FOR THE REPROCESSING TO INCLUDE THE CRR PAYMENT TO IME AND MCO’S FOR THE DATES OF SERVICE.” WHAT IS THE INTENT OF THEM SUBMITTING TO IME? CAN YOU PROVIDE FURTHER CLARIFICATION ON WHAT THIS STATEMENT MEANS FOR PACE PROGRAMS?

Providers should submit claims to IME for FFS resident or the MCOs, if they are enrolled in managed care. For PACE residents, NF should bill the PACE provider.

IF A RESIDENT THAT IS COVID-19 POSITIVE DISCHARGES FROM THE HOSPITAL INTO A SKILLED CARE STAY, THE PROVIDER WOULD TYPICALLY PAY BASED ON THE STANDARD FEE SCHEDULE FOR SKILLED STAYS. HOW WILL THIS BE IMPACTED BY THIS NEW GUIDANCE?

If the stay is a Medicare covered stay and Medicare is the primary payer, the resident is not eligible for the CRR payment. If Medicaid is the payer, they would qualify for the CRR payment as long as all other criteria are met.

GRANTS FOR HCBS, SUD, AND MH PROVIDERS

Refer to [Informational Letter No. 2146-MC-FFS-CVD](#) for more details regarding the State's distribution of \$50 million in grants to be divided between Home- and Community-Based Services (HCBS), Substance Use Disorder (SUD) and Mental Health (MH) providers. This money was provided to the State under the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.

WHAT IF A PROVIDER ONLY FALLS UNDER HCBS, BUT HAS TWO NATIONAL PROVIDER IDENTIFIERS (NPIS), CAN THEY DO AN APPLICATION FOR BOTH NPIS UNDER THE HCBS BUCKET?

Yes. Submit a request for each NPI that you believed had a qualifying payment in FY 2019.

THE APPLICATION FOR THIS GRANT REQUIRES THE SUBMISSION OF A MINORITY IMPACT STATEMENT, HOW DO YOU TO SUBMIT THE FORM AND THE STATEMENT?

Providers should complete and submit the online application and then complete the Minority Impact Statement and email it to IMEProviderServices@dhs.state.ia.us. Unfortunately, there isn't a way to attach the Minority Impact Statement to the online application.

THE APPLICATION ASKS FOR A PROVIDER TYPE, BUT ONLY ALLOWS ONE CHOICE. IF AN AGENCY PROVIDES MORE THAN ONE OF THESE SERVICES IE: PROVIDES MH AND SUD SERVICES - DO THEY NEED TO SUBMIT AN APPLICATION FOR EACH PROVIDER TYPE OR WILL IME AUTOMATICALLY CALCULATE ALL APPLICABLE CLAIMS ACROSS EACH OF THE APPLICABLE PROVIDER TYPES LISTED (MH, SUD, HCBS, ETC.) PER THE AGENCY'S SINGLE NPI #?

Providers with an NPI paid under multiple provider-type categories may submit a request under each category.

HOW MANY YEARS DO THE RECORDS NEED TO BE KEPT? THE APPLICATION SAYS FIVE YEARS, BUT THE TERMS AND CONDITIONS SAYS SEVEN YEARS.

Providers should keep records for seven years, as listed in the Terms and Conditions.

PROVIDERS NEED TO CHOOSE BETWEEN HCBS AND HABILITATION ON THE APPLICATION. HABILITATION IS HCBS, AND SHOULD BE INCLUSIVE OF BOTH THOSE PROGRAMS. PLEASE CLARIFY.

Selecting "HCBS" can be thought of categorically as "non-Habilitation HCBS."

ARE INTEGRATED HEALTH HOMES (IHHS) CONSIDERED A MENTAL HEALTH (MH) PROVIDER, ELIGIBLE FOR MH PROVIDER RELIEF FUNDS?

Any provider who believes they are eligible based on the language in the Informational Letter should apply.

ARE PROVIDERS WHO HAVE BEEN IN RECEIPT OF PAYCHECK PROTECTION PROGRAM (PPP) MONIES ELIGIBLE FOR THE CARES ACT GRANTS?

Providers are bound by the terms of that grant as well as the CARES Act COVID Relief Fund Terms and Conditions. Providers should refer to the Small Business Administration and/or U.S. Treasury for additional information.



RETAINER PAYMENTS

Refer to Informational Letter No. 2136-MC-CVD for more details regarding retainer payments for habilitation and Home- and Community-Based Services providers.

IS THE RETAINER PAYMENT ONLY FOR PROVIDERS WHO DID NOT BILL THE DAILY SUPPORTED COMMUNITY LIVING (SCL) RATE WITHOUT DAY PROGRAMS? IF WE BILLED SCL WITHOUT DAY PROGRAMS, ARE WE EXCLUDED?

Retainer payments are made only for services that were authorized in a service plan, but not provided due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. If the amount of day habilitation authorized was less than 40 hours per month and the SCL provider billed the SCL without day services, the day habilitation could be billed as authorized as a retainer payment.

IS GROUP RESPITE INCLUDED?

Respite services are not eligible for a retainer payment.

IS JOB COACHING INCLUDED?

Yes, as long as the authorization was requested on or before April 30, 2020, and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-FFS.

HOW DO WE HANDLE BILLING FOR DAY HABILITATION WHEN THOSE INDIVIDUALS RECEIVED DAY HABILITATION IN THE HOME WHEN THEY NORMALLY RECEIVE DAY HABILITATION AT A FACILITY?

Providers are only able to bill for the services authorized that were not provided due to COVID-19. Day habilitation providers that delivered authorized day habilitation services in the member's home will bill as they usually do and use POS code 12 (home) when billing for day habilitation provided in the member's home. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

WILL THESE RETAINER PAYMENTS BE USED AS A "PRE-PAYMENT" BALANCE LATER ON FOR FUTURE SERVICES TO BE TAKEN AGAINST?

No, this is not considered a pre-payment.

IF WE CHANGED THE TIER FOR JOB COACHING AND DID CHECK IN FOR THE EMPLOYER ARE WE ELIGIBLE FOR THE RETAINER PAYMENT?

No, if services are provided, a retainer payment does not apply.



RETAINER PAYMENTS

IF DAY HABILITATION SERVICES WERE PROVIDED IN HOMES FOR THE CLIENTS WE HAVE IN RESIDENTIAL AND DAY HABILITATION, BUT NOT TO THE CLIENTS WE ONLY SERVE IN DAY HABILITATION, ARE WE ABLE TO BILL FOR THE CLIENTS WE DID NOT SERVE?

Providers are eligible for the retainer payment for T2020 and T2021 if the member was unable to receive normally authorized and scheduled services due to the COVID-19 public health emergency. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

DO WE SUBMIT THE BILLING JUST AS WE WOULD HAVE IF THE SERVICE OCCURRED?

Yes, providers should bill as they normally would have had the service been provided using the modifier outlined in IL 2136-MC-CVD. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

WHAT IF YOU BILLED THE H2016 CODE IN RESIDENTIAL BECAUSE YOU DIDN'T PROVIDE DAY HABILITATION TO A PERSON (CODE WHERE PERSON IS NOT OUT OF THE HOME 40 HOURS A MONTH), CAN YOU STILL BILL FOR DAY HABILITATION OR DO YOU NEED TO GET A DIFFERENT AUTHORIZATION FOR SCL CODES S5136, OUT OF HOME 40 HOURS A MONTH CODE, BEFORE YOU CAN BILL THE DAY HABILITATION OR EMPLOYMENT CODES?

Yes, as long as the day habilitation service was prior authorized and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

WE PROVIDE DAY HABILITATION AT GOODWILL, BUT HAD TO STOP PROVIDING SERVICES DUE TO COVID-19. SOME OF THOSE INDIVIDUALS THEN RECEIVED DAY HABILITATION IN THE HOME DURING THIS TIME. CAN WE BILL FOR THOSE INDIVIDUALS OR WOULD THAT BE CONSIDERED DOUBLE BILLING?

The retainer payments for the specific codes identified in IL 2136-MC-CVD and where the member otherwise had the services prior authorized, but the services were not provided only due to specific conditions related to COVID-19. If any combinations of providers were already paid for that code/date of service without the specialized modifiers/condition code it would be considered duplicative billing in this case and will be treated as such.

IF THE MODIFIER IS GOING TO BE A DIFFERENT MODIFIER THEN WHAT THE CLIENT IS AUTHORIZED FOR, WILL THE MCO HAVE EXCEPTIONS TO ALLOW THESE CLAIMS TO GO THROUGH AND NOT DENY?

The IME and the MCOs have configured their claims systems to adjust for the retainer modifier. The normal modifier should be billed with the CR modifier in the second position.

H2016 IS NOT DAILY SCL WITHOUT DAY SERVICES; IT IS DAILY SCL WITHOUT 40 HOURS OR MORE DAY SERVICES. WE HAVE MEMBERS THAT HAVE ALWAYS BEEN UNDER THE SCL CODE H2016 AND STILL WE WERE ABLE TO BILL FOR DAY

(Continued)



RETAINER PAYMENTS

HABILITATION UP TO 40 HOURS PER MONTH.

Correct. Providers can bill the service for which the member was prior authorized, but did not receive due to COVID-19 related conditions with the applicable modifier(s).

IF YOU ARE A DUAL SERVICE PROVIDER (RESIDENTIAL AND DAY HABILITATION/ DAY PROGRAMS) AND YOU REQUESTED TO GO FROM A RESIDENTIAL RATE WITH DAY PROGRAM TO WITHOUT DAY PROGRAM, YOU “ARE” OR “ARE NOT” ABLE TO BILL FOR THE 30 DAY RETAINER PAYMENT?

Providers are only able to bill for services that were authorized, but were not provided due to a COVID-19 related condition. If the dual day habilitation / SCL provider received authorization for SCL without day habilitation then the provider would only be able to bill separately for day habilitation for the dates of service when the day habilitation service was authorized, but not delivered. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

IS THE RETAINER AMOUNT GOING TO BE A ONE-UNIT FEE OR DOES THE PROVIDER NEED TO DETERMINE HOW MANY DAYS WERE MISSED FOR THE MONTH OF APRIL SERVICES AND BILL THOSE UNITS?

The provider would bill the respective amount of units the member was planned to utilize in the month of April 2020, but did not receive due to a condition related to COVID-19 as identified in IL 2136-MC-CVD.

YOU STILL HAVE FIXED COSTS IN YOUR DAY PROGRAMS (AS A DAY HABILITATION PROVIDER) AND THEY ARE TWO SEPARATE BUSINESSES. PROVIDERS THAT DON'T HAVE THE DUAL SERVICE (RESIDENTIAL AND DAY HABILITATION/ PROGRAMS) WILL GET THIS ADDITIONAL FUNDING.

The provider would bill the respective amount of units the member was authorized and planned to utilize in the month of April 2020, but did not receive due to a condition related to COVID-19 as identified in IL 2136-MC-CVD.

WILL PROVIDERS NEED TO SUBMIT A SERVICE RECORD PER CLIENT FOR THE MONTH, OR FOR THE DAILY SERVICE, THEY WOULD HAVE RECEIVED?

No. At this time, there will be no additional records or documentation request outside of what was already provided during the time the member was originally prior authorized for the service, which would have taken place in the month of April 2020.

IF A RESIDENTIAL PROVIDER BILLED WITH DAY SERVICE, CAN THE CONSUMER'S REGULAR DAY SERVICE PROVIDER BILL RETAINER?

Yes. The regular day habilitation service may bill for the services the member was prior authorized for, but did not receive due to COVID-19 related conditions with the applicable modifier(s). Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

WHAT IF THE SCL PROVIDER IS DIFFERENT FROM THE DAY HABILITATION PROVIDER AND THE INDIVIDUAL WAS ON SCL WITH DAY HABILITATION, BUT THEY



RETAINER PAYMENTS

WERE SWITCHED TO SCL WITHOUT DAY HABILITATION SO THE SCL PROVIDER COULD PROVIDE THE DAY HABILITATION IN THE HOME. WOULD THE DAY HABILITATION PROVIDER WHO DOESN'T NORMALLY PROVIDE SCL BE ABLE TO STILL BILL FOR THE TIME THEY LOST WITH THE INDIVIDUAL?

The retainer payment is service driven. If the service was provided, retainer payment is not available. As long as the service was prior, authorized and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

IF THE RESIDENTIAL PROVIDER IS A DIFFERENT AGENCY AND GOT PAID FOR THE DAILY RATE WITHOUT DAY HABILITATION, THE DAY HABILITATION PROVIDER WILL NOT GET PAID. SO WE ARE STILL LOSING THOSE RETAINER PAYMENTS?

The retainer payment is service driven. If the service was provided, retainer payment is not available. As long as the service was prior authorized and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

STANDALONE DAY HABILITATION WILL STILL GET THE RETAINER PAYMENT, EVEN IF THE CLIENT MAY HAVE GOTTEN THE DAY HABILITATION WITH SCL FROM ANOTHER AGENCY?

Yes. As long as the service was prior authorized and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD.

WE HAVE INDIVIDUALS THAT GOT DAY HABILITATION AT OUR PROGRAM, BUT LIVE AT ANOTHER PROVIDER GETTING THE DAILY SCL. THE DAILY SCL PROVIDER GOT SPECIAL AUTHORIZATIONS TO PROVIDE IN HOME DAY HABILITATION WHILE WE WERE CLOSED. IF WE RETAINER BILL WILL THAT BE CONSIDERED "DOUBLE BILLING"?

The retainer payments for the specific codes identified in IL 2136-MC-CVD and where the member otherwise had the services prior authorized, but the services were not provided only due to specific conditions related to COVID-19.

DUAL SERVICE PROVIDERS SHOULD BE ABLE TO BILL THE 30-DAY RETAINER PAYMENT FOR DAY HABILITATION/PROGRAM (THEY HAVE ADDITIONAL COSTS DUE TO THE PERSON BEING HOME ALL DAY ON TOP OF THE PERSONAL PROTECTIVE EQUIPMENT).

Yes. As long as the authorization was requested on or before April 20, 2020 and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD.



RETAINER PAYMENTS

I'M A DAY HABILITATION/RESIDENTIAL SERVICE DUAL PROVIDER, BUT THE MEMBER ONLY RECEIVES A SMALL NUMBER OF HOURS OF DAY HABILITATION SO THEREFORE THEY ALREADY USED H2016. CAN A PROVIDER SUBMIT FOR RETAINER PAYMENT FOR THESE MEMBERS?

Yes. As long as the authorization was requested on or before April 20, 2020 and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD.

ARE PROVIDERS PAID FOR THE WHOLE AMOUNT OF THE AUTHORIZATION FOR THE MONTH, ASSUMING THE CLIENT ATTENDED ALL OF THEIR SCHEDULED DAYS?

Yes. Providers can bill the respective amount of units the member planned to utilize in the month of April 2020, but did not receive due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

FOR SUPPORTED EMPLOYMENT, DO WE BILL THE NUMBER OF HOURS THE CLIENT HAD BEEN AUTHORIZED FOR, IF HOURLY?

Yes. Providers can bill the respective amount of units the member planned to utilize in the month of April 2020, but did not receive due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

IF THE PROVIDER HAS BOTH THE RESIDENTIAL DAILY SCL AND DAY HABILITATION AND THE MEMBER WAS PREVIOUSLY AUTHORIZED AT THE TIER LEVEL WITHOUT DAY ACTIVITY DUE TO RECEIVING LESS THAN 40 HOURS PER MONTH, SO NO CHANGE IN AUTHORIZATION, CAN WE BILL FOR THE RETAINER PAYMENT FOR THE ONE DAY PER WEEK?

Providers can bill the respective amount of units the member planned to utilize in the month of April 2020, but did not receive due to a condition related to COVID-19 as identified in IL 2136-MC-CVD.

WHAT IF YOU ARE A DAY PROGRAM ONLY AND RECEIVED CANCELLATION OF AUTHORIZATION AS THE RESIDENTIAL PROVIDER WAS GOING TO PROVIDE THE SERVICE. AS WE HAD AN AUTHORIZATION PRIOR TO THE PROCLAMATION, CAN WE BILL FOR RETAINER PAYMENT?

Providers should only bill the retainer payment if the service was authorized in the service plan and was unable to provide the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. If the provider received a cancellation for the service and therefore it was no longer authorized in the service plan, the provider is not eligible for the retainer payment.



RETAINER PAYMENTS

IF AN INDIVIDUAL WAS RECEIVING DAILY SCL, DAY HABILITATION AND SEP AND DAY HABILITATION WAS CLOSED AND THE INDIVIDUAL WAS MOVED FROM SCL WITH DAY SERVICES TO SCL WITHOUT DAY SERVICES CAN WE BILL THE RETAINER FOR SEP?

Yes. Providers can bill for Supported Employment Services as long as the service was prior authorized and the member did not receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. Providers should bill based on historical utilization and not rely solely on units authorized in the service plan.

THE NURSING HOME BED HOLD ANNUAL TOTAL IS 30 BILLABLE DAY. I THINK MOST FOLKS ARE LOOKING AT ONLY REQUESTING A RETENTION PAYMENT FOR 30 CALENDAR DAYS. WE OUGHT TO BE ABLE TO BILL FOR 30 BILLABLE DAYS, RIGHT?

The Department has determined that the retainer payments pertains to authorized services/units for April 2020, not 30 billable days. Nursing facilities are exclude from retainer payments at this time.

FOR THE ONE DAY PER WEEKDAY HABILITATION RETAINER, IT WOULD ONLY BE BILLING FOR THE ONE DAY PER WEEK THAT THE MEMBER NORMALLY ATTENDED DAY HABILITATION PRIOR TO CLOSURE?

Providers can bill the respective amount of units the member planned to utilize in the month of April 2020, but did not receive due to a condition related to COVID-19 as identified in IL 2136-MC-CVD.

OUR DAY HABILITATION WAS CLOSED MARCH 17, 2020. WE HAVEN'T BILLED OR PROVIDED ANY SERVICES SINCE. DOES THE RETAINER PAYMENT PAY FOR THE FULL AMOUNT OF THE CLIENT'S AUTHORIZED SERVICE FOR APRIL, EVEN IF THE CLIENT HAS A HISTORY OF ATTENDING ONLY 75 PERCENT OF THEIR SCHEDULED SHIFTS IN PREVIOUS MONTHS?

Providers can bill the respective amount of units the member planned to utilize in the month of April 2020, but did not receive due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. The provider should bill based on historical utilization. E.g., if a provider typically bills for 75 percent of authorized services, the provider should bill 75 percent of authorized services, not 100 percent.

HOW WOULD YOU DETERMINE WHAT TO BILL FOR IF THE INDIVIDUAL RECEIVES A VARYING COMBINATION OF DAILY AND 15-MINUT DAY HABILITATION UNITS?

Providers can bill the respective amount of units the member planned to utilize in the month of April 2020, but did not receive due to a condition related to COVID-19 as identified in IL 2136-MC-CVD.



RETAINER PAYMENTS

REGARDING SUPPORTED EMPLOYMENT ADDENDUMS – SINCE RETAINER PAYMENTS ARE BASED ON SERVICE AUTHORIZATIONS, WILL THE ADDENDUMS AFFECT THIS? FOR EXAMPLE, IF SOMEONE USUALLY HAS A TIER U5, BUT DUE TO FEWER HOURS BEING WORKED, AN ADDENDUM WAS PUT IN PLACE FOR A U3, CAN WE STILL BILL AT U5 FOR APRIL FOR THE RETAINER PAYMENT?

Yes. As long as the service was prior authorized and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD. The provider may only bill for services authorized for the month of April. If an addendum to the service plan changed the Tier, the provider would only be able to bill for the Tier authorized.

WILL AUTHORIZATIONS FOR DAILY SCL ID BE AUTOMATICALLY RETURNED TO TIER RATES WITH DAY ACTIVITY, OR WILL THIS BE A PROCESS THAT ALLOWS FOR THOSE NOT YET COMFORTABLE WITH RETURNING TO THEIR DAY ACTIVITIES?

Yes. As long as the service was prior authorized and the member did not actually receive the service due to a condition related to COVID-19 as identified in IL 2136-MC-CVD The provider may only bill for services authorized for the month of April. If an addendum to the service plan changed the Tier, the provider would only be able to bill for the Tier authorized.



TELEHEALTH

The expanded telehealth services are in effect statewide through at least 60 days after the public health emergency declaration is lifted. The IME is reviewing the continuation of expanded telehealth services beyond that.

CAN PROVIDERS PROVIDE TELEHEALTH SERVICE FROM THEIR HOME?

The IME, in collaboration with our Managed Care partners, is working to develop additional guidance for providers around the waivers requested by the State that will expand the application of technology to service delivery for our members during the duration of the COVID-19 emergency. The Department intends for providers to utilize technology to facilitate appropriate care reimbursable within the Medicaid program during this public health emergency. Part of this emergency provision will allow services that by definition are direct contact services and are typically rendered in person to be rendered via telehealth when clinically appropriate and necessary to preserve the health and safety of our Medicaid member. Providers must practice within the scope of their practice and are reminded that services must be documented in accordance with applicable documentation standards.

Regarding billing: The location of the provider becomes the distant site and defacto office. The provider performing the service (e.g. individual therapy, evaluation, etc.), may bill POS 02 and their regular CPT or HCPS codes along with modifier 95 as appropriate.

WHAT IS MEANT BY TELEPHONIC CONTACT – ONLY VIDEO?

Telephonic contact refers to contact relating to or happening by means of a telephone system. It does not mean video only. For the duration of the current emergency, services that typically require direct or face to face contact may be rendered via telehealth when clinically appropriate to the member's condition and needs and when provided within the clinician's scope of practice. Nothing in this statement otherwise effects a provider's responsibility to bill only for service performed and to comply with legal authority related to proper billing, claims submission, cost reporting or related conduct.

or Copy this link: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>

or Copy this link: <https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf>



TELEHEALTH

IS AN AUDIO-ONLY CALL PAID AT A LOWER RATE THAN A VIDEO CONFERENCE CALL?

There is no change in reimbursement rate, structure or methodology. Refer to [Informational Letter 2115-MC-FFS-CVD](#) for billing.

WILL IOWA MEDICAID BE ALLOWING DENTAL PROVIDERS TO BILL VIA TELEDENTISTRY IN EMERGENCY SITUATIONS WHERE PATIENTS CAN REACH A PROVIDER IF NECESSARY USING PHOTOGRAPHS OR VIDEOS?

Yes. Iowa Medicaid is opening codes for teledentistry in response to the COVID-19 pandemic to ensure our members access to necessary care.

ARE PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT) AND SPEECH THERAPY (ST) SERVICES COVERED AT THIS TIME FOR TELEHEALTH WITH BOTH THE IME AND THE MCOS?

The Department intends for providers to utilize technology to facilitate appropriate care reimbursable within the Medicaid program during this public health emergency. Part of this emergency provision will allow services that by definition are direct contact services and are typically rendered in person to be rendered via telehealth when clinically appropriate and necessary to preserve the health and safety of our Medicaid member. Providers must practice within the scope of their practice and are reminded that services must be documented in accordance with applicable documentation standards.

Regarding billing: Bill the appropriate CPT or HCPCS code with POS 02 and a 95 modifier.

IF A PROVIDER IS ENROLLED WITH IOWA MEDICAID AND CREDENTIALLED WITH AN MCO, BUT THEIR CLINIC IS IN OMAHA, NEB. AND THEY ARE PROVIDING TELEHEALTH SERVICES TO IOWA MEDICAID MEMBERS LOCATED IN IOWA, WOULD THAT BE COVERED?

Enrolled providers delivering Medicaid service to enrolled Iowa Medicaid members are covered.

CAN PROVIDERS DO TELEHEALTH AT A DIFFERENT LOCATION THAN THEY TYPICALLY PRACTICE AT DURING COVID-19?

Yes.

IS TELEHEALTH ALLOWED FOR MENTAL HEALTH THERAPY SESSIONS?

The Department has expanded the telehealth benefit for mental health therapy sessions when the service provided to Medicaid members is clinically appropriate and within the provider's scope of practice. Covered telehealth provider types (e.g., psychiatrist, clinical psychologist, nurse practitioner, CNS, CSW, LISW, LMFT, LMHC or CADC) may bill POS 02 with their regular BH codes.

HAS THE IME CONSIDERED OFFERING ADDITIONAL GUIDANCE TO PROVIDERS AROUND TELEHEALTH – BOTH HOW TO PROVIDE TELEHEALTH SERVICES AND HOW TO BILL FOR THEM?

Yes. The IME team in collaboration with the MCOs is working to develop additional guidance, including billing guidance, for providers.



TELEHEALTH

ARE OUTPATIENT PT SERVICES INCLUDED?

Yes, when clinically appropriate, documented appropriately and within the provider's scope of practice.

CAN CHILDREN'S MENTAL HEALTH WAIVER SERVICES AND HABILITATION STAFF UTILIZE TELEHEALTH?

Yes, the Department intends for providers to utilize technology to facilitate appropriate care reimbursable within the Medicaid program during this public health emergency. Part of this emergency provision will allow services that by definition are direct contact services and are typically rendered in person to be rendered via telehealth when clinically appropriate and necessary to preserve the health and safety of Medicaid members. Providers must practice within the scope of their practice and are reminded that services must be documented in accordance with applicable documentation standards.

WILL GROUP THERAPY VIA TELEHEALTH BE REIMBURSED?

The Department has expanded the telehealth benefit to include group therapy when the service provided to the Medicaid member is clinically appropriate and within the provider's scope of practice. Providers may bill POS 02 with modifier 95.

WHAT IS THE PROJECTED TIMELINE WHEN THE NEW TELEHEALTH CODES AND COST-SHARE POLICIES WILL BE UPDATED IN YOUR SYSTEM FOR CLAIMS PAYMENT?

Procedure codes U0001 and U0002 for lab testing are available and payable. Another new lab test, CPT 87635 will be added effective March 13, 2020. A new ICD-10 diagnosis code U07.1 will be added, effective April 1, 2020. Amerigroup Iowa systems will be configured for payment by March 31, 2020. Iowa Total Care systems will be configured for payment by April 2, 2020. IME systems are configured for payment.

WHAT PLACE OF SERVICE SHOULD BE USED FOR DRIVE-THRU COVID-19 TESTING SITES?

Providers should bill POS 15 (mobile unit).

WHAT TYPE OF BILL SHOULD BE USED FOR DRIVE-THRU COVID-19 TESTING SITES?

Hospitals should use bill type 014X. Other providers should use the CMS-1500 with place of service 15 (mobile unit).

CAN TELEHEALTH BE DONE VIA FACETIME OR SKYPE?

Refer to [Informational Letter 2115-MC-FFS-CVD](#) regarding virtual visits. HIPAA guidelines must be followed and use of social media platforms is prohibited.

WHAT CPT CODES WOULD A PROVIDER USE TO BILL A 45-MINUTE SESSION (CURRENTLY USE CPT CODE 90834) AND A DIAGNOSTIC EVALUATION (CPT 90791)?

Covered telehealth provider types may bill POS 02 and their regular BH codes along with modifier 95 as appropriate.



TELEHEALTH

DOES THE PATIENT HAVE TO BE ESTABLISHED IN ORDER TO RECEIVE TELEPHONIC AND/OR TELEHEALTH SERVICES?

The “established patient” requirement is part of the telehealth rules that are currently suspended. However, providers must practice within the scope of their practice and are reminded that services must be documented in accordance with the standards in Iowa Code. Use POS 02 and bill traditional CPT and HCPS codes along with modifier 95 as appropriate.

FOR THE ORIGINATING SITE ARE THERE ANY RECORDS OR DOCUMENTATION THAT IS RECOMMENDED TO BE KEPT IN THE MEMBER FILE TO BILL THE FACILITY FEE?

441 IAC 79.3(3) should be referenced regarding what documentation should be kept for auditing purposes.

WHAT HAPPENS IF THE ORIGINATING SITE DOESN'T FILE A CLAIM FOR THE FACILITY FEE? ARE THESE CROSS-REFERENCED WITH THE DISTANT SITE'S CLAIM? COULD THE PAID DISTANT SITE'S CLAIM BE RECOUPED IF THE ORIGINATING SITE DOESN'T SUBMIT A CLAIM FOR THE FACILITY FEE?

The originating site claim will not be cross referenced with the distant site claim. During the COVID-19 public health emergency the Department expects the originating site in many cases will be the member's home so no originating site claim would be billed.

FOR BEHAVIORAL HEALTH INTERVENTION SERVICES (BHIS), CAN WE PROVIDE AND BILL FOR TELEHEALTH SERVICES WITH CLIENTS THAT ARE NOT COMFORTABLE HAVING A PROVIDER IN THEIR HOME?

Covered telehealth provider types may bill POS 02 with the regular behavioral health codes along with modifier 95, as appropriate. As this telehealth is related to and covers the COVID-19 pandemic and BHIS is an intervention, it is recommended that there is significant documentation about the telehealth intervention, how BHIS was performed in the past and how the intervention matches the level of service provided in the past.

HOW DOES THE DEPARTMENT PLAN TO DIFFERENTIATE THE TELEHEALTH/ TELEPHONIC SERVICES BEING PERFORMED? HAS THERE BEEN THOUGHTS ABOUT INCLUDING OR ADDING MODIFIERS TO IDENTIFY THE DIFFERENT SERVICES – ESPECIALLY FOR HOME- AND COMMUNITY-BASED SERVICES (HCBS)?

Current payment methodologies and codes should be used for billing for services that are provided via telehealth or telephonic means, even for HCBS services. If the service is not a service that is traditionally a telehealth service and would normally be performed face-to-face, the service should be billed as it normally would with POS 02 that will identify the services were provided via telehealth or telephonically.

TELEPHONE VISIT CODES 99441-99443 ARE NEW SERVICES RELATED TO THE COVID-19 OUTBREAK AND ARE NOT A TRUE TELEHEALTH ENCOUNTER, HOW SHOULD RURAL HEALTH CLINICS (RHCS) BILL THESE CLAIMS?

RHCs were added to deliver telehealth services as a distant site as of March 13, 2020. RHC providers should bill the T1015 code with POS 02 to document the visit and bill any other CPT codes on the subsequent lines for informational purposes only. Payment will be made for the all-inclusive encounter rate.



TELEHEALTH

HOW DO FACILITIES BILL FOR TELEHEALTH SERVICES WHEN THERE IS NO PLACE OF SERVICE ON A UB04? WOULD IT JUST BE THE MODIFIER?

Facilities should bill their regular codes (RV and CPT/HCPCS codes) and modifier 95, as appropriate, to denote services performed via telehealth.

CAN A CRITICAL ACCESS HOSPITAL PROVIDE TELEHEALTH SERVICES AS THE DISTANT SITE PROVIDER IN AN RHC?

RHCs were added to deliver telehealth services as a distant site as of March 13, 2020. RHC providers should bill the T1015 code with POS 02 to document the visit and bill any other CPT codes on the subsequent lines for informational purposes only. Payment will be made for the all-inclusive encounter rate.

IS TELEHEALTH REIMBURSED IF THE 95 MODIFIER IS ADDED TO HOSPITAL-BASED CLAIMS, WHILE CHANGING THE POS TO 02 ON THE FREESTANDING CLINICS AND PROCEED WITH NORMAL CPT CODES?

Facilities should bill their regular codes (RV and CPT/HCPCS codes) and modifier 95, as appropriate, to denote services performed via telehealth. Professionals and freestanding clinics should bill POS 02 with modifier 95, as appropriate, and their regular service codes.

WHEN WILL THE VIRTUAL CARE SERVICES CODES BE ADDED TO THE FEE SCHEDULE?

The virtual care service codes are in the system and available for billing. The codes will be included in the next Medicaid Fee Schedule update.

ARE THESE CODES ONLY AVAILABLE DURING THIS PUBLIC HEALTH CRISIS OR WILL THESE REMAIN BILLABLE BEYOND THAT?

The expanded telehealth benefits are temporary and will be lifted post-pandemic.

FOR PROVIDERS DOING TELEHEALTH AT HOME DURING THE COVID-19 OUTBREAK, CAN THEY CONTINUE USING THE PRACTICE LOCATION IN BOX 32, WHICH IS LOCATION SERVICES RENDERED?

The location of the provider becomes the distant site and defacto office. The provider performing the service (e.g., individual therapy, evaluation, etc.), may bill POS 02 and their regular CPT or HCPCS codes along with modifier 95, as appropriate.

IF NURSES ARE DOING A MEDICAL CHECK VIA TELEHEALTH, CAN THEY BILL THE Q3014? WHAT ABOUT THERAPY?

Covered telehealth provider types may bill POS 02 and their regular E/M codes along with modifier 95, as appropriate. Providers should not bill Q3014 for originating site fee when they are performing the actual service.

ARE HOME HEALTH AND HOSPICE COVERED UNDER TELEHEALTH? HOW DOES A PROVIDER BILL FOR THESE?

Hospice bills Iowa Medicaid on UB-04 using a revenue code that denotes the level of service, e.g., general inpatient, routine, respite, continuous care. The rate is an all-inclusive daily rate that would



TELEHEALTH

encompass services, drugs, DME, etc. that may or may not be provided via telehealth. The current billing process remains in effect. No changes are needed. For calculation of service intensity add-on (SIA) payments, visits may be performed via telehealth and the traditional code should be used with a modifier 95, as appropriate.

Home care bills Iowa Medicaid on UB-04 using a revenue code or the appropriate HCPCS code that denotes the service discipline visit, e.g., skilled nursing care, physical therapy, speech therapy, occupational therapy, medical social worker, home health aide. Payment for home care is based on LUPA and private duty nursing is based on an hourly fee. The current billing process remains in effect. Visits may be performed via telehealth and the traditional revenue code or HCPCS code should be used with a modifier 95, as appropriate.

ARE COMPLETE DIAGNOSTIC EVALUATIONS THROUGH TELEHEALTH COVERED?

The IME has expanded the telehealth benefit for diagnostic services when the service is provided to Medicaid members, is clinically appropriate and within the provider's scope of practice. Use POS 02 and bill traditional CPT and HCPCS codes along with modifier 95, as appropriate.

DO PROVIDERS NEED TO USE BOTH POS 02 AND A MODIFIER 95 ON CLAIMS FOR TELEHEALTH SERVICES?

Use POS 02 and additionally use the 95 modifier, if necessary.

ARE VERBAL RELEASES FOR TELEHEALTH OK?

Yes, follow the procedures for pharmacy and write, "COVID-19" in place of the signature.

FROM CMS: HOW DO THE MEDICAID FLEXIBILITIES AROUND USE OF TELEHEALTH AS A SERVICE DELIVERY MODE INTERACT WITH MEDICARE AND COMMERCIAL THIRD PARTY LIABILITY (TPL) REQUIREMENTS, WHICH MAY BE LESS FLEXIBLE AROUND TELEHEALTH? FOR EXAMPLE, A MEDICARE OR COMMERCIAL PAYER MAY REQUIRE A FACE-TO-FACE PHYSICIAN VISIT TO ORDER CARE OF SUPPLIES.

Please note that Medicare has recently increased flexibilities related to telehealth due to the public health emergency, as summarized in the [fact sheet](#). While Medicare and commercial payers have increased flexibilities for telehealth, there may still be instances where coordination of benefits is necessary.

Medicaid payment allows for state plan flexibilities in the event Medicare or a commercial insurer denies payment. If the third party denied the claim for a substantive reason (e.g., service not covered) and the service is covered under the Medicaid state plan, Medicaid would review for payment accordingly. If at a later time, the state is made aware of a third party's coverage for these specific services, the state, as it currently does, would chase recovery of payment accordingly. Therefore, in the example above, once Medicare or a commercial payer reviews a claim and denies for a substantive reason, such as face-to-face physician visit requirement, Medicaid would review and pay according to the state plan. If telehealth is permitted under the Medicaid state plan, Medicaid would pay accordingly.



TELEHEALTH

CAN SUBSTANCE USE DISORDER (SUD) GROUP SERVICES BE PROVIDED THROUGH TELEHEALTH SERVICES?

Group therapy can be provided in a clinically appropriate manner within the provider's scope of practice. Providers may bill POS 02 with modifier 95. Substance Abuse and Mental Health Services Administration (SAMHSA) continues to send out [guidance](#) regarding SUD and mental health services via telehealth.

MOBILE CRISIS IS ALLOWED UNDER TELEHEALTH. HOW SHOULD PROVIDERS BILL FOR THIS? WILL THE INTERNAL TEAM STILL OBTAIN THE PRIOR AUTHORIZATION (PA)?

Refer to [Informational Letter 2115-MC-FFS-CVD](#) for appropriate billing codes. Mobile crisis does not currently require a PA unless the provider is out of network.

IS PLACE OF SERVICE (POS) 23 OR 31 VALID FOR TELEHEALTH?

The IME has expanded the telehealth benefit to include non-traditional telehealth services provided to Medicaid members is clinically appropriate and within the provider's scope of practice. Providers should bill using the appropriate CPT or HCPS code with POS 02 and a 95 modifier.

IS THE CR MODIFIER REQUIRED ON ANY OF THE TELEHEALTH SERVICES?

No, the CR modifier is not required on telehealth services.

CAN A NEW MENTAL HEALTH ASSESSMENT BE DONE VIA TELEHEALTH?

The "established patient" requirement is part of the telehealth rules that are currently suspended. However, providers must practice within the scope of their practice and are reminded that services must be documented in accordance with the standards located in 441 IAC 79.3(3). Use POS 02 and bill the traditional CPT and HCPS codes along with modifier 95, as appropriate.

FOR AUTISM SERVICES, DO PROVIDERS NEED TO AMEND THEIR AUTHORIZATIONS IN RELATION TO THE MODIFIER OR NUMBER OR UNITS REQUESTED? HOW SHOULD PROVIDERS DO THIS?

Submit an authorization and include the existing reference number and requested changes.

HOW SHOULD PROVIDERS BILL FOR AUTISM SERVICES VIA TELEHEALTH? SHOULD PROVIDERS SUBMIT AUTHORIZATION REQUESTS FOR THESE?

Use current authorizations and use the 95 modifier.

A FEDERALLY QUALIFIED HEALTH CENTER (FQHC) WANTS TO DO PARKING LOT TESTING AFTER THE INDIVIDUAL HAS BEEN SCREENED VIA TELEHEALTH BY THEIR NURSING STAFF, HOW WOULD THE PROVIDER BILL FOR THIS?

FQHCs should bill the T1015 code with POS 02 to document the visit and bill any other CPT codes on the subsequent lines for informational purposes only. Payment will be made for the all-inclusive encounter rate.



TELEHEALTH

WOULD AN OUTPATIENT HOSPITAL (BILLED ON A UB) BE COVERED BY TELEHEALTH?

The IME has expanded access to care by allowing telehealth delivery for Medicaid beneficiaries when the service is clinically appropriate and within the provider's scope of practice. Refer to Informational Letters related to COVID-19 for more guidance. Bill the traditional revenue, HCPS or CPT codes and add the 95 modifier.

WILL THE SITE OF SERVICE DIFFERENTIAL APPLY TO TELEHEALTH CLAIMS?

Effective March 13, 2020, the site of service differential (see IL 1815) with the place of service 02 will not be applied to telehealth claims during the COVID-19 public health emergency.

ARE BHIS CODES H2019HA, H2019HR AND H2014 COVERED THROUGH TELEHEALTH DUE TO CHANGES WITH COVID-19?

All Iowa Medicaid covered services that providers are able to provide via a telehealth mechanism, such as telephonic or video chat, is included in the expansion of telehealth for the duration of this emergency. Providers need to document the service delivery and ensure that the delivery and documentation aligns to what is billed. If audio will support the service delivery, it's acceptable. However, services that are more reliant on physical modeling, hands on intervention or visual observation will need to be vetted by the individual provider as part of the member's overall plan of support to determine appropriateness of delivery via telehealth.

ARE FACE-TO-FACE VISITS REQUIRED FOR HOME HEALTH REFERRALS?

Iowa Medicaid has expanded access to home health by allowing telehealth delivery for Medicaid members when the service is clinically appropriate and within the provider's scope of practice.

ARE PROVIDERS ABLE TO BE REIMBURSED FOR PROVIDING VIRTUAL ROUNDS FROM OUT OF STATE?

It is permissible to bill Locum during the COVID-19 emergency. Virtual rounds are paid just like any other telehealth service.

IS A DURABLE MEDICAL EQUIPMENT (DME) PROVIDER ABLE TO PERFORM A WHEELCHAIR (OR OTHER EQUIPMENT) EVALUATION BY REMOTE TECHNOLOGY?

Iowa Medicaid has expanded access to care by allowing telehealth delivery of DME services for Medicaid beneficiaries when the service is clinically appropriate and within the provider's scope of practice.

IS A DME PROVIDER ABLE TO PERFORM A WHEELCHAIR (OR OTHER EQUIPMENT) DELIVERY BY REMOTE TECHNOLOGY?

Iowa Medicaid has expanded access to care by allowing telehealth delivery of DME services for Medicaid beneficiaries when the service is clinically appropriate and within the provider's scope of practice.



TELEHEALTH

IS A DME PROVIDER ABLE TO CONFIRM THAT THE HOME IS ACCESSIBLE FOR THE REQUESTED EQUIPMENT BY REMOTE TECHNOLOGY?

Iowa Medicaid has expanded access to care by allowing telehealth delivery of DME services for Medicaid beneficiaries when the service is clinically appropriate and within the provider's scope of practice.

WILL ANY PORTION OF THE PRIOR AUTHORIZATION REQUIREMENTS FOR DME BE WAIVED? FOR EXAMPLE, WHEN REQUESTED REPAIRS TO EXISTING EQUIPMENT.

The IME is not suspending prior authorizations at this time. We continue to work in collaboration with our managed care partners to monitor prior authorizations. Please work with the MCO on prior authorization requirements.

WILL THE SIGNATURE REQUIREMENT AT DELIVERY FOR DME BE WAIVED OR MODIFIED TO ALLOW FOR COLLECTION OF DELIVERY SIGNATURE BY OTHER MEANS THAN IN-PERSON?

If a signature is not obtained due to COVID-19 precautions, documentation of a verbal confirmation of delivery would be appropriate. Documentation should include the date, time, the location, and the name and contact information of the person who delivered and received the DME. Note "COVID-19" in the signature space.

WITH GOV. REYNOLDS LOOSENING RESTRICTIONS FOR 77 COUNTIES THROUGHOUT THE STATE, WHEN DO THE EXPANDED TELEHEALTH SERVICES END?

The expanded telehealth services will resume until final guidance is given by the IME.

DURING THE COVID-19 CRISIS, WILL MEDICAID ALLOW FOR PHYSICAL THERAPIST ASSISTANTS (PTAS) AND ATHLETIC TRAINER, CERTIFIED (ATCS), AS WELL AS PHYSICAL THERAPISTS TO BILL FOR PHYSICAL AND OCCUPATIONAL THERAPY FOR TELEHEALTH?

PTAs and ATCs are not currently enrolled providers in Iowa Medicaid. This has not changed due to the public health emergency and therefore they would not be allowed to bill for physical and occupational therapy for telehealth services.

ARE ANNUAL WELLNESS VISIT CODES REIMBURSED BY IOWA MEDICAID WHEN DONE VIA VIRTUAL VISIT AT THIS TIME (CODE 99395)?

Yes. Code 99395 can be billed as a telehealth visit. Based on recent CMS guidance, providers should bill the place of service code that would have been billed had telehealth not been used.

IS SCHOOL-BASED TELE PRACTICE COVERED FOR THE FOLLOWING DISCIPLINES UNDER MEDICAID FOR CHILDREN UNDER THE AGE OF 21 IN PUBLIC AND CHARTER SCHOOLS IN IOWA: SPEECH AND LANGUAGE PATHOLOGIST, OCCUPATIONAL THERAPIST, PHYSICAL THERAPIST, BOARD CERTIFIED BEHAVIORAL ANALYST, SCHOOL PSYCHOLOGIST, AND SOCIAL WORKER?

If the provider would traditionally be able to provide and bill for the service, they may provide the service via telehealth if it is medically necessary, clinically appropriate and within the provider's scope of practice.



TELEHEALTH

SOME OF THE LOCAL EDUCATION AGENCY (LEA) SERVICES ARE PERFORMED BY STAFF THAT DO NOT HAVE A PROFESSIONAL PRACTICE ACT LIKE THE AREA EDUCATION AGENCY (AEA) STAFF. AS LONG AS THEY ARE ONLY DOCUMENTING AND CLAIMING FOR SERVICES DEFINED BY THE INDIVIDUALIZED EDUCATION PROGRAM (IEP) AND NORMALLY COVERED BY MEDICAID, WOULD THE LEA BE ABLE TO CLAIM FOR THE PARAPROFESSIONAL SERVICES VIA TELEHEALTH?

The intervention must be clinically appropriate to the identified need in the member's IEP, i.e. if the intervention is clinically appropriate to be delivered via telehealth. Providers will need to document the service delivery and ensure that the delivery and documentation aligns to what is billed. However, services that are more reliant on physical modeling, hands on intervention or visual observation will need to be vetted by the individual provider as part of the member's overall plan of support to determine appropriateness of delivery via telehealth.

REGARDING BILLING FOR A LEA RENDERING PARAPROFESSIONAL SERVICES VIA TELEHEALTH: (A) WOULD THE POS NEED TO INDICATE TELEHEALTH OR STILL AT SCHOOL, AS THE STAFF ARE STILL LOCATED IN THE BUILDINGS? (B) WOULD THE DISTRICT ALSO BE ABLE TO CLAIM THE FACILITY FEE THAT THEY ARE ALLOWED FOR THE AEA TELEHEALTH SERVICES? (C) WOULD THESE SERVICES ONLY BE ALLOWED FOR DATES THE DISTRICTS ARE IN AN 'OPEN' STATUS WITH ONLINE OR VIDEO INSTRUCTION? (D) IS THE COST RATE FOR THE REGULAR PARAPROFESSIONAL SERVICE THE SAME COST FOR THE TELEHEALTH PROVIDED SERVICE?

- A.** Based on recent CMS guidance, bill the appropriate CPT or HCPS code with a POS as if you would have otherwise reported had the service been furnished in person, using the 95 modifier as informational.
- B.** No, if the child is not located at the school, the LEA or AEA cannot bill the facility fee.
- C.** Yes, school-based services are only billable for the dates of service the child is participating in education as documented in the date span in the child's IEP.
- D.** Yes

HOW DO WE BILL REMOTE PATIENT MONITORING SERVICES (CPT 99457, 99458) AS AN FQHC? FFS OR ENCOUNTER RATE? WILL THESE BE COVERED TEMPORARILY ONLY DURING THE COVID-19 EMERGENCY? OR, WILL A MORE PERMANENT PROCESS BE SET IN PLACE? WHAT ARE THE REIMBURSEMENT RATES?

FQHCs would bill the T1015 code with POS 02 to document the visit and bill any other CPT codes on the subsequent lines for informational purposes only. Payment will be made for the all-inclusive encounter rate. The expanded telehealth services will be in effect statewide for at least 60 days after the public health emergency declaration is lifted.



HOME DELIVERED MEALS

or Copy this link: <https://dhs.iowa.gov/sites/default/files/Expanded%20Home%20Delivered%20Meals.pdf?032320201328>

CAN ADDITIONAL MEALS BE PROVIDED EVEN IF NOT INCLUDED WITHIN THE CURRENT MANAGED CARE ORGANIZATION (MCO) MEAL PLAN?

Iowa Medicaid has requested authority to extend coverage of home-based meals to all waiver and home bound, non-waiver Medicaid members. However, the two meal per day limit remains in effect. For changes in individual member plans, connect with the member's MCO.

WHAT IS THE ROLE OF AREA AGENCIES ON AGING (AAA) IN HOME DELIVERED MEALS?

The expansion of the Medicaid benefit for home delivered meals does not change the role of the AAAs who currently provide home delivered meals to Medicaid members. All meal providers who identify a member who needs meal coverage as a result of the impact of COVID-19 should reach out to the member's Fee-for-Service (FFS) or Managed Care Organization (MCO) case manager. If the member does not have a case manager, connect to IME Member Services at 1-800-338-8366. [The Iowa Department on Aging](#) also plays a role regarding meals provided via resources outside of Medicaid.

HOW WILL MEAL PROVIDERS BE NOTIFIED THAT CLIENTS ARE APPROVED FOR HOME DELIVERED MEALS IF MEALS WERE NOT APPROVED UNDER THAT WAIVER INITIALLY?

Providers with questions about member-specific plan changes for waiver members should connect with the member's MCO community-based case manager or the FFS case manager.

HOW WILL MEAL PROVIDERS BE NOTIFIED OF INCREASED MEAL APPROVALS FOR THOSE THAT WERE ALREADY APPROVED AND RECEIVING HOME DELIVERED MEALS?

Providers with questions about member-specific plan changes for waiver members should connect with the member's MCO community-based case manager or the fee-for-service case manager. For home-bound, non-waiver MCO members, referrals may be made to an assigned community based case manager, the MCO member call center or other designated MCO point of contact as made available by the MCO. For home-bound, medically fragile, non-waiver FFS members connect to IME Member Services at 1-800-338-8366.

WILL THERE BE ANY DOCUMENTATION GIVEN THAT WILL ENSURE PROVIDERS WILL BE PAID FOR MEALS PROVIDED UNDER THIS APPROVAL?

The State has requested authority from the Centers for Medicare and Medicaid Services (CMS) to expand meal benefits during the duration of the emergency proclamation. For waiver members,

(Continued)



HOME DELIVERED MEALS

connect with the MCO community-based case manager or FFS case manager to discuss individual plan changes. For home-bound, non-waiver MCO members, referrals may be made to an assigned community based case manager, the MCO member call center or other designated MCO point of contact as made available by the MCO. For home-bound, medically fragile, non-waiver FFS members connect to IME Member Services at 1-800-338-8366.

IF PROVIDERS ARE SET UP TO BILL WAIVER MEALS ARE THEY OK TO BILL ALL OTHER MEALS APPROVED AT THIS TIME?

Connect with the MCO or FFS case managers regarding any new or increased authorizations needed. If the member does not have an assigned case manager, connect to IME Member Services at 1-800-338-8366.

IS THE TIME SPAN FOR THIS APPROVAL THROUGH THE END OF THE CLIENT'S SERVICE PLAN DATE OR IS IT THROUGH A SET DATE ACROSS THE BOARD?

Approvals are anticipated to extend through the duration of the emergency proclamation.

WILL PROVIDERS RECEIVE AUTHORIZATIONS FROM EACH COMPANY DIRECTLY OR WILL APPROVALS BE REFERRALS FROM THE CASE WORKERS?

Providers should work with the MCO or FFS case managers directly.

CAN PROVIDERS OFFER ASSISTANCE WITH ONLINE ORDERING OF GROCERIES AND THEN HAVE STAFF PROVIDE PICK UP AND PORCH DELIVERY – WOULD THIS BE A BILLABLE SERVICE UNDER HOMEMAKER SERVICES?

Iowa Medicaid has [expanded benefits](#) for home delivered meals for members who are impacted by the COVID-19 pandemic. This is a billable service under Medicaid during the pandemic.



PREMIUMS SUSPENDED

SHOULD PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) ORGANIZATIONS CONTINUE TO COLLECT CLIENT PARTICIPATION EFFECTIVE MARCH 2020?

Yes, there is no change to client participation.

DOES THE PREMIUM/SHARE OF COST SUSPENSION APPLY TO LONG-TERM CARE CLIENT PARTICIPATION COPAYS?

No. Client participation is not suspended at this time.

FOLLOWING THE SUSPENSION PERIOD, WILL A MEMBER WHO WAS PAST DUE ON THEIR HAWKI PREMIUM PAYMENT FOR JANUARY AND/OR FEBRUARY BE REQUIRED TO PAY THEIR PAST DUE BALANCE BEFORE RECEIVING SERVICES AGAIN?

Yes.

WILL SPENDDOWN FOR RESOURCE LIMIT OF \$2,000 BE WAIVED DURING THE PANDEMIC?

We are not disenrolling anyone even if they've not spent down their resources. For any new applicant, they have to meet all eligibility requirements before they become eligible, including meeting the resource limit.

ARE INDIVIDUALS IN THE MEDICALLY NEEDY PROGRAM INCLUDED IN THE WAIVER OF COST-SHARING?

We are not disenrolling anyone, even if they've not spent down their resources. For any new applicant, they have to meet all eligibility requirements before they become eligible, including meeting the resource limit.

ARE YOU NO LONGER REQUIRING THE PHARMACY CO-PAY?

During the national COVID-19 epidemic, the Department is suspending the pharmacy co-pay. The MCOs are not charging a pharmacy co-pay at this time and we have configured the FFS system for this.



SOCIAL SECURITY INCOME (SSI)/UNEMPLOYMENT

DURING THE EMERGENCY DECLARATION WILL UNEMPLOYED INDIVIDUALS BE ALLOWED TO KEEP THEIR MEDICAID BENEFITS AND BE EXCLUDED FROM THE UNEARNED INCOME THAT THEY RECEIVE FROM UNEMPLOYMENT?

During this declared timeframe, loss of SSI benefits due to unemployment benefits will not dis-enroll an individual from Medicaid. However, when the declaration is lifted, if the member is no longer eligible for SSI, we would take appropriate action to re-determine eligibility under a different coverage group.

ARE ALL MEDICAID RECIPIENTS IN THE STATE REQUIRED TO NOTIFY DHS OF RECEIPT OF THE STIMULUS MONEY, AND IF NOT, WHO IS EXEMPT FROM THE NORMAL REQUIREMENT TO REPORT MONEY WITHIN 10 DAYS?

All Medicaid recipients are required to report the stimulus money.

HOW DOES THE STIMULUS PAYMENT AFFECT MEDICAID RECIPIENTS?

The COVID-19 stimulus payments to individuals and families is not countable income for Medicaid applicants and recipients. Stimulus payments not spent in the month it is received are excluded as a resource for 12 months.

IF THE STIMULUS PAYMENT IS NOT TREATED AS INCOME IN THE MONTH IT IS RECEIVED, THEN IT JUST BECOMES PART OF THE COUNTABLE ASSETS THE PERSON HAS. IN SOME CASES, AFTER A PERSON HAS RECEIVED AN ASSET, THE PERSON HAS SOME NUMBER OF DAYS TO GET BACK UNDER THE \$2,000 LIMIT. HOW LONG IS THAT IN THIS CASE?

The COVID-19 stimulus payments to individuals and families is not countable income for Medicaid applicants and recipients. Stimulus payments not spent in the month it is received are excluded as a resource for 12 months.

FORM FOR EMPLOYERS TO REPORT UNEMPLOYED CLAIMANTS IN IOWA WHO HAVE REFUSED LEGITIMATE JOB OFFERS:

or Copy this link: <https://www.iowaworkforcedevelopment.gov/job-offer-decline-form-employers>

HOW DO UNEMPLOYMENT PAYMENTS AFFECT MEDICAID RECIPIENTS?

Federal Pandemic Unemployment Compensation (FPUC) payments are issued to individuals receiving unemployment benefits for \$600 per week. FPUC payments are not countable for Medicaid members.



BEHAVIORAL HEALTH SERVICES

CAN BEHAVIORAL HEALTH INTERVENTION SERVICE (BHIS) BE PROVIDED USING TELEHEALTH?

All Iowa Medicaid covered services that our providers are able to provide via a telehealth mechanism, such as telephonic or video chat is included in the expansion of telehealth for the duration of this emergency. Providers will need to document the service delivery and ensure that the delivery and documentation aligns to what is billed. If audio will support the service delivery, it's acceptable. However, services that are more reliant on physical modeling, hands on intervention or visual observation will need to be vetted by the individual provider as part of the member's overall plan of support to determine appropriateness of delivery via telehealth.

CAN APPLIED BEHAVIORAL ANALYSIS (ABA) BE PROVIDED VIA TELECOMMUNICATION, TELEHEALTH, SMART PHONE VIDEO CONFERENCE OR OTHER ELECTRONIC MEANS?

The Department issued Informational Letter [2119-MC-FFS-CVD](#) which provides guidance on services that typically require direct or face-to-face contact, may be rendered via telehealth when clinically appropriate to the member's condition and needs when provided within the clinician's practice. See general telehealth guidance above.

CAN SUBSTANCE USE DISORDER (SUD) SERVICES BE PROVIDED IN THE MEMBER'S HOME?

Yes, Opioid Treatment Programs (OTPs) providing buprenorphine treatment may render services in the member's home via telecommunication, telehealth, smart phone video conference or other electronic means. The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided [guidance](#) to OTP providers.

CAN BHIS SERVICES BE PROVIDED VIA TELEHEALTH TO A CLIENT WHO IS TEMPORARILY OUT OF STATE ON A VISIT?

Yes. BHIS services may be furnished via telehealth if the client is temporarily out of state on a visit and the provision of the BHIS is clinically appropriate to the member's identified needs.



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

IS IT OK FOR A SUPPORTED COMMUNITY LIVING (SCL) PROVIDER TO GROCERY SHOP OR PICK UP MEDICATIONS FOR A MEMBER WHO WOULD NORMALLY PARTICIPATE IN THESE ACTIVITIES, BUT DUE TO COVID-19 IS UNABLE TO PARTICIPATE AT THIS TIME?

If a member is unable to leave their home due to a situation resulting from the COVID-19 pandemic, staff may complete tasks or activities that are identified in the member's service plan. Staff must engage the member in the activities to the greatest extent possible. If the service is billed as SCL in 15-minute units, the provider must engage the member using telephonic or video technology (e.g., Skype) so the member can be engaged in the SCL service delivery process. The billing must reflect the member's engagement and must only reflect the duration of the service delivered. Daily SCL providers bill in a daily unit for all services provided to the member during the day. Daily SCL providers will need to document all services provided and assure they meet the eight hours per day average criteria to bill the member's SCL daily rate.

CAN A PROVIDER CONTINUE A SERVICE THAT WOULD BE SUBJECT TO THE GOVERNOR'S PROCLAMATION?

The Governor's proclamation speaks to service settings and limits the number of persons able to gather. Those services should not continue at this time.

ARE SMALL GROUP EMPLOYMENTS SUSPENDED LIKE DAY HABILITATION AT THIS TIME?

Many employers and businesses may be closed at this time; however supported employment services may continue for members who are healthy, and who need support to maintain their jobs with employers who consider them essential workers.

CAN A PARENT, LEGAL GUARDIAN OR IMMEDIATE FAMILY MEMBER PROVIDE HCBS SERVICES IF ANOTHER PROVIDER ISN'T AVAILABLE?

Yes. The State has requested this option in its waiver authority request for the duration of the COVID-19 emergency. Work with the member's case manager regarding provider needs and any changes that need to be made to member's service plans.

ARE WORKSHOP SETTINGS WITH MORE THAN 10 MEMBERS ALLOWED TO CONTINUE TO PROVIDE SERVICES?

Please follow the proclamation of the Governor. The Department cannot grant an exception to the Governor's proclamation.

WHAT SHOULD PROVIDERS DO REGARDING THE BILL THAT WILL MANDATE PAYING SICK LEAVE?

Providers are encouraged to monitor the Iowa Workforce Development [website](#).



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

WHAT SHOULD BE DONE FOR SIGNATURES ON THE SERVICE PLAN AND THE CONSUMER-DIRECTED ATTENDANT CARE (CDAC) AGREEMENT WHEN THE INDIVIDUAL DEVELOPMENT TEAM (IDT) IS COMPLETED VIA WEBEX OR CONFERENCE CALL?

Work with the member's case manager. Both MCO and FFS case management have mitigation plans in place for signatures.

IF A PROVIDER WERE TO HAVE AN OUTBREAK OF COVID-19, AND THEY END UP HAVING MORE THAN FOUR INDIVIDUALS AT AN ISOLATION HOUSE AT THE SAME TIME, WOULD THAT BE OK?

Yes. This is part of the State's waiver authority request.

WHAT ADULT DAY SERVICES ARE INCLUDED IN THE GOVERNOR'S PROCLAMATION?

The Governor's proclamation speaks to service settings and limits the number of persons able to gather. This is impactful for all Iowans and includes, but is not limited to, day habilitation, prevocational services, and adult day care. Providers need to adhere to the proclamation. The Department cannot override the proclamation of the Governor.

ARE SUPPORTED EMPLOYMENT SERVICES SUSPENDED LIKE ADULT DAY CARE AND DAY HABILITATION AT THIS TIME?

Many employers and businesses may be closed at this time; however supported employment services may continue for members that are healthy, and who need support to maintain their jobs with employers who consider them essential workers.

ARE FACILITY BASED DAY SERVICE SETTINGS WITH MORE THAN 10 MEMBERS ALLOWED TO CONTINUE TO PROVIDE SERVICES?

The Governor's proclamation speaks to service settings and limits the number of persons able to gather together. This includes facility-based day habilitation, prevocational services, and adult day care.

ARE HCBS PROVIDERS CONSIDERED ESSENTIAL STAFF IF IT GETS TO THE POINT WHERE THERE IS A "SHELTER IN PLACE" ORDER?

Essential personnel guidance is issued by the Iowa Department of Public Health (IDPH). Please refer to "Isolation Guidance for Essential Services Personnel."

or Copy this link: <https://idph.iowa.gov/Portals/1/userfiles/7/3222020UpdatedIsolation%20guidance%20for%20Iowa%20essential%20services%20personnel.pdf>



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

HOW SHOULD HCBS PROVIDERS, PARTICULARLY HOURLY/15-MINUTE SERVICES, MODIFY THEIR GOAL-BASED SERVICES SO THAT THEY CAN STILL PROVIDE AND BILL FOR SERVICES IF THEY CANNOT TAKE MEMBERS OUT IN THE COMMUNITY?

Providers will need to modify their service provision in a way to meet the individual's needs. Providers will need to document the service delivery and ensure that the delivery and documentation aligns to what is billed. If audio will support the service delivery, it's acceptable. However, services that are more reliant on physical modeling, hands on intervention or visual observation will need to be vetted by the individual provider in collaboration with the member and the IDT as part of the member's overall plan of support to determine appropriateness of delivery via alternate mechanisms, such as audio support or video conferencing.

CAN HCBS PROVIDERS TEMPORARILY WAIVE TRAINING REQUIREMENTS IF THEY HAVE EMERGENCY STAFFING NEEDS, AS LONG AS THE STAFF MEETS BACKGROUND CHECK REQUIREMENTS?

The Department is amenable to waiving training requirements in emergency staffing scenarios. For example, if a provider is unable to safely staff for member needs due to COVID-19 impact, the provider may choose to delay training required to meet some standards of accreditation. It is expected that providers will track any emergency planning deployed and will ensure staff complete their training once the emergency is mitigated.

CAN A PROVIDER DO DAY HABILITATION WITH ONE PERSON IN THE HOME AND HAVE THE OTHER PEOPLE DO THEIR NORMAL SUPPORTED COMMUNITY LIVING (SCL) ACTIVITY WITH THEIR SCL STAFF?

For the duration of the public health crisis the Department is waiving the requirement that day habilitation occur outside of the member's home. Providers will need to document the service delivery and ensure that the delivery and documentation aligns to what is billed. If audio will support the service delivery, it's acceptable. However, services that are more reliant on physical modeling, hands on intervention or visual observation will need to be vetted by the individual provider in collaboration with the member and the IDT as part of the member's overall plan of support to determine appropriateness of delivery via alternate mechanisms, such as audio support or video conferencing.

ARE PROVIDERS ABLE TO REQUEST AN EXCEPTION TO POLICY (ETP) TO ALLOW A "HOST HOME" SCENARIO FOR SCL AND HOME-BASED HABILITATION MEMBERS MOVING INTO STAFF HOMES UNTIL THE PANDEMIC IS OVER?

In reference to adult members, the Department does not plan to approve overarching ETPs for a provider to move all of their members served into "host home" like scenarios. Moving members from their homes into the homes of provider staff is expected to be used only a last resort option. If all other options are exhausted and the only path that preserves member safety is to move them out of their homes, providers need to work with the member's case manager and the IDT. All will need to agree to the change in the member's plan and safety planning will need to be in place. The agency remains responsible for ensuring the health, safety, and welfare of the members when services are provided in a staff home.

For Residential Based Supported Community Living (RBSCCL) each individual request must receive Department approval.



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

HOW WILL ASSESSMENTS FOR THE HCBS WAIVERS AND HABILITATION BE CONDUCTED DURING THE CURRENT SITUATION?

The Department will continue to process HCBS waiver applications, with some changes in processes to allow for applicant and assessor safety. interRAI has issued guidance about performing assessments through live video stream, including guidance for assessor awareness of effects on COVID-19 or isolation on the applicant/member. Supports Intensity Scale (SIS) off year assessments will continue to be done telephonically. Both IME FFS and the MCO assessment teams have plans in place to continue to conduct assessments safely.

WHAT SHOULD PROVIDERS DO IF THEY HAVE MEMBERS ASKING THEM TO TAKE THEM TO NON-ESSENTIAL PLACES AS PART OF THEIR HCBS SERVICES?

It is everyone's responsibility to do what we can to flatten the curve. Providers may need to limit their service provision to essential services only (such as support for medical appointments or grocery shopping) in response to the COVID-19 pandemic. Providers can use guidance provided by the Centers for Disease Control (CDC) when making decisions about limits they put in place on non-essential service delivery.

WITH PROVIDER OFFICES CLOSED CAN STAFF CALL IN, HAVE DOCUMENTATION TRANSCRIBED, AND GIVE A VERBAL SIGNATURE UNTIL THEY ARE ABLE TO COME IN AND SIGN? CAN PROVIDERS BILL WITH A VERBAL SIGNATURE?

Over the phone dictation, when necessary due to the impact of COVID-19, is acceptable with a documented verbal signature from staff. Staff must sign documentation as soon as possible. Providers are able to submit to billing with a verbal signature, however, providers are reminded that documentation may be subject to review later.

IF A MEMBER IS APPROVED FOR INTERIM MEDICAL MONITORING AND TREATMENT (IMMT) AND THEIR SISTER IS AN EMPLOYEE OF THE AGENCY, BUT IS 16 YEARS OLD, CAN THE AGE LIMIT BE WAIVED DURING THE PANDEMIC, AS THERE ARE NO OTHER AVAILABLE STAFF?

Work with the member's MCO Community-Based Case Manager (CBCM) or FFS Targeted Case Management (TCM) and the IDT to assess all options to support the member's needs. If all options are exhausted and there is a need to waive the age limit in order to maintain medically necessary services to the member, an ETP can be submitted via the typical ETP process.

FOR PROVIDERS OF HCBS SERVICES (INTELLECTUAL DISABILITY/ DEVELOPMENTAL DISABILITY) HOW ARE WE CLASSIFIED AS FAR AS ESSENTIAL VERSUS NON-ESSENTIAL? SHOULD WE ASSOCIATE AS AN INTERMEDIATE CARE FACILITY (ICF), RESIDENTIAL CARE FACILITY (RCF)?

HCBS provides community-based long-term care. Consider guidance related to essential personnel from the [Iowa Department of Public Health](#). Providers are also encouraged to monitor the [CDC website](#). DHS also has a broad range of [COVID-19 resources](#).

CAN RESPITE BE PROVIDED WHILE FAMILY IS IN HOME OR WORKING FROM HOME?

Yes, this flexibility has been requested by the State for waiver services.



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

HAS THE 30-DAY BED HOLD FOR INTERMEDIATE CARE FACILITIES (ICF) BEEN LIFTED?

If there is an individual need to waive the bed hold limit in order to maintain medically necessary services to the member, the provider should work with the member's MCO to submit an ETP via typical [ETP process](#).

CAN RESPITE OCCUR WHILE THE PRIMARY CARETAKER IS WORKING FROM HOME DURING THE COVID-19 PANDEMIC SHOULD THE FAMILY NEED IT?

Yes, this flexibility is available, if appropriate to the member needs. Work with the member's case manager and IDT to make any necessary changes to the member's plan.

IS THE LONG TERM CARE HEALTHCARE SCREENING PROTOCOLS BEFORE WORKING (E.G. TAKING TEMPERATURE) GUIDELINES APPLY TO HOME CARE AGENCIES?

HCBS and home care are community-based long term care services. Everyone should be taking the necessary precautions as outlined by the [IDPH](#).

HAS THE DEPARTMENT THOUGHT ABOUT REQUESTING THAT NORMAL MEDICAID RESPITE RESTRICTIONS BE TEMPORARILY LIFTED IF THE PRIMARY CARE GIVER IS ALSO DEEMED AN ESSENTIAL WORKER?

The additional flexibility allowed in the waivers from CMS is to allow caregivers working from home to access respite care for members. Additionally, member-specific flexibility can be granted, if needed, via an [Exception to Policy](#).

WILL THERE BE AN EXTENSION OF MORE THAN 366 DAYS FOR THE INDIVIDUAL SERVICE PLAN (ISP) MEETING SINCE THERE CANNOT BE MORE THAN 10 PEOPLE IN A GROUP?

Case managers are working with members and their respective Interdisciplinary Teams (IDTs) to schedule ISP meetings via teleconference whenever possible. If the meeting is not able to be held, there are provisions to extend plans.

DO PROVIDERS HAVE TO COMPLETE ADDENDUMS TO PERSON CENTERED PLANS TO PROVIDE SERVICE VIA TELEPHONE?

If the service is in the plan and can be completed without "hands on" intervention, it can be done via telephone without needing a change to the person centered plan.

WILL SCHOOL AGED CHILDREN WHO RECEIVE RESPITE CARE HAVE ANY CHANGES PERMITTED TO THEIR CONTRACTS DUE TO SCHOOL CLOSURES?

Providers and IDTs can work with case managers regarding any needed changes in the member's service plan.

WILL RESPITE CARE SERVICE HOURS BE INCREASED?

Providers and IDTs can work with case managers regarding any needed changes in member service plans.



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

ARE PARENTS ABLE TO USE RESPITE CARE WORKERS TO PROVIDE CARE FOR PARENTS IF THEY ARE WORKING?

The additional flexibility allowed in the waivers from CMS is to allow caregivers working from home to access respite care for members. Additionally, member-specific flexibility can be granted, if needed, via an [Exception to Policy](#).

CAN DAY HABILITATION AND OTHER ADULT DAY PROGRAMS THAT HAVE LESS THAN 10 PEOPLE CONTINUE TO PROVIDE SERVICES?

Please follow the proclamation of the Governor. The Department cannot grant an exception to the Governor's proclamation.

IS THE DEPARTMENT PUTTING OFF LEVEL OF CARE REVIEWS FOR INDIVIDUALS ON THE HCBS WAIVERS?

Level of care assessors are completing reviews via alternate mechanisms whenever possible. If a review is not able to be completed, there are provisions to extend level of care review dates.\

REGARDING DAY PROGRAMS, EMPLOYEES HAVE BEEN FURLOUGHED. CAN THEY BE MOVED TO OTHER LOCATIONS? CAN THE RATES BE ENHANCED FOR DAILY SCL SERVICES?

The Department is looking at different scenarios regarding this, but it's dependent on many factors. We have to be able to adapt to the ever-changing environment.

IS THERE A WAY TO OBTAIN PHONES FOR MEMBERS?

This service is not reimbursable for Medicaid. Look into the SafeLink program.

IF A MEMBER IS AUTHORIZED FOR HOME-BASED HABILITATION (HBH) AND THE PROVIDER CANNOT PROVIDE THE MINIMUM AMOUNT OF TIME/SERVICES REQUIRED TO BILL FOR THE HBH TIER THE MEMBER IS CURRENTLY AUTHORIZED TO RECEIVE, CAN THE PROVIDER BILL FOR THE TIER AUTHORIZED?

The provider may only bill for the services provided. When a provider is unable to provide the minimum amount of time required to bill for the HBH Tier the member is assigned, the provider should contact the member's Integrated Health Home Care Coordinator (IHHCC) or Community-Based Case Manager (CBCM) to notify them of the change in services. The IHHCC or CBCM will submit a spread sheet to the MCO indicating the members that are changing HBH Tiers due to the provider's inability to render the minimum amount of hours/minutes required for the tier the member is assigned. The IHHCC or CBCM updates the member's service plan with the tier change and the habilitation provider updates the member's treatment plan with the tier change and the change to service delivery. When normal service provision resumes, the IHHCC or CBCM and the HCBS Habilitation service provider will follow the same process to resume typical service provision.

WHEN HABILITATION CHANGES, FOR EXAMPLE FROM A UB TO A UA, DOES THE TREATMENT PLAN NEED TO BE UPDATED?

Yes, when the member's needs change resulting in a change in services the service plan needs to be updated. The service plan should be a living document that reflects current services, needs, etc.



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

IS THE ANNUAL COST LIMIT FOR RESPITE FOR THE ID WAIVER BEING REMOVED? IF THIS IS THE CASE, ARE THERE ANY PARAMETERS FOR HOW MUCH ADDITIONAL RESPITE CAN BE AUTHORIZED?

Yes, the annual cost limit for respite in the ID waiver is lifted during the pandemic. Please work with the member's case manager and IDT to make any changes to the member's plan based on the member's need.

HOW SHOULD A MEMBER IN A HABILITATION HOME THAT HAS TESTED POSITIVE FOR COVID-19 REPORT THIS INFORMATION?

The member should let their Community-Based Case Manager (CBCM) know.

HOW WOULD THE STATE LIKE TO HANDLE EXCEPTION TO POLICY REQUESTS (ETPS) TO GO OVER THE WAIVER CAPS OR ADDING MEALS TO WAIVERS THAT DON'T COVER MEALS DURING COVID-19? CAN WE APPROVE TIME LIMITED ETPS THAT ARE DUE TO COVID-19 AND CARE ACCESS?

ETPs are not required for additional services, including meals, that are put in place due to COVID-19. However, providers and members need to be aware that once the national state of emergency is lifted, those services will no longer be allowed if they are not in accordance with the Medicaid program and assessed need of the member.

CAN HOME-BASED HABILITATION AND SCL PROVIDERS BILL FOR GETTING GROCERIES OR MEDICATIONS FOR MEMBERS AND DELIVERING TO THEM IN LIEU OF TAKING MEMBERS WITH THEM?

Clinically appropriate services required to meet the member's needs, including shopping for and delivering groceries and medications, will be reimbursed during the COVID-19 pandemic.

CAN A SPOUSE, A PARENT OF A MINOR CHILD, OR A FAMILY MEMBER BE APPROVED TO PROVIDE SERVICES TO THEIR SPOUSE?

Yes. The state applied for and received permission from CMS to allow a spouse, a parent of a minor child, or a family member to provide personal care services to their spouse. If no other service provider options are available due to the COVID-19 emergency, a spouse, a parent of a minor child, or a family member may be paid to provide services to their spouse.

WHAT IS THE START DATE OF THE STATE'S APPROVAL TO ALLOW PAYMENT TO A SPOUSE, A PARENT OF A MINOR CHILD, OR A FAMILY MEMBER FOR SERVICES RENDERED?

The provisions in Iowa's approved Appendix K, including the flexibility to allow payment for spouses, parents, or other family members for services, are available to be exercised at the discretion of the IME when the member's services have been impacted by the COVID-19 pandemic. Although the approval date is effective for service dates on or after January 27, 2020, Iowa did not experience a first diagnosed case of COVID-19 or program closures until mid-March.



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

DOES A SPOUSE, A PARENT OF A MINOR CHILD, OR A FAMILY MEMBER NEED TO PASS A CRIMINAL AND DEPENDENT CHILD OR ADULT BACKGROUND CHECK PRIOR TO BECOMING A PAID CAREGIVER?

Yes. Knowing that it may take time to complete a background check, a spouse, a parent of a minor child, or a family member may provide the direct services prior to the final determination of the background check(s). If a spouse, a parent of a minor child, or a family member passes the background check, the services provided may be paid for on or after January 27, 2020. If the spouse, parent of a minor child, or the family member cannot pass a background check, they may not be paid for any service rendered. If needed, please work with the member's case manager to assure that no other service provider options are available.

WHAT IS THE PROCESS FOR EXTENDING THE REQUIREMENT OF PSYCHOLOGICAL EVALUATION UPDATES FOR ID WAIVER MEMBERS?

The IME has been approved to conduct assessments via telehealth. If it is not possible to conduct the psychological evaluation through telehealth, the Department has been approved to adjust assessment requirements during the COVID-19 pandemic. An assessment can be extended during the pandemic and can be extended for up to one year past the due date, if needed.

IS THE EXISTING LIMITATION ON FIVE PERSON HOMES LIFTED? CAN A PROVIDER TEMPORARILY TRANSITION SIX OR SEVEN PEOPLE INTO A FIVE BEDROOM HOME? CAN A PROVIDER TURN OTHER AREAS IN THE HOME INTO A BEDROOM AND IF SO ARE THERE SPECIFIC REQUIREMENTS FOR THIS OR IS AN EXCEPTION TO POLICY (ETP) NEEDED?

An ETP is not needed to temporarily exceed the five person home limit when it is necessary to consolidate individuals due to the need to isolate or due to staffing shortages related to COVID-19. The Department must be made aware of these situations. The provider will need to have a documented plan of the temporary relocation, (who, what, where, why, and how) and a documented plan as to when the members will return to their own homes. It will be important to communicate with the member's case managers / guardians in advance of the relocations and to provide updates to the case managers / guardians as agreed upon while the members are temporarily relocated.

IF A MEMBER IS ENROLLED IN HOURLY SCL OR HABILITATION AND RECEIVES SERVICES TWO TIMES PER DAY (ONE VIA TELEHEALTH AND ONE VIA FACE-TO-FACE) AND BOTH SERVICES ARE COMBINED INTO ONE FOR BILLING PURPOSES, WHAT PLACE OF SERVICE (POS) CODE SHOULD BE ADDED TO THE CLAIM? WOULD IT BE 02 FOR TELEHEALTH OR 12 FOR HOME?

Hourly SCL and Habilitation services are not considered traditional telehealth services. Based on recent CMS guidance, providers should bill the POS code that would have been reported had telehealth not been used. As long as the twice daily services is included in the service plan and not a change in service provision during the pandemic, providers should bill as normal and use the 95 modifier as informational. In this scenario, the provider would bill POS 12 (home).



HOME- AND COMMUNITY-BASED SERVICES (HCBS)

REGARDING THE CLOSURE OF ADULT DAY HABILITATION: WE UNDERSTAND THAT WE CANNOT PROVIDE SERVICES IN HOUSE OR IN GROUPS, BUT WE WERE WONDERING IF IT WOULD BE POSSIBLE TO BILL (WITHOUT BREAKING THE ORDERS IN PLACE) FOR SOME, MAYBE TWO INDIVIDUALS TO ONE STAFF RATIO ACTIVITIES TO BE PROVIDED?

As long as the adult day habilitation provider can adhere to the [CDC guidelines](#) and IDPH's recommendations, i.e. social distancing requirements, congregating limitations, etc. the adult day hab may deliver the service if it is clinically appropriate, medically necessary, and documented as such in the service documentation, and within the provider's scope of practice.

ARE CASE MANAGERS ABLE TO COMPLETE THE HCBS RESIDENTIAL ASSESSMENT DURING A MEMBER'S ANNUAL MEETING VIRTUALLY IF THE CASE MANAGER MEETS WITH THE MEMBER IN THEIR HOME EVERY OTHER MONTH AND KNOWS THEIR CURRENT LIVING SITUATION?

Yes, residential assessments can be completed virtually as needed due to the COVID-19 emergency declaration. This is in line with other guidance for the completion of CSR assessments.

WHEN WILL INDIVIDUALS UTILIZING EMPLOYMENT SERVICES (PREVOCATIONAL AND SMALL GROUP) THROUGH A WAIVER BE ALLOWED TO RETURN TO WORK?

The IME will follow the guidelines set forth in the Governor's Public Health Emergency Proclamation of March 17, 2020, and its successive modifications, which remain in effect.

WILL AUTHORIZATIONS FOR DAILY SCL ID BE AUTOMATICALLY RETURNED TO TIER RATES WITH DAY ACTIVITY OR WILL THIS BE A PROCESS THAT ALLOWS FOR THOSE NOT YET COMFORTABLE WITH RETURNING TO THEIR DAY ACTIVITIES?

No, it will not be completed automatically. Please work with your respective MCO case managers.

SO RIGHT NOW, IT'S MY UNDERSTANDING THAT THERE IS A PROVISION DUE TO COVID-19 THAT RESPITE CAN BE FOR WORK FROM HOME PARENTS. I HAVE SOME MEMBERS RETURNING TO THE AGENCY TO RECEIVE RESPITE SERVICES. CAN THE PROVIDER BILL RESPITE IF THEIR PARENTS ARE STILL WORKING FROM HOME? OR, IS THAT ONLY FOR WHEN RESPITE WORKERS ARE COMING INTO THE HOME?

Yes, this flexibility is available, if appropriate to the member's needs. Work with the member's case manager and IDT to make any necessary changes to the member's plan.



CONSUMER CHOICES OPTION (CCO)

IS THE DEPARTMENT GOING TO CONSIDER PAYING CCO EMPLOYEES EVEN IF THEY CAN'T CURRENTLY WORK FOR THE MEMBER SO THAT THE MEMBER DOESN'T LOSE THEIR EMPLOYEES DURING THIS TIME?

Our first priority is ensuring our members are supported. Anyone concerned about securing their income due to the impact of COVID-19 should connect with Iowa Workforce Development.

CAN A SPOUSE OR PARENT/GUARDIAN BE PAID PROVIDERS THROUGH CCO?

Yes. The State has been approved for this option in its waiver authority request for the duration of the COVID-19 emergency.

WHEN CAN A SPOUSE OR PARENT/GUARDIAN BEGIN WORKING AND RECEIVE PAYMENT USING CCO FUNDS?

The spouse or parent/guardian is required to submit all of the required enrollment paperwork to Veridian Fiscal Solutions (VFS). The spouse or parent/guardian will receive a start date from VFS once all of the paperwork is submitted accurately. The spouse or parent/guardian can begin receiving payment for dates of services on or after the start date provided by VFS. VFS will not be able to issue payments for any services provided prior to the employee start date.

Knowing that it may take time to complete a background check, a spouse or parent/guardian may provide the direct services prior to the final determination of the background check has been completed. If the spouse or parent/guardian cannot pass a background check, they cannot be paid for any service rendered.

HOW CAN THE EMPLOYEE PROCESS BE STREAMLINED TO ALLOW A SPOUSE OR PARENT OF A CCO MEMBER TO BE A PAID EMPLOYEE?

Important: Payment may not be made prior to the date that a completed employee application has been received by the Financial Management Services (FMS) provider (Veridian Fiscal Solutions). Knowing that it may take time to complete a background check, a spouse or parent may provide the direct services prior to the final determination of the background check has been completed. If the spouse or parent passes the background check, the services provided may be paid for on or after January 27, 2020. Although the CMS approval date is effective for service dates on or after January 27, 2020, Iowa did not experience a first diagnosed case of COVID-19 or program closures until mid-March. If the spouse or parent cannot pass a background check, they cannot be paid for any service rendered. If needed, please work with the member's case manager to assure that no other service provider options are available. In order to get paid, an updated CCO monthly budget must be submitted for the month that the parent has worked as a paid employee.

WHY CAN'T A SPOUSE OR PARENT/GUARDIAN BE BACK PAID WITH CCO FUNDS?

The spouse or parent/guardian is required to complete the enrollment paperwork to establish the employee and employer relationship. The employee start date must be after an accurately submitted packet is verified by VFS to ensure all requirements are met to establish this legal employment relationship.



CONSUMER CHOICES OPTION

IF THE SPOUSE OR PARENT/GUARDIAN IS APPLYING TO WORK FOR THE MEMBER, CAN THE SPOUSE OR PARENT/GUARDIAN SIGN AS BOTH THE EMPLOYEE AND THE EMPLOYER ON TAX FORMS AND TIME CARDS?

Yes, for the duration of the COVID-19 emergency.

CAN A BUDGET BE CHANGED MID-MONTH?

The monthly budget amount *cannot* change during the month. Budgets *can* be changed during the month to reallocate how funds are used during the month. For example, adding employees or increasing or decreasing staff time due to sickness or inability to work shifts due to COVID-19. Any mid-month budget change must include all services that have been provided and billed prior to the change.

IF A MEMBER HAS TO LAY OFF AN EMPLOYEE, WOULD THEY BE ELIGIBLE FOR UNEMPLOYMENT?

Information on unemployment and COVID-19 can be found on the Iowa Workforce Development website.

CAN CCO FUNDS BE USED TO RETAIN STAFF?

No. CCO funds must be used to pay for direct service provisions.

CAN HOME DELIVERED MEALS, COMPANION AND HOMEMAKER SERVICES BE INCLUDED IN A CCO BUDGET?

The Department has been approved for these service options in its waiver authority request for the duration of the COVID-19 emergency. Work with the member's case manager regarding provider needs and any changes that need to be made to the member's service plans.

HAS THE DEPARTMENT CONSIDERED ADDING A CCO DAILY RATE FOR INDIVIDUALS WHO DO NOT HAVE ACCESS TO DAY PROGRAMMING?

At this time, the current CCO daily rate will remain in effect. If appropriate, the written person centered service plan can be amended to allow the current CCO provider to provide services in the member's home. The delivery of day habilitation services must fit within the member's service goals.

WHAT HAPPENS IF A SPOUSE OR PARENT/GUARDIAN BEGINS WORK AS A PROVISIONAL HIRE AND THEY DO NOT PASS THE BACKGROUND SCREENING?

The member/employer will not be able to pay the spouse or parent/guardian for the services provided using Medicaid funds. The member/employer, since they have established a legal employment relationship with their spouse or parent/guardian, will be legally obligated to pay for these services using their personal funds.

CAN PARENTS THAT ARE CCO PROVIDERS RECEIVE RESPITE DURING THE CURRENT CRISIS?

No. The CCO rules have not changed in light of the COVID-19 crisis.

IS THERE ANY CHANGE TO CCO OVERTIME?

The CCO rules changes that went into effect July 1, 2019 removed the limit on overtime pay to CCO employees.



CONSUMER CHOICES OPTION

DOES THE 40 HOURS A WEEK FOR LEGAL REPRESENTATIVES AND PARENTS STILL APPLY?

The CCO rules changes that went into effect July 1, 2019 removed the limit on overtime pay that applied to legal representatives.

CAN RESPITE SERVICES THAT ARE INCREASED IN A MEMBER'S SERVICES PLAN DUE TO THE COVID-19 PANDEMIC BE PLACED INTO SAVINGS WHEN USING THE CCO PROGRAM?

The IME received federal approval to lift the annual cost limit of respite services in the ID waiver to address immediate family needs because of the COVID-19 pandemic. Additionally, for all applicable waivers, the State has removed the limitation on respite being provided for children while parents or primary caregivers are working from home in order to relieve pressure created by work, school, and daycare closures during the COVID-19 emergency. The State requested lifting the respite limit to address needs created by the COVID-19 pandemic. As such, the additional respite must be authorized to address immediate family needs. If the family is using CCO, the increase in respite services cannot be placed into savings for future use. The pandemic restrictions will be lifted sometime in the future and the waiver programs will go back to the normal respite limits. Members should work with their case managers to identify additional respite needs because of COVID-19, and have additional respite authorized in the member's services plan.



HEALTH HOMES

INTEGRATED HEALTH HOME (IHH) ELIGIBILITY: INDIVIDUALS ON MEDICAID FOR EMPLOYED PEOPLE WITH DISABILITIES (MEPD) WHO ARE NOT ABLE TO WORK RIGHT NOW ARE CONCERNED ABOUT LOSING MEDICAID DURING THIS TIME. IS THERE ANY OPTION TO WAIVE THIS EXPECTATION DURING THESE CIRCUMSTANCES?

Iowa has requested a waiver with CMS that will include an extension of eligibility and will waive co-pays and premiums for MEPD during the COVID-19 pandemic.

IHH ENROLLMENT: WHAT IS THE BEST PRACTICE TO GET NEEDED PAPERWORK SIGNED UNTIL STAFF ARE ABLE TO MEET WITH FAMILIES FACE-TO-FACE?

The Department is requesting that if staff is not able to sign their name, they may type it on the form and put 'COVID' behind it. There is no need to have a face-to-face meeting with the member during the pandemic. Providers need to obtain release of information (ROIs) to request supporting documentation – which can take some time or providers, can request the guardian to contact the office and request a copy of what is needed. For signatures from members, write or type the name on the signature page and state completed by phone. Providers need to maintain documentation of the verbal approval given in lieu of a written signature. Providers do not need to go back and collect physical signatures post pandemic.

IHH ENROLLMENT: ARE PROVIDERS ABLE TO ENROLL MEMBERS BASED ON SELF-REPORT OR OUTDATED RECORDS?

No.

IHH ENROLLMENT: CAN PROVIDERS COMPLETE IHH ENROLLMENTS BY PHONE DURING THIS TIME?

Yes.

IHH SERVICES: DOES A MEMBER NEED TO BE SHOWING SYMPTOMS OF COVID-19 FOR A CARE COORDINATOR TO REPLACE A FACE-TO-FACE VISIT WITH A PHONE CALL?

Face-to-face visits have been suspended at this time to help control the spread of COVID-19 in Iowa. When clinically appropriate to the service being rendered, providers have the ability to render services that are typically face-to-face via telehealth, video conferencing or other electronic means. Further information regarding telehealth services is available in the “telehealth” section.

IHH SERVICES: WHAT CAN MEMBERS EXPECT WHEN IDENTIFIED AS NEEDING HOME DELIVERED MEALS ASSISTANCE?

Iowa has expanded Medicaid benefits to provide meals to Medicaid members who are home bound and concerned for access to meals due to the COVID-19 pandemic. Further information regarding home delivered meals is available in the “home delivered meals” section.



HEALTH HOMES

IHH SERVICES: HAS THERE BEEN ANY DISCUSSION ABOUT INCREASING INDIVIDUAL RESPITE FOR THE CHILDREN'S MENTAL HEALTH WAIVER?

Yes, providers may increase respite based on the needs of the member and they will be evaluated on a case-by-case basis.

IHH SERVICES: WILL PROVIDERS BE ALLOWED TO GO OVER THEIR MONTHLY LIMIT FOR INDIVIDUAL RESPITE?

This would require a plan change. Follow the normal process for this.

IHH SERVICES: IS THE INTERDISCIPLINARY TEAM ABLE TO REQUEST AN INCREASE OF HOME-BASED HABILITATION UNITS AND/OR TIERS TO SUPPORT MEMBER NEEDS?

Yes, the interdisciplinary team is able to request an increase in home-based habilitation units and/or tiers to support member needs.

IHH SERVICES: IS THERE ANYTHING IN STATE POLICY THAT WOULD REQUIRE A FACILITY TO MAINTAIN SERVICES WITH MEMBERS FOR A CERTAIN LENGTH OF TIME IN THE EVENT OF A STATE EMERGENCY?

The member's need for supervision and ability to self-supervise or to be alone for a period of time must be considered on an individual basis by the member and their interdisciplinary team and documented in the member's service plan as required by HCBS rules and regulations. The member's service authorization level must also reflect the amount of staff supervision and support needed. If the residential care facility were to close, they must provide advance notice and will be required to participate in a facility closure process with the Department and the Department of Inspection and Appeals, which includes frequent updates on their progress of finding alternative placements.

IHH SERVICES: CLOSURE OF PROGRAMS ARE AFFECTING HABILITATION SERVICES SUCH AS ENCLAVE AND DAY HABILITATION. HOW SHOULD PROVIDERS REPORT THIS IN REGARDS TO SERVICE TRACKING AND USE OF APPROVED UNITS?

Providers should document change in the member record and notify the IME and the MCOs.

IHH ASSESSMENTS: CAN PROVIDERS WAIVE THE REQUIREMENT FOR DISTRIBUTION OF THE INTERRAI WITHIN THREE DAYS?

Yes.

IHH ASSESSMENTS: CAN PROVIDERS COMPLETE THE QUARTERLY FACE-TO-FACE AND/OR CARE PLAN TEAM MEETING BY PHONE, IF NEEDED, DUE TO THE CIRCUMSTANCES SURROUNDING COVID-19? ARE PROVIDERS ABLE TO COMPLETE THE INTERRAI BY PHONE IF NEEDED?

Yes, when clinically appropriate to the service being rendered, providers have the ability to render services that are typically face-to-face via telehealth, video conferencing or other electronic means.



HEALTH HOMES

IHH PERSON-CENTERED PLANS: CAN PROVIDERS WAIVE THE REQUIREMENT FOR DISTRIBUTION OF THE CARE PLANS WITHIN THREE DAYS?

There is no timeframe for the care plan.

IHH PERSON-CENTERED PLANS: IF A PROVIDER WANTS TO CHANGE THE FREQUENCY OF HOME-BASED HABILITATION OR THE TIER DIRECTLY RELATED TO THE CIRCUMSTANCES SURROUNDING COVID-19, DO THEY NEED TO UPDATE THE PERSON-CENTERED CARE PLAN / COMPLETE AN ADDENDUM?

Yes.

IHH PERSON-CENTERED PLANS: IS THE DEPARTMENT GOING TO UPDATE THE RIGHT RESTRICTIONS SECTION TO ADDRESS A RESTRICTION ON COMMUNITY TIME DUE TO THE CIRCUMSTANCES SURROUNDING COVID-19?

If the provider is not imposing more strict protocols than the Centers for Disease Control (CDC) recommends at this time regarding infection control or precautions with COVID-19, the right restrictions do not need to be updated.

IHH PERSON-CENTERED PLANS: IS IT NECESSARY FOR PROVIDERS TO ASK FOR ADDENDUMS IN ORDER TO CHANGE GOALS?

Assess the need to do an addendum based on the goal and how it is written.

IHH FACE-TO-FACE REQUIREMENTS: CAN A PROVIDER BILL THE INTENSIVE CARE MANAGEMENT (ICM) RATE FOR ALL ICM MEMBERS IF THEY HAVE DOCUMENTED ATTEMPTS TO CONTACT AND ARE WORKING WITH OTHER PROVIDERS TO SUPPORT THE SERVICE PROVISION?

Yes. Be sure to document all attempts.

CAN A PRACTITIONER WHO IS TEMPORARILY OUT OF STATE ON A VISIT PROVIDE IHH SERVICES VIA TELEHEALTH?

Yes. The provider may furnish Health Home services to members via telehealth when clinically appropriate to the member's needs. The expanded telehealth services are in effect statewide for at least 60 days after the public health emergency declaration is lifted.



PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)

CAN A PMIC ALLOW MORE THAN 30 RESERVED BEDS PER DAY FOR CALENDAR YEAR OR ALLOW MEMBERS TO BE GONE FOR MORE THAN 14 CONSECUTIVE DAYS IN A ROW?

The IME remains focused on ensuring children have all of the supports and services they need throughout the duration of the emergency. If a scenario comes up that a PMIC provider will need to exceed the current reserved bed days for a member due to the impact of COVID-19, they can file an exception to policy (ETP) to request the reserve bed day limit be waived.



LONG TERM CARE

WHAT IS THE EFFECTIVE START DATE OF WHEN THE IME IS SUSPENDING PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) FOR NURSING FACILITIES?

There is no effective date at this time. The IME will continue to evaluate and share information as it develops.

INTERMEDIATE CARE FACILITY/INTELLECTUAL DISABILITY (ICF/ID) PROVIDERS ARE IN A REBASE YEAR. THERE IS CONCERN THAT PROVIDERS WHO RECEIVE FUNDS FROM THE PAYCHECK PROTECTION PROGRAM THROUGH THE FEDERAL LOAN PROGRAM MAY HAVE THESE FUNDS COUNTED AGAINST THEM IF THE LOANS ARE FORGIVEN. COULD THE DEPARTMENT PROVIDE GUIDANCE ON THIS?

Iowa Medicaid is not able to provide guidance on this topic. Please refer to Iowa Workforce Development for more information.

DUE TO VISITOR RESTRICTIONS AT NURSING FACILITIES, DURABLE MEDICAL EQUIPMENT (DME) PROVIDERS ARE HAVING A TOUGH TIME GETTING INTO MEMBER'S ROOMS TO CHECK ON OXYGEN CONCENTRATORS. IS THE REQUIREMENT OF 12 OR MORE HOURS A DAY OF USAGE WHEN REVIEWING THE METERS ON MACHINES GOING TO BE WAIVED DURING COVID-19?

Throughout the pandemic, DME providers can document the inability to access the meter and report the past month's usage as proof of past use of more than 12 hours and the requirement will be waived. New DME providers can request that facility personnel obtain the meter readings and report them to you

HAS THE IME ALREADY REQUESTED SUSPENSION OF THE PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) LEVEL 1 AND LEVEL II ASSESSMENTS?

The IME has not suspended PASRR screenings at this time and they should continue to be performed as required. The IME is monitoring PAs and timeframes for approval and will make changes as needed. The IME has temporarily suspended the two-week aide supervision requirements by a registered nurse for home health agencies in it's 1135 waiver request to CMS



NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

WITH HOSPITAL MANDATES IN PLACE REGARDING VISITORS, CAN A MEMBER'S SPOUSE CONTINUE TO RECEIVE HOTEL AND MEAL REIMBURSEMENT THROUGH ACCESS2CARE WHILE THE MEMBER IS HOSPITALIZED?

There's been no change to policy relative to reimbursement available for spouses while a member is hospitalized.



OPERATIONS

WILL MEDICAID COVER THE COST OF N95 MASKS FOR PROVIDERS IF/WHEN ONE OF THE MEMBERS IN THEIR CARE HAS COVID-19?

If you have concerns about personal protective equipment, [contact](#) your local emergency management team.

or Copy this link: https://www.homelandsecurity.iowa.gov/documents/county/COORD_Public_List.pdf

WILL THE DEPARTMENT BE WAIVING THE ENFORCEMENT OF EMTALA TO TREAT PATIENTS OFFSITE TO PREVENT THE SPREAD OF COVID AND WAIVING CREDENTIALING REQUIREMENTS DUE TO THE PUBLIC HEALTH EMERGENCY?

Iowa Medicaid doesn't control the enforcement of EMTALA as it applies to all regardless of payer source. CMS issued guidance on March 9, 2020 regarding EMTALA. We will work with our MCO partners to discuss mechanisms to waive certain credentialing requirements in response to the COVID-19 pandemic.

or Copy this link: <https://www.cms.gov/files/document/qso-20-15-hospitalcahemtala.pdf>

HAS THE IME CONSIDERED SEEKING A WAIVER OF PRIOR AUTHORIZATIONS (PAS) FOR ALL MEDICAID MEMBERS DURING THE NATIONAL PUBLIC HEALTH EMERGENCY?

We are not seeking a waiver of all Medicaid PAs at this time. The IME is monitoring PAs, including time frames for approval, and will use this data to make any changes needed.

HAS THE IME CONSIDERED REQUIRING MCO INTERIM OR PERIODIC INTERIM PAYMENTS FOR PROVIDERS EXPERIENCING CASH FLOW ISSUES DUE TO THE GOVERNOR'S MANDATE TO CEASE NON-ELECTIVE SURGERIES AND OTHER PROCEDURES?

Providers impacted by the COVID-19 pandemic are encouraged to work with the MCOs regarding potential opportunities for relief. Any relief offered via the MCOs is likely to be offset by future claims and may be subject to cost settlement. In addition, the IME continues to explore options to support and maintain our provider network through the duration of the crisis.



OPERATIONS

HAS THE IME CONSIDERED SUSPENDING TIMELY FILING RULES FOR MEDICAID CLAIMS?

Pursuant to the Governor's state of emergency, Iowa Total Care and Amerigroup have extended initial filing for first-time claims submissions for both IA Health Link and Hawki as an interim policy change in response to the unprecedented demands related to Coronavirus and COVID-19. Effective with dates of service (DOS) beginning April 1, 2020, providers will have an additional 90 calendar days to submit first time claims and encounters. Specifically, providers must submit first time claims/encounters within 270 calendar days of the date of service except as provided for in the Iowa Total Care and Amerigroup Provider Billing Manuals inclusive of retroactive eligibility claims & when Iowa Total Care and Amerigroup is the secondary payer. After the interim period ends Iowa Total Care and Amerigroup will return to normal billing guidelines. Providers are encouraged to reach out to their individual Provider Relations representative with any questions or concerns.

IS THE TEMPORARILY SUSPENSION OF TWO-WEEK AIDE SUPERVISION REQUIREMENTS BY A REGISTERED NURSE FOR HOME HEALTH AGENCIES INCLUDED IN THE 1135 WAIVER?

Yes, it was included in Iowa's 1135 request to CMS. IME is working with CMS to identify if it has the authority to implement.

HAS THE IME REQUESTED TO HAVE PRIOR AUTHORIZATIONS (PAS) CONTINUED BY THE MCOS DURING THE COVID-19 PANDEMIC?

We are not seeking a waiver of all Medicaid PAs at this time. The IME is monitoring PAs, including time frames for approval, and will use this data to make any changes needed.

WILL THE IME WAIVE THE REQUIRED 60 RECERTIFICATION FOR HOME HEALTH DUE TO COVID-19 CONCERNS?

Providers are encouraged to leverage telehealth mechanisms to complete recertification reviews.

DOES IOWA'S 1135 WAIVER REQUEST INCLUDE TEMPORARY SUSPENSION OF PA REQUIREMENTS FOR ALL LABORATORY TESTING OR JUST COVID-19 RELATED TESTS?

We are not seeking a waiver of all Medicaid PAs at this time. The IME is monitoring PAs, including time frames for approval, and will use this data to make any changes needed.

HAS THE DEPARTMENT ASKED CMS FOR PERMISSION TO SHORTEN THE REVIEW PROCESS BY THE MCOS FOR WHEN AN INDIVIDUAL FILES AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION?

We are not seeking a waiver of appeals time frames at this time. The IME is working closely with the MCOs to monitor time frames and will use this data to make any changes needed.

WILL COVID-19 TESTING AND TREATMENT COUNT FOR EMERGENCY MEDICAID FOR INDIVIDUALS WHO QUALIFY FOR EMERGENCY MEDICAID?

For individuals that qualify for medical assistance under emergency Medicaid which is known as Limited Medicaid for Certain Aliens, appropriate Medicaid services, including COVID-19 testing and treatment,

(Continued)



OPERATIONS

would be a covered, emergent service. Providers should refer to Informational Letters [1546](#) and [1892](#) for more details about eligibility and coverage requirements under this provision.

HAS THE DEPARTMENT ASKED CMS FOR ANY SUPPORT FOR RURAL HOSPITALS?

Yes. Effective March 13, 2020, telehealth coding to identify Rural Health Clinics (RHCs) as originating sites has been opened. In addition, the overall expansion of telehealth supports all Iowa providers in ensuring member access to care. Expansion of presumptive eligibility allows hospitals to conduct presumptive eligibility for all Medicaid eligibility groups until the national emergency declaration is lifted. Additionally, IME requested hospital 24-hour nursing flexibility which allows a nurse to cover more than one ward in the event of a staffing emergency. There are provisions contained in CMS' "blanket waivers" including provisions that lift the current 25-bed limit for critical access hospitals and also lift the 96 hour limit on length of stay. IME continues to work closely with CMS to identify developing opportunities in Federal legislation, including the provisions in the CARES Act. We will continue to share information as available.

WHAT IS THE DEPARTMENT'S PLAN AND PROCESS FOR MAKING RETAINER PAYMENTS THAT WERE PART OF THE DEPARTMENT'S APPENDIX K APPLICATION TO CMS?

The IME is working with CMS to determine if or how retainer payments can be deployed.

WHERE SHOULD EMPLOYEES GO TO RECEIVE A BADGE OR LETTER STATING THEY ARE AN ESSENTIAL EMPLOYEE?

There are no badges issued by the Medicaid agency identifying essential employees. Employers should monitor guidance from all sources, including Iowa Workforce Development and the Iowa Department of Public Health.

CAN YOU CLARIFY WHAT THE DEPARTMENT MEANS BY IMPLEMENT THE WAIVERS AS NEEDED?

The Department is not going to implement all the requests right away. We developed requests of what we'd potentially need during the national crisis into one submission to CMS. We're monitoring and evaluating the situation on a daily basis.

IN AN EFFORT TO PROCESS MEDICAID APPLICATIONS TIMELY AND QUICKER, AND TO PLACE LESS BURDEN ON PROSPECTIVE MEMBERS DURING THIS TIME OF CRISIS WILL IME START USING REAL TIME PROCESSING OF MEDICAID APPLICATIONS?

Unfortunately, the Department is not able to process applications in real time due to an increased number of applications during the COVID-19 pandemic for not only Medicaid but also other public assistance programs, such as food assistance, that are handled by the same Department staff. While the Department has made every effort to make sure that everyone who has had Medicaid in the month of March, continues to have Medicaid during the pandemic, the eligibility requirements to qualify for initial eligibility have not changed. Staff is working overtime to keep up with the increased volume. The current statewide processing time for Medicaid applications is 20 days

Even though the Department is unable to process Medicaid applications in real time, the effective date



OPERATIONS

of eligibility is backdated to the first of the month in which the application was filed. Therefore, once the application is approved, coverage would go back to the first of the month.

CAN YOU CLARIFY WHAT THE DEPARTMENT MEANS BY IMPLEMENT THE WAIVERS AS NEEDED?

The Department is not going to implement all the requests right away. We developed requests of what we'd potentially need during the national crisis into one submission to CMS. We're monitoring and evaluating the situation on a daily basis.

IN AN EFFORT TO PROCESS MEDICAID APPLICATIONS TIMELY AND QUICKER, AND TO PLACE LESS BURDEN ON PROSPECTIVE MEMBERS DURING THIS TIME OF CRISIS WILL IME START USING REAL TIME PROCESSING OF MEDICAID APPLICATIONS?

Unfortunately, the Department is not able to process applications in real time due to an increased number of applications during the COVID-19 pandemic for not only Medicaid but also other public assistance programs, such as food assistance, that are handled by the same Department staff. While the Department has made every effort to make sure that everyone who has had Medicaid in the month of March, continues to have Medicaid during the pandemic, the eligibility requirements to qualify for initial eligibility have not changed.

Even though the Department is unable to process Medicaid applications in real time, the effective date of eligibility is backdated to the first of the month in which the application was filed. Therefore, once the application is approved, coverage would go back to the first of the month.

WILL IOWA MEDICAID CONSIDER TEMPORARY COVERAGE OF NON-INVASIVE PRENATAL TESTING FOR AVERAGE RISK WOMEN IN RESPONSE TO COVID-19?

This testing has no bearing on COVID-19. Whether an infection by this virus during pregnancy increases the risk of birth defects is currently not known.

WILL THE DEPARTMENT IMMEDIATELY SUSPEND ALL ADMINISTRATIVE REQUIREMENTS, INCLUDING BUT NOT LIMITED TO PRECERTIFICATION, UTILIZATION REVIEW, CLAIM APPEAL SUBMISSION, AND ALL TIMELY FILING REQUIREMENTS INCLUSIVE OF THOSE RELATED TO AUDIT OR RECOUPMENT, FOR ALL PRODUCTS/BENEFICIARIES AS WE WORK TOGETHER TO MEET THE VOLUMINOUS NEEDS AND CHALLENGES BROUGHT ABOUT BY COVID-19?

The IME is working in collaboration with the MCOs to reduce administrative burden where possible while maintaining high quality care during the pandemic.

IS CODE G2012 COVERED BY MEDICAID?

G2012 is a covered service for certain provider types. This code will be included in the next Iowa Medicaid Fee Schedule update.

IF A PATIENT IS QUARANTINED TO A HOSPITAL OR FACILITY, HOW SHOULD THE PROVIDER BILL FOR THIS?

Providers should bill with the appropriate diagnosis-related group (DRG).

(Continued)



OPERATIONS

WHAT IF A MEMBER RUNS OUT OF MINUTES ON THEIR CELLPHONE, WILL THE MCOS SUPPORT MEMBERS WITH ADDITIONAL MINUTES?

SafeLink, a federal program for all eligible Medicaid beneficiaries, is offering all new and existing SafeLink customers unlimited talk and text and an extra 5GB of free data (in addition to the beneficiary's current plan allotment) during the COVID-19 crisis. Members don't need to do anything. This benefit will be automatically applied to their account.

ARE CODES G2023 AND G2024 COVERED BY MEDICAID?

G2023 and G2024 are covered codes. Bill with the traditional POS. Code G2024 should only be used when the provider must obtain the specimen from a patient that is not onsite. These codes will be added to the fee schedule at the next update.

HOW WILL PROVIDERS BE ABLE TO BILL AS CREDENTIALING MAY OR MAY NOT HAVE HAPPENED? WILL THE MCOS PAY PROVIDERS AS PAR EVEN IF THE PROVIDER IS NOT PAR?

Iowa Medicaid is able to expedite provider enrollment, if necessary, to complete provider enrollment within a 24-48 hour period. Once enrolled, each MCO has the capacity to perform an expedited provider load within 24-48 hours after the health plan receives the daily enrollment file update from Iowa Medicaid. Some variance could occur depending upon the completeness of the provider submission, volume of submissions and other factors. Once the provider is loaded by the health plans, provider claims submission is enabled. The credentialing process is separate from the provider load. However, if the goal is to bring a provider into the MCO network, the credentialing process typically requires 15-18 days. Both MCOs have agreed to pay all providers as PAR during the public health emergency.

IN CONSIDERATION FOR THE TEMPORARY CESSATION OF ELECTIVE AND NON-ESSENTIAL CARE AND PROCEDURES, WILL THE PROCEDURE/SERVICE AUTHORIZATION PERIODS FOR THOSE PRIOR AUTHORIZATIONS (PAS) ALREADY OBTAINED BY HEALTH CARE PROVIDERS BE EXTENDED OR WILL PROVIDERS NEED TO GO THROUGH THE PROCESS OF SEEKING NEW PAS WHEN OPERATIONS RESUME?

In consideration for the temporary cessation of elective and non-essential care and procedures, the procedures/service authorizations for PAs already obtained by health care providers will be extended. Providers are encouraged to work with the individual MCO or FFS to address extensions to existing PAs.

IS HELPING A JOB CLIENT FILE FOR UNEMPLOYMENT BILLABLE TO MEDICAID CONSIDERING MOST ARE BEING FURLOUGHED OR LAID OFF DUE TO COVID-19?

Members receiving Supported Employment services may require assistance from a job coach in seeking and maintaining community employment. This includes, but is not limited to, assisting the member with filing for unemployment, conducting ongoing job search activities or other employment related supports as needed.

WHEN DO THE FLEXIBILITIES WAIVERS FROM CMS EXPIRE?

All will remain in effect until the public health emergency declaration has been lifted as well as 60 days past that date.



OPERATIONS

LOOKING AHEAD TO ACCREDITATIONS COMING UP. IN THE PAST THESE HAVEN'T BEEN COMPLETELY TIMELY AND PROVIDERS HAVE LOST THEIR DEEMED STATUS. HOW DOES THE IME ENSURE THEY DON'T LOSE DEEMED STATUS?

The IME is aware of this and is working with all providers on an appropriate timeline.

CAN A NURSE PRACTITIONER AND/OR A PHYSICIAN'S ASSISTANT ORDER HOME HEALTH UNDER A COVID-19 RELATED WAIVER SIMILAR TO THE WAIVER FOR MEDICARE PATIENTS?

During the public health emergency, CMS has expanded the providers who can sign the care plan and order home health services to include a nurse practitioner or physician assistant. The IME will follow this guidance for the duration of the public health emergency.

WILL MEDICAID COVER THE COST FOR PROVIDERS TO TEST THEIR STAFF FOR COVID-19?

No. Medicaid funding is limited to Medicaid-eligible individuals only.

IS THERE A LIMIT ON THE NUMBER OF TIMES CODES 99307 AND 99308 CAN BE BILLED FOR NURSING HOME PATIENTS IN A CALENDAR MONTH DURING THIS PANDEMIC?

Currently, there are no imposed maximum monthly limits on these procedure codes; however, the codes are limited to one time per day. In all cases, documentation in the medical record must support the medical necessity for the services provided.

DURING THIS PANDEMIC CAN A RURAL HEALTH CLINIC (RHC) PHYSICIAN DO A HOME VISIT? IS THIS SOMETHING THAT IS REIMBURSED DURING COVID-19? IF SO, HOW DOES A RHC BILL FOR THIS?

RHCs and FQHCs are able to bill the encounter rate with POS 12 for FFS members. The MCO systems are currently being configured to accommodate this as well, with an anticipated completion date of June 30, 2020.



OPERATIONS

AN UNDOCUMENTED PATIENT WAS APPROVED FOR LIMITED MEDICAID FOR EMERGENCY ONLY. THEY ARE HOSPITALIZED AND THEY NEED AN AMBULANCE TRANSFER TO A REHAB FACILITY AS IT IS NOT AVAILABLE AT THE ACUTE HOSPITAL WHERE THEY ARE HOSPITALIZED. THEY ARE RECOVERING FROM COVID-19. WILL THE AMBULANCE TRANSFER BE A COVERED EMERGENCY SERVICE BILLABLE UNDER MEDICAID?

COVID-19 public health emergency provisions require that limited Medicaid coverage, once established, must thereafter be maintained until the end of the public health emergency. This included coverage of additional emergency services (including, but not limited to, COVID-related testing and treatment.)

REGARDING HOME HEALTH PROVIDERS: FOR OUR CLIENTS THAT CAN ATTEND SCHOOL WE USUALLY BILL THE SCHOOL DIRECTLY FOR THOSE HOURS OUR NURSE GOES WITH THE CLIENT. FROM OUR UNDERSTANDING, THE SCHOOL CAN THEN BILL THE STATE FOR THOSE HOURS AS WE ARE NOT. WITH THE UNKNOWN IF SCHOOL WILL RESUME LIKE NORMAL THIS FALL OR IF THEY WILL BE OFFERING VIRTUAL CLASSES FOR KIDS, WE ARE TRYING TO DETERMINE IF SCHOOLS GO VIRTUAL FOR THE 2020-2021 SCHOOL YEAR IF THE SCHOOLS COULD BILL THE STATE SINCE THE CLIENT AND THEIR NURSE ARE NOT PHYSICALLY AT THE SCHOOL. IF THEY CAN'T BILL FOR THOSE HOURS BECAUSE OF THIS, THEN WE CAN'T BILL THE SCHOOL AND WE MAY NEED TO INCREASE AUTHORIZATION REQUESTS FOR THOSE CLIENTS.

As the public health emergency changes, the IME is continually analyzing, adapting, and revising its policies regarding telehealth and virtual services. We will be looking at the issues surrounding telehealth and school-based issues as the guidance surrounding the 2020-2021 school year emerges.

CMS CAME OUT WITH GUIDANCE ON APRIL 30, 2020 IN AN INTERIM FINAL RULE TO ALLOW CPT 99211 TO BE BILLED FOR SPECIMEN COLLECTION OF THE COVID-19 TEST IF THAT IS THE ONLY SERVICE PROVIDED THAT DAY. WILL IOWA MEDICAID ALSO ALLOW BILLING OF 99211 FOR SPECIMEN COLLECTION?

Yes. The IME will follow the CMS guidance.

IS NEW CPT CODE C9803 PAYABLE BY IOWA MEDICAID?

Yes. This code is payable.

WITH COVID-19 STILL BEING AN ONGOING PROBLEM, WHAT ARE THE RULES IN REGARDS TO ANNUAL MEDICAID REVIEWS? NOT ALL RESIDENTS ARE ABLE TO SIGN FOR THEMSELVES AND IT'S VERY DIFFICULT TO TRY AND FIND A WAY TO MEET WITH FAMILY WHO MUST SIGN FOR THEM. IS THERE AN EXTENSION OR ANYTHING IN PLACE FOR THESE?

Medicaid reviews are being extended during the public health emergency. A member's eligibility will continue and will be reviewed once the pandemic has ended.



OPERATIONS

PROVIDERS WHO HAVE RECEIVED BUSINESS LOANS THROUGH THE PAYCHECK PROTECTION PROGRAM, HOW WILL THIS AFFECT FUTURE REIMBURSEMENT RATES?

We are awaiting final guidance from CMS on this and are working with our Provider Cost Audit team on the impact this will have on providers.



BILLING / REIMBURSEMENT

WHAT IS THE STATUS OF THE INCREASED FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)?

The State has received the funds for the first quarter increase.

WHAT IS IME'S PLAN FOR THE INCREASED FMAP?

The IME is developing recommendations for utilization of the increased FMAP dollars. These recommendations will be based on estimates to include increased Medicaid beneficiaries and increased services available during the pandemic.

IF A PATIENT IS QUARANTINED IN A HOSPITAL OR FACILITY, HOW SHOULD THE PROVIDER BILL FOR THIS?

Providers should bill with the appropriate diagnosis-related group (DRG).



MCO RESOURCES

or **Copy this link:** <https://www.amerigroup.com/amerigroup/coronavirus.html>

or **Copy this link:** <https://www.iowatotalcare.com/providers/coronavirus.html>