IA Health Link
Frequently Asked Questions

IA Health Link is the new name of the State of Iowa's Medicaid Managed Care program. UnitedHealthcare Community Plan is one of three managed care organizations providing benefits to IA Health Link members. IA Health Link brings together physical, behavioral and long-term care under one program. Most Medicaid members were enrolled in IA Health Link as of April 1, 2016. When a member enrolls, they are given a health risk assessment so we can determine the support services they need.

To support our network care providers in their interactions with us, UnitedHealthcare Community Plan offers a variety of resources at **UHCCommunityPlan.com** for Iowa. You can access information about member eligibility and enrollment, billing, claims submission and status, prior authorization and provider training resources.

If you have questions, please call Provider Services at 888-650-3462. They also can give you the name of your local Provider Advocate. A Provider Advocate locator map is also available on UHCCommunityPlan.com > For Health Care Professionals > Iowa.

The following answers to frequently asked questions are based on common questions we've received from care providers and their staff about IA Health Link and UnitedHealthcare Community Plan.

Frequently Asked Questions by Topic

Member Benefits, Eligibility, and Enrollment

Here are a few things to remember: UnitedHealthcare Community Plan manages vision, behavioral health and non-emergent transportation services for its members. If you need to refer a member for these services, please call Provider Services at 888-650-4362.

Q1. Can a member change their Managed Care Organization (MCO) retroactively?

A. No. A UnitedHealthcare Community Plan member cannot retroactively change to another MCO.

Q2. Under IA Health Link, will members have two identification (ID) cards?

A. UnitedHealthcare Community Plan IA Health Link members will receive both a State-issued ID card and a UnitedHealthcare Community Plan ID card. The State-issued ID number is the member ID number we will recognize and the one that should be used. ***hawk-i*** members will only receive a UnitedHealthcare Community Plan ID card.

Q3. Are PCPs able to limit their member panels?

A. For auto-assignments, the PCP standard capacity is 1500 members. Once a PCP reaches the limit, they will not receive additional auto-assignments. However, members can continue to select that care provider. In these circumstances, a Member Services representative will call the care provider to verify the PCP assignment is okay. To adjust PCP panel size, PCPs should contact their Provider Advocate.

Medical Management

Q4. What is the expected PCP/member relationship and associated referral requirements?

A. The PCP directs the member's health care and referrals to specialists and other care providers. PCPs do not need to complete a referral request when a member is seen by a network care provider unless those services require prior authorization. For services that require prior authorization, go to UHCCommunityPlan.com > Health Care Professional > Iowa.

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Admissions

Q5. If a member has an emergent or elective inpatient admission, when should care providers notify UnitedHealthcare Community Plan?

A. Please notify UnitedHealthcare Community Plan within 24 hours of admission or by 5 p.m. the following business day of any inpatient admissions.

Q6. When does UnitedHealthcare Community Plan issue approval for notifications of inpatient hospital admissions and how are care providers and members notified?

A. We will review and respond with a determination no later than the following business day. We notify the facility by phone with the determination as to whether it is approved or denied. The facility is responsible for contacting the member. We provide written notification to the care provider and to the member for denials.

Q7. Does UnitedHealthcare Community Plan use concurrent reviews and what utilization management criteria do you use?

A. We conduct concurrent reviews using MCG Care Guidelines.

Prior Authorizations

Here are a few reminders about prior authorization. Check the member's eligibility before a service is rendered that requires prior authorization. Requests will be reviewed within four calendar days for standard requests, and two business days for expedited requests. Pharmacy prior authorizations will be processed within 24 hours. Authorization is not required when UnitedHealthcare Community Plan is the secondary payer unless the service is not covered by the member's primary insurance. Observation stays do not require prior authorization.

Q8. For what length of time are prior authorizations approved?

A. Authorizations will be reviewed and approved based on the timeframe requested/ordered, medical necessity and the service being provided.

- Radiology and Cardiology prior authorizations will be approved for 45 days.
- Early Periodic Screening Diagnosis and Treatment Private Duty Nursing/Personal Care (EPSDT/PC) prior authorizations will be approved for eight weeks with nurse review for ongoing needs.

Q9. How do care providers update or change an authorization after the service was performed if the wrong code was authorized?

A. Our claims processing system will use the type of service to match authorizations with the claim received in the event there are slight coding differences. The care provider can also call Provider Services at 888-650-3462 to provide clinical justification for the change. For radiology and cardiology claims, CPT crosswalk tables are available at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Cardiology / Radiology.

Q10. Who should I contact for a peer-to-peer consultation?

A. For peer-to-peer consultation requests in the event of the need to discuss a member's clinical situation or documentation for prior authorizations, please call Provider Services at 888-650-3462.

Long Term Services and Supports (LTSS)/ Home- and Community-Based Services (HCBS)

Q11. Is an authorization required for custodial care (non-medical activities of daily living such as bathing, grooming, dining assistance, and personal hygiene) in a nursing facility?

A. No, an authorization is not required.

Q12. For nursing facilities, if the bed-hold threshold is exceeded, will a new authorization be required for skilled nursing services?

A. Yes. If the bed-hold threshold is exceeded and a member still requires a skilled level of care at the nursing facility, an authorization will be required due to a change in level of care. For example, if a facility transfers a UnitedHealthcare Community Plan member who is a resident to a hospital or allows the member to go on therapeutic leave, the facility must submit a new authorization request and provide written information to the member and their family or legal representative about when the member can return and resume living at the facility.

Q13. How is UnitedHealthcare Community Plan managing HCBS waiver transportation for medical appointments?

A. HCBS waiver transportation services are not included in the standard non-emergency medical transportation services, which only offer members transportation to/from medical appointments. HCBS waiver transportation services are arranged through the member's Community-Based Case Manager. HCBS waiver transportation providers can contract with us to offer HCBS waiver transportation services by calling 888-650-3462.

Q14. What out-of-pocket expenses can be billed to the LTSS/HCBS member?

A. Patient liability, also referred to as client participation, is determined by IME for members in an institutional setting and enrolled in an HCBS waiver program.

Q15. Will UnitedHealthcare Community Plan manage HCBS provider cost reporting?

A. No, IME will continue to manage HCBS provider cost reporting.

Billing & Claims

Here are a few reminders for billing and claims: Provider remittance advices are separated by line of business. UnitedHealthcare Community Plan processes reimbursement payments daily, Monday through Friday. The MCO/Medicaid is the payer of last resort. Care providers cannot balance bill the member for deductibles, co-payments or coinsurance amounts not covered by Medicaid. For information on coordination of benefits, please refer to section 11.11 of the Administrative Manual available at UHCComunityPlan.com > Health Care Professionals > Iowa > Provider Administrative Manual.

Q16. Do UnitedHealthcare Community Plan benefit plans require copayments?

A. As a value-added benefit to our members, we have waived member copays, with the exception of non-emergent care provided in the emergency room.

Q17. Is UnitedHealthcare Community Plan responsible for coverage of Medicare crossover claims for members?

A. Yes, we will be responsible for Medicare crossover claims including both claims from Medicare Advantage plans and traditional Medicare. Please see **IME Informational Letter 1619-MC** for details regarding crossover claims.

Q18. What is the notification process when a claim has been overpaid?

A. We mail an overpayment notification letter to the care provider indicating that they have 30 days to refund the overpaid amount to us or file an appeal. If no refund or appeal has been made after 30 days, we will initiate recovery by adjusting the amount of the claim payment and recovering via offset against any new claims submitted by the care provider.

Q19. Will UnitedHealthcare Community Plan be retroactively reviewing claims coding?

A. Yes, we will conduct retroactive reviews. These reviews will occur during the transition of care period for new members if services requiring an authorization are rendered but there is no prior authorization on file.

Q20. How should maternity care be billed?

A. Care providers should follow IME's **Maternity Billing Guidelines**.

Q21. How should Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) bill?

A. FQHCs/RHCs should bill using the T1015 all-inclusive face-to-face encounter code. The T1015 code should be submitted on Box 24D line 1 of the claim, with any and all subsequent claim lines containing the applicable specific procedure codes for services rendered as "informational only" and billed at $0. Claims submitted without the "informational only" procedure codes will be denied.

Q22. Can care providers buy-and-bill for specialty medications?

A. Yes, the process does not change for specialty medications covered under the medical benefit. For details, go to the **Iowa Department of Human Services Physician Services Provider Manual** page 36.

Q23. Can PCPs providing behavioral health services bill UnitedHealthcare Community Plan directly?

A. Prior to the launch of IA Health Link, care providers billed the behavioral health vendor. Today, providers should bill UnitedHealthcare Community Plan for all medical and behavioral health using Payer ID 87726.

Other Member Benefits

Q24. Will the member's chiropractic visit limits be based on a calendar year or a rolling year and how many are covered per year?

A. Visit limits are based on a calendar year. For visit limits, we follow chiropractic benefit guidelines as defined by IME in the **Chiropractic Services** provider manual available at dhs.iowa.gov > Policy Manual > Medicaid Provider.

- Category 1 diagnosis: 12 visits per calendar year
- Category 2 diagnosis: 18 visits per calendar year
- Category 3 diagnosis: 24 visits per calendar year
- Diagnosis category combinations: 28 visits per calendar year

Q25. How is non-emergent care in an emergency room defined?

A. The diagnosis code will drive the determination of whether care is considered non-emergent in an emergency room. A list of emergency diagnosis codes can be found at **dhs.iowa.gov > Provider Services > Claims and Billing**. The state's Provider Manual outlines when ER care providers should charge a copay to the members for non-emergent services.

Q26. Are interpreter services covered?

A. Yes, interpretative services may be covered, whether done verbally or through sign language by an interpreter. The services must meet the following criteria:

- Interpreters may be employed or contracted by the billing care provider
- The interpretive services must be used in conjunction with a Medicaid covered service, such as an office visit. If interpretive services are used for a non-covered service and the care provider bills for it, both the interpretive service and the non-covered service will be denied.

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