

Behavioral Health Intervention Services Provider Manual





Iowa
Department
of Human
Services

Provider and Chapter

**Behavioral Health Intervention
Services**

Page

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PROVIDERS ELIGIBLE TO PARTICIPATE

A provider of behavioral health intervention services is eligible to participate in the Iowa medical assistance program when the provider is enrolled in the Iowa Plan for Behavioral Health pursuant to 441 Iowa Administrative Code Chapter 88, Division IV.

1. Enrollment

Providers eligible to participate in the Iowa Plan must also be enrolled with the Iowa Medicaid Enterprise (IME) for any payment to be made for non-Iowa Plan members. Please submit a copy of the welcome letter from the Iowa Plan with your enrollment application.

Each provider shall provide the IME Provider Services Unit with the current address of the provider's primary location and any satellite offices. It is the responsibility of the provider to contact the IME Provider Services Unit and provide an update whenever:

- ◆ There is a change of address.
- ◆ Other changes occur that affect the accuracy of the provider enrollment information.

2. Provider Requirements

As a condition of enrollment, providers of behavioral health intervention services must:

- ◆ Request criminal history record information, child abuse, and adult abuse background checks on all employees and applicants to whom an offer of employment is made, as required by Iowa Code section 135C.33(5).
- ◆ Follow standards in 441 Iowa Administrative Code 79.3(249A) for maintenance of records. These standards pertain to **all** Medicaid providers. (See [Documentation](#).)
- ◆ Assure that any services delivered by an individual or agency, either through employment by or a contract with the enrolled provider, shall comply with the requirements that are applicable to the enrolled provider.



3. Staff Education and Experience

The Iowa Plan contractor will use the following combination of education and experience when reviewing your agency for certification.

	Education and Experience	Clinical Supervision	Clinical Consultation
Community BHIS staff	Bachelor's degree in social sciences field plus: <ul style="list-style-type: none"> • 1 year experience, or • 20 hours training in child mental health, or Bachelor's degree in non-social science field plus: <ul style="list-style-type: none"> • 2 years experience, or • 30 hours training in child mental health 	Licensed master's level prepared mental health practitioner (e.g., social work, marriage and family therapy, mental health counselor), license number required	Independently licensed master's level prepared mental health practitioner available for consultation as needed, license number required
Residential BHIS staff	Bachelor's degree in social sciences field, or Bachelor's degree in non-social science field plus 30 hours training in child mental health, or AA degree in social sciences field plus one year experience in child mental health services, or High school diploma or GED plus a minimum of five years of child mental health service experience	Licensed, master's level prepared mental health practitioner (e.g., social work, marriage and family therapy, mental health counselor), license number required or Bachelor's degree with five years or more child mental health service experience	Independently licensed master's level prepared mental health practitioner available for consultation as needed, license number required



B. MEMBERS ELIGIBLE TO RECEIVE SERVICES

Medicaid members may receive behavioral health intervention services when they meet the following requirements, as determined by a licensed practitioner of the healing arts acting within the practitioner's scope of practice as allowed under state law:

- ◆ The member has been diagnosed with a psychological disorder. (See [Diagnosis](#).)
- ◆ The member has a need for behavioral health intervention services related to the member's psychological disorder. (See [Need for Service](#).)

1. Diagnosis

To qualify for behavioral health intervention services, a member must be diagnosed with a psychological disorder that impairs the member's independent functioning relative to primary aspects of daily living such as personal relations or living arrangements. The Axis I diagnosis (ICD-9 or DSM-IV-TR numeric code and description) must be supportable by available documentation.

The primary diagnosis shall be the diagnosis the treatment plan is designed to address. Additional diagnoses are considered secondary. Information relating to a diagnosis that is over 12 months old needs to be confirmed.

A licensed practitioner of the healing arts must make the diagnosis and develop a treatment plan. The licensed practitioner must:

- ◆ Be enrolled in the Iowa Plan, and
- ◆ Be qualified to perform the clinical assessment for the purpose of establishing a diagnosis of psychological disorder under the Iowa Plan.

Clinical assessment of psychological disorders must be within the diagnosing practitioner's scope of practice under state licensing rules.

Qualified practitioners currently include providers credentialed in the Iowa Plan network as physicians, advanced registered nurse practitioners, psychologists, independent social workers (MSW, LISW), marital and family therapists, and mental health counselors.

Practitioners without an independent license must have clinical supervision as defined by their respective board.



2. Need for Service

A licensed practitioner of the healing arts (see [Diagnosis](#) for qualifications) must:

- ◆ Assess the member and develop a treatment plan that is comprehensive in nature and details all services the member requires, including services that are provided by other sources. The member's need for services must meet specific individual goals that are focused to address:
 - Risk of harm to self or others,
 - Behavioral support in the community,
 - Specific skills impaired due to the member's mental illness, and
 - Risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.
- ◆ Complete a standardized outcome tool during assessment and reassessments and provide the results to the behavioral health intervention provider.
- ◆ Reexamine the member at least every six months (or more frequently if conditions warrant) to:
 - Review the original diagnosis and treatment plan, and
 - Evaluate the member's progress, including a formal assessment.

The treatment plan will be provided to behavioral health intervention service providers to use as a basis for an implementation plan. (See [Implementation Plan](#).)



C. COVERED SERVICES

Behavioral health intervention services are skill-building interventions that ameliorate behaviors and symptoms associated with an Axis I psychological disorder that has been assessed and diagnosed by a licensed practitioner of the healing arts.

The services must be medically necessary. "Medically necessary" means that the service is:

- ◆ Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by an Axis I disorder,
- ◆ Required to meet the medical needs of the member and needed for reasons other than the convenience of the member or the member's caregiver,
- ◆ The least costly type of service that can reasonably meet the medical needs of the member, and
- ◆ In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:
 - Knowledgeable Iowa clinicians practicing or teaching in the field, and
 - The professional literature regarding evidence-based practices in the field.

The services address mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life and reduce or manage the behaviors that interfere with the member's 's ability to function.

Services must be designed to reduce or eliminate the symptoms or behaviors resulting from the member's psychological disorder that prevent the member from functioning at the member's best possible functional level.

The focus of the intervention is to improve the member's health and well-being using cognitive, behavioral, or social interventions designed to ameliorate specific diagnosis-related problems.

Services are covered and payable only for Medicaid members meeting the criteria under [MEMBERS ELIGIBLE TO RECEIVE SERVICES](#) under an approved plan. (See [Service Authorization](#).)



1. Service Setting

Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

- ◆ Behavior intervention,
- ◆ Crisis intervention,
- ◆ Skill training and development, and
- ◆ Family training.

Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441 Iowa Administrative Code subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

- ◆ Behavior intervention,
- ◆ Crisis intervention, and
- ◆ Family training.

NOTE: Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, detention center, state institution, or a psychiatric medical institution for children.



2. Service Descriptions

a. Behavior Intervention

Behavior intervention is covered only for Medicaid members aged 20 or under. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

- ◆ Cognitive flexibility skills,
- ◆ Communication skills,
- ◆ Conflict resolution skills,
- ◆ Emotional regulation skills,
- ◆ Executive skills,
- ◆ Interpersonal relationship skills,
- ◆ Problem-solving skills, and
- ◆ Social skills.

Behavior intervention shall be provided in a location appropriate for skill identification, teaching, and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

The services must be directed toward the child. Services directed at a family member such as a parent, to meet the protective, supportive, or preventive needs of a child are not covered services.

A unit of service is 15 minutes.



b. Crisis Intervention

Crisis intervention is covered only for Medicaid members aged 20 or under. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

Crisis intervention shall be provided as outlined in a written treatment plan.

Crisis intervention services do not include control room or other restraint activities.

A unit of service is 15 minutes.

c. Family Training

Family training is covered only for Medicaid members aged 20 or under. Family training services shall:

- ◆ Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
- ◆ Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

Training provided must:

- ◆ Be for the direct benefit of the member, and
- ◆ Be based on a curriculum with a training manual.

A unit of service is 15 minutes.



d. Skills Training and Development

Skill training and development is covered only for Medicaid members who are aged 18 and older.

Skill training and development includes interventions to enhance independent living, social and communication skills that minimize or eliminate psychological barriers to a member's ability to manage symptoms associated with a psychological disorder effectively and maximize the member's ability to live and participate in the community.

Interventions may include training in the following skills for effective functioning with family, peers, and community:

- ◆ Communication skills,
- ◆ Conflict resolution skills,
- ◆ Daily living skills,
- ◆ Problem-solving skills,
- ◆ Social skills, or
- ◆ Interpersonal relationship skills.

The unit of service is 15 minutes.

3. Excluded Services

Behavioral health intervention services do not include any of the following:

- ◆ Day care.
- ◆ Recreation.
- ◆ Non-skill-based activities.
- ◆ Mentoring.
- ◆ Respite services.
- ◆ Room and board.
- ◆ Family support services.
- ◆ Inpatient hospital services.
- ◆ Services that are solely educational in nature. Educational services should not be interrupted to provide behavioral health intervention services.



- ◆ Job-specific and task-specific vocational services.
- ◆ Any services not provided directly to the eligible member.
- ◆ Services that are not in the person's behavioral health intervention services treatment plan.
- ◆ Services to persons under 65 years of age residing in institutions for mental diseases.
- ◆ Services directed at a parent or family member to meet the protective, supportive, or preventive needs of a child.
- ◆ Services provided by the licensed practitioner of the healing arts (LPHA). These services must be billed to the Iowa Plan separately.
- ◆ Habilitative services, which are services that are designed to assist individuals in **acquiring** skills that they **never had**, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.
- ◆ Collateral contacts. Contacts such as phone calls with a member or a provider participating in the interdisciplinary team meeting are **not** billable as a behavioral health intervention service.
- ◆ Child welfare services and maintenance as defined in the DHS **Foster Group Care Services Provider Handbook**, [Chapter C](#), are not included as behavioral health intervention services.
- ◆ Services that are otherwise covered by the Iowa Medicaid program or that are an integral and inseparable part of another Medicaid-reimbursable service, including but not limited to:
 - Targeted case management services,
 - Institutional services,
 - Home- and community-based waiver services, or
 - Control room or restraint activities.



D. REQUIREMENTS FOR SERVICE COVERAGE AND PAYMENT

1. Medical Necessity

To be payable by Medicaid as a behavioral health intervention service, a service must be:

- ◆ Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by an Axis I disorder.
- ◆ Rehabilitative in nature and not habilitative.
- ◆ Designed to promote a member's integration and stability in the community and quality of life.
- ◆ Consistent with professionally accepted guidelines and standards of best practice for the service being provided.
- ◆ Designed to promote a member's ability to obtain or retain employment or to function in non-work settings.
- ◆ Designed to address mental and functional disabilities and behaviors resulting from a psychological disorder that interferes with an individual's ability to live and participate in the community.
- ◆ Furnished in the most appropriate and least restrictive available setting in which the service can be safely provided, consistent with the member's goals identified in the treatment plan and defined in the member's implementation plan.
- ◆ Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver.
- ◆ In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:
 - Knowledgeable Iowa clinicians practicing or teaching in the field, and
 - The professional literature regarding evidence-based practices in the field.



2. Implementation Plan

Services must be included in a behavioral health intervention implementation plan that is based on the identified goals in the treatment plan and the member's diagnosis of a psychological disorder.

The behavioral health intervention services provider shall develop an implementation plan based on the treatment goals and service recommendations that the licensed practitioner prescribes in the member's treatment plan.

a. Components of the Implementation Plan

An implementation plan must include the following demographic information:

- ◆ The member's name
- ◆ The member's address
- ◆ The member's date of birth
- ◆ The member's Medicaid state identification number
- ◆ The behavioral health intervention services provider's name
- ◆ The date the plan was developed and revised

The plan must include the diagnosis and treatment order from the licensed practitioner of the healing arts, including scope, amount, and duration of services.

b. Evaluation of the Implementation Plan

The implementation plan will be evaluated according to the following criteria:

- ◆ The plan is consistent with licensed practitioner of the healing arts' written diagnosis and treatment recommendation.
- ◆ The plan addresses the member's mental health symptoms or behaviors.
- ◆ The plan is individualized.
- ◆ The plan incorporates strengths of the member and, if applicable, of the member's family into the interventions.



- ◆ The interventions are specific with roles and responsibilities identified.
- ◆ The services and treatment are consistent with best practice guidelines.
- ◆ The plan reflects the participation of the member and the member's legal representative, as applicable.
- ◆ The plan conforms to the medical necessity requirements.
- ◆ The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose.
- ◆ The goals and objectives are measurable and time-limited.
- ◆ The treatment results and outcomes are specified.

3. Iowa Plan Service Authorization

Service is authorized by the Iowa Plan contractor. The Iowa Plan authorization process will be used for all behavioral health intervention service requests.

Contact the Iowa Plan at 800-638-5820 to schedule a telephone authorization. The mental health professional who performed the assessment will participate in the authorization request.

For members who have not received behavioral health intervention services, providers may request up to 50 units online at www.magellanprovider.com.

4. Non Iowa Plan Eligible Authorization

When the member does not have Iowa Plan eligibility for a month in which services are provided, the provider must obtain an authorization from the Iowa Medicaid Enterprise.

Fax the Iowa Plan authorization to the IME Medical Services Unit at 515-725-1355 along with form 470-4621, *IME BHIS Fax Cover Letter*. (Click [here](#) to see a sample of form 470-4621.)

Upon receipt of the Iowa Plan authorization, the IME Medical Services Unit will provide an authorization within two business days. The IME will authorize behavioral health intervention services for up to 60 days' duration by sending form 470-5034, *BHIS IME Notice of Decision*. (Click [here](#) to see a sample of form 470-5034.)



The authorization will not be valid for any month in which the member gains Iowa Plan eligibility. If the IME determines that the member has become enrolled in the Iowa Plan by the time the authorization is requested, the IME will issue form 470-5033, *BHIS IME Authorization Not Needed*. (Click [here](#) to see a sample of form 470-5033.)

5. Documentation

Providers must maintain medical records for five years from the date of service as evidence that the services provided were:

- ◆ Medically necessary;
- ◆ Consistent with the diagnosis of the member's condition; and
- ◆ Consistent with evidence-based practice.

Each page of the medical record shall contain:

- ◆ The member's full name.
- ◆ The member's date of birth.
- ◆ The member's Medicaid state identification number.

a. Progress Notes

The provider's file for each Medicaid member **must** include progress notes for **each** date of service that details specific services rendered related to the covered behavioral health intervention service for which a claim is submitted.

The following items must be included in **each** progress note entry, for **each** Medicaid member, and for **each** date of service:

- ◆ The date and amount of time services were delivered, including the beginning and ending time of service delivery, including AM or PM.
- ◆ The full name of provider agency.
- ◆ The first and last name and title of provider staff actually rendering service, as well as that person's signature.
- ◆ A description of the specific components of the Medicaid-payable behavioral health intervention service being provided (using service description terminology from this manual).



- ◆ The nature of contact, relative to the Medicaid-payable service that was rendered. The progress note **must** describe what specifically was done, relative to both:
 - The goal as stated in the member's treatment plan or implementation plan **and**
 - How the behavioral health intervention service provided addressed the symptoms or behaviors resulting from the member's psychological disorder.
- ◆ The place or location where service was actually rendered.
- ◆ The nature, extent, and number of units billed.

Progress notes shall include the progress and barriers to achieving:

- ◆ The goals stated in the treatment plan; and
- ◆ The objectives stated in the implementation plan.

b. Medical Record

The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

At the conclusion of services, the member's record shall include a discharge summary that identifies:

- ◆ The reason for discharge,
- ◆ The date of discharge,
- ◆ The recommended action or referrals upon discharge, and
- ◆ The treatment progress and outcomes.

The discharge summary shall be included in the member's record within 72 hours of discharge.



E. PROCEDURE CODES AND NOMENCLATURE

The following procedure codes may be used in submitting bills for behavioral health intervention services for members age 18 or over:

<u>Code</u>	<u>Modifier</u>	<u>Description</u>
H2014	HB for individual HQ for group	Skills training and development, per 15 minutes

The following procedure codes may be used in submitting bills for behavioral health intervention services for members under age 21:

<u>Code</u>	<u>Modifier</u>	<u>Description</u>	<u>Service Delivery</u>	<u>Unit</u>
H2019	HA	Skills training related to a specific MH diagnosis	Individual	15 minutes
H2019	HQ	Skills training related to a specific MH diagnosis that is appropriate to age and group model	Group	15 minutes
H2019	HR	Skills training related to a specific MH diagnosis and specific to assessment of family interaction/functioning	Family	15 minutes
H0019		Behavioral health long-term residential, without room and board		Per diem

The following code may be used for all ages:

<u>Code</u>	<u>Description</u>	<u>Service Delivery</u>
H2011	Crisis intervention	Individual

Submit bills for whole units of service only. If the time of service provision for a given billing period totals more or less than a whole unit, round 0.5 unit or higher up to the next whole unit; round less than 0.5 unit down to the next whole unit.



Bill a service with 15-minute units as follows:

- ◆ For eight minutes or higher, round up to the next whole unit.
- ◆ For seven minutes or lower, round down to the next whole unit.

NOTE: The beginning and ending time recorded in the progress notes must match the units billed on the claim for that date of service.

F. BASIS OF PAYMENT FOR SERVICES

Reimbursement for behavioral health intervention services provided on or after July 1, 2011, shall be paid on a fee schedule established by the Iowa Plan for Behavioral Health. See [http://www.magellanofiowa.com/for-providers-ia/behavioral-health-intervention-services-\(formerly-known-as-remedial\).aspx](http://www.magellanofiowa.com/for-providers-ia/behavioral-health-intervention-services-(formerly-known-as-remedial).aspx).

G. CMS-1500 CLAIM FORM

Providers of behavioral health intervention services to members who were not enrolled in the Iowa Plan shall submit claims using form CMS-1500, *Health Insurance Claim Form*. To view a sample of this form on line, click [here](#).

The table below contains information that will aid in the completion of the claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

Providers interested in billing electronically can contact EDISS (Electronic Data Interchange Support Services) at 800-967-7902 or by e-mail at edi@noridian.com. Electronic media claim (EMC) submitters should also refer to your EMC specifications for claim completion instructions.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	REQUIRED. Check the applicable program block.
1a.	INSURED'S ID NUMBER	REQUIRED. Enter the Medicaid member's Medicaid number, found on the <i>Medical Assistance Eligibility Card</i> . The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	REQUIRED. Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	OPTIONAL. Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	OPTIONAL. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	OPTIONAL. Enter the address and phone number of the member, if available.
6.	PATIENT RELATIONSHIP TO INSURED	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	REQUIRED, IF KNOWN. Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME, ETC.	SITUATIONAL. Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
10a-c.	IS PATIENT'S CONDITION RELATED TO	REQUIRED, IF KNOWN. Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	<p>REQUIRED. If the Medicaid member has other insurance, check "yes" and enter payment amount in field 29. If "yes," then boxes 9a-9d must be completed.</p> <p>If there is no other insurance, check "no."</p> <p>If you have received a denial of payment from another insurance, check both "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record.</p> <p>Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.</p> <p>NOTE: Auditing will be performed on a random basis to ensure correct billing.</p>
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	SITUATIONAL. If treatment is the result of an accident, enter the date of the accident or the onset of treatment. For pregnancy, enter the date of the last menstrual period (LMP). Make the entry in MM/DD/YY format. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	SITUATIONAL. Required for chiropractors only. Chiropractors must enter the current X-ray date in MM/DD/YY format.
16.	DATES PATIENT UNABLE TO WORK...	OPTIONAL. No entry required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	SITUATIONAL. Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the healthcare provider that directed the patient to your office.
17a.		LEAVE BLANK. The claim will be returned if any information is entered in this field.
17b.	NPI	SITUATIONAL <ul style="list-style-type: none">◆ If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring provider.◆ If this claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider.◆ If the patient is on lock-in and the lock-in provider authorized the service, enter the NPI of the lock-in primary care provider (PCP).
18.	HOSPITALIZATION DATES RELATED TO...	OPTIONAL. No entry required.
19.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box "Y – Pregnant."



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
20.	OUTSIDE LAB	OPTIONAL. No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	REQUIRED. Indicate the applicable ICD-9-CM diagnosis codes in order of importance to a maximum of four diagnoses (1-primary, 2-secondary, 3-tertiary, and 4-quaternary). Do not enter descriptions. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION	No entry required.
23.	PRIOR AUTHORIZATION NUMBER	SITUATIONAL. If there is a prior authorization, enter the prior authorization number. Obtain the number from the prior authorization form.
24. A	DATE(S) OF SERVICE TOP SHADED PORTION LOWER PORTION	SITUATIONAL. Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). Do not use spaces or symbols. REQUIRED. Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	<p>REQUIRED. Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	OPTIONAL. No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	<p>REQUIRED. Enter the codes for each of the dates of service. Do not list services for which no fees were charged. Do not enter descriptions.</p> <p>Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show HCPCS code modifiers with the HCPCS code.</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. E	DIAGNOSIS POINTER	REQUIRED. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. Do not write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	\$ CHARGES	REQUIRED. Enter the usual and customary charge for each line item. The charge must include both dollars and cents.
24. G	DAYS OR UNITS	REQUIRED. Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	SITUATIONAL. Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	LEAVE BLANK.
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	LEAVE BLANK. REQUIRED. Enter the NPI of the provider rendering the service.
25.	FEDERAL TAX ID NUMBER	OPTIONAL. No entry required.
26.	PATIENT'S ACCOUNT NUMBER	FOR PROVIDER USE. Enter the account number you have assigned to the patient. This field is limited to 10 alpha/numeric characters.
27.	ACCEPT ASSIGNMENT	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
28.	TOTAL CHARGE	<p>REQUIRED. Enter the total of the line item charges on the LAST page of the claim.</p> <p>If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Total Charge. On the earlier pages, enter "continued" or "page 1 of ___" in Box 28.</p>
29.	AMOUNT PAID	<p>SITUATIONAL. Required if the member has other insurance and the insurance has made a payment on the claim. Enter only the amount paid by the other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim.</p> <p>Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.</p> <p>If more than once claim form is used to bill services performed and a prior payment was made, the third-party payment should be entered on each page of the claim in Box 29.</p>
30.	BALANCE DUE	<p>REQUIRED. Enter the amount of total charges less the amount entered in field 29.</p>
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	<p>REQUIRED. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form.</p> <p>If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.</p>
32.	SERVICE FACILITY LOCATION INFORMATION	<p>OPTIONAL. Enter complete address of the treating or rendering provider.</p>
32a.	NPI	<p>OPTIONAL. Enter the NPI of the facility where services were rendered.</p>
32b.		<p>LEAVE BLANK.</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
33.	BILLING PROVIDER INFO AND PHONE #	REQUIRED. Enter the name and complete address of the billing provider. NOTE: The address must contain the ZIP code associated with the billing provider's NPI. The ZIP code must match the ZIP code confirmed during NPI verification.
33a.	NPI	REQUIRED. Enter the 10-digit NPI of the billing provider.
33b.		REQUIRED. Enter "ZZ" followed by the taxonomy code associated with the billing provider's NPI. The taxonomy code must match the taxonomy code confirmed during NPI verification.

H. REMITTANCE ADVICE

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click [here](#).

1. Remittance Advice Explanation

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- ◆ **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ **Denied** represents all processed claims for which no reimbursement is made.
- ◆ **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).



Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.



2. Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status



	Field Name	Field Description
X	Copay Amt.	Total copayment amount within same claim type or status
1	Patient Name	Last, first name or initial of the member as shown on the Medical Assistance Eligibility Card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total member copayment on claim
8	Med Rcd Num	Medical record number or patient account number
9	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on this line
15	Paid by Mcaid	Amount paid by Medicaid on this line
16	Copay Amt.	Copayment amount on this line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number



Field Name		Field Description
18	S	<p>Source of payment. Allowed charge source codes are as follows:</p> <ul style="list-style-type: none"> A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
19	EOB	Explanation of benefits denial reason code