

441—88.41 (249A) Definitions.

“*Contract*” shall mean a contract between the department and a Medicaid-participating provider or clinic as specified in rule 441—88.44(249A) and subrule 88.45(1) for the purpose of providing patient management to enrolled recipients.

“*Covered eligibles*” shall mean those groups of Medicaid-eligible recipients specified in subrule 88.42(1) who are eligible to receive services under patient management.

“*Department*” shall mean the Iowa department of human services.

“*Designee*” shall mean an organization designated by the department of human services to act on behalf of the department in the administration of Medicaid managed health care.

“*Eligible providers*” shall mean those providers specified in rule 441—88.44(249A) and subrule 88.45(1) with whom the department may contract to be patient managers.

“*Emergency care*” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“*Emergent medical condition*” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient’s medical condition including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

“*Enrolled recipient*” shall mean a covered eligible who has been enrolled with a patient manager according to procedures set forth in rule 441—88.46(249A).

“*Extended-participation program*” shall mean mandatory six-month enrollment period with a managed care entity.

“*Grievance*” shall mean a complaint expressed verbally or in writing by an enrolled recipient or provider relative to services under patient management. A grievance at the informal level is one which can be resolved by short-term intervention on the part of the department or its designee via the toll-free managed health care telephone line or through informational correspondence. A formal grievance is one which must be taken to another level for quality of care or policy determination.

“*Managed care entity*” shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

“*Managed health care*” shall mean any of the options for alternative delivery of Medicaid services that provides coordinated delivery of health care. The current options offered by the department

are Medicaid patient management, known as MediPASS, health maintenance organization (HMO) enrollment and prepaid health plan (PHP) enrollment.

“Managed health care review committee” shall mean a committee composed of representatives from the department and its designee. The committee shall review and render decisions on all requests for disenrollment from managed health care that are not automatically approvable, all requests for exception to eligible provider provisions, and other exceptions to managed health care procedures.

“Mandatory enrollment” shall mean a mandatory participation in managed health care as specified in subrule 88.46(1).

“Mandatory project county” shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

“Managed services” shall mean services as specified in subrule 88.48(1) that require preauthorization from the patient manager in order to be payable by Medicaid.

“Medical service area” means a geographic area within which recipients must reside in order to enroll in the managed health care MediPASS option.

“MediPASS” shall mean Medicaid patient access to service system and shall be the acronym used to identify the Medicaid patient management program.

“Nonmanaged services” shall mean services as specified in subrule 88.48(2) that do not require authorization by the patient manager in order to be payable by Medicaid.

“Patient management” shall mean the provision of services to enrolled recipients by a patient manager in accordance with the contract.

“Patient manager” shall mean an eligible provider who has signed a contract with the department to perform patient management for enrolled recipients.

“Urgent care” shall mean those medical services rendered for an urgent medical condition or protection of the public health.

“Urgent medical condition” shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

If the recipient is assigned to a patient manager (e.g., MediPASS or HMO), the patient manager shall arrange for necessary care within 24 hours by either providing it or referring and authorizing another appropriate provider to provide care.