STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID

Provider Manual

Ambulatory Surgical Centers

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I. CENTERS ELIGIBLE TO PARTICIPATE

Ambulatory surgical centers which are not part of a hospital are eligible to participate in the Medicaid program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

II. COVERAGE OF SERVICES

The services provided by ambulatory surgical centers are those services furnished by ambulatory surgical centers in connection with a covered surgical procedure. These services are the same services that are defined and covered by the Medicare program.

If an ambulatory surgical center offers laboratory services or professional physicians' services which are not considered facility services, these services must be billed by the providers rendering such services.

III. EXCLUSIONS AND LIMITATIONS ON COVERED PROCEDURES

Covered surgical procedures shall be those medically necessary procedures that are eligible for payment under the same circumstances as physicians' services and performed on an eligible recipient.

A. Cosmetic Surgery

Cosmetic surgery or expenses incurred in connection with such surgery is not covered under the Medicaid program except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member.

For the purposes of this program, cosmetic reconstructive or plastic surgery is surgery which can be expected primarily to improve physical appearance of which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions.

When a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions of this policy.

Coverage under the program is generally not available for cosmetic, reconstructive or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- Correction of a congenital anomaly.
- Restoration of body form following an accidental injury.
- Revision of disfiguring and extensive scars resulting from neoplastic surgery.
- Generally, coverage is limited to those cosmetic, reconstructive or plastic surgery procedures provided no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration or exception will be given to cases involving children who may require a growth period.

B. Excluded Services

Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
- Procedures related to transsexualism or hermaphroditism, except as specifically provided for in this policy.
- Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
- Breast augmentation mammoplasty, surgical insertion or prosthetic testicles, and penile implant procedures, whether or not they would otherwise qualify for coverage under this policy.

- Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age, ethnic or racial background.
- Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.
- Face lifts and other procedures related to the aging process.
- Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.
- Panniculectomy and body sculpture procedures.
- Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.
- Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.
- Chemical peeling for facial wrinkles.
- Dermabrasion of the face.
- Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.
- Removal of tattoos.
- Hair transplants.
- Electrolysis.

When it is determined that a cosmetic reconstructive or plastic surgery procedure does not qualify for coverage under this program, all related services and supplies, including any institutional costs, are also excluded.

Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident of treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions.

Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. Examples of complications similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne or repair of a prolapsed vagina in a biological male who has undergone transsexual surgery.

C. Abortions

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid Program to the following situations:

- The attending physician certifies in writing on the basis of professional judgment that the life of the pregnant woman would be endangered if the fetus was carried to term.

  Federal funding is available in these situations only if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

- The attending physician certifies in writing on the basis of professional judgment that the fetus is physically deformed, mentally deficient, or afflicted with a congenital illness and states the medical indications for determining the fetal condition.

- The pregnancy resulted from incest, and:
  - The incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident.
  - The report contains the name, address, and signature of the person making the report.
  - An official of the agency or physician so certifies in writing.

  Federal funding is available to terminate a pregnancy that was the result of rape or incest.
- Payment will be made for treatment of a spontaneous abortion or miscarriage where all the products of conception are not expelled.

A copy of form 470-0836, *Certification Regarding Abortion* (see pages 15 and 16), must be attached to the physician's claim if payment is to be made for an abortion. Payment cannot be made to the attending physician, to other physicians assisting in the abortion, to the anesthetist, or to the hospital or ambulatory surgical center if the required certification is not submitted with the claim for payment.

In case of a pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required, as set forth above. It is the responsibility of the recipient, someone acting in her behalf, or the attending physician to obtain the necessary certification from the agency involved. Form 470-0836 is also to be used for this purpose.

It is the responsibility of the physician to make a copy of form 470-0836 available to the hospital, other physicians, CRNAs, anesthetists, or ambulatory surgical centers billing for the service. This will facilitate payment to the hospital and other physicians on abortion claims.

All abortion claims must be billed with the appropriate ICD-9 diagnosis and procedure code indicating the abortion on the UB hospital claim and the appropriate ICD-9 abortion diagnosis and CPT abortion procedure code on the HCFA 1500 claim.

In addition to form 470-0836, documentation identifying the reason for the abortion must be attached to the claim. This includes, but is not limited to:

- The operative report
- Pathology report
- Laboratory reports
- Ultrasound report
- Physician's progress notes
- Other documents that support the diagnosis identified on the claim

1. Covered Services Associated With Noncovered Abortions

The following services are covered if they would have been performed on a pregnant woman regardless of whether she was seeking an abortion. These services include charges for:

- Pregnancy tests.
- Tests to identify sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphilis).
- Other laboratory tests routinely performed on a pregnant patient, such as pap smear and urinalysis, hemoglobin, hematocrit, rubella titre, hepatitis B and blood typing.

Note: Family planning or sterilizations must not be billed on the same claim with an abortion service. These services must be billed separately from the abortion claim.

2. Noncovered Services

The following abortion related services are not allowed when the abortion is not covered by federal or state criteria:

- Physician and surgical charges for performing the abortion. These charges include the usual, uncomplicated preoperative and postoperative care and visits related to performing the abortion.
- Hospital or clinic charges associated with the abortion. This includes:
  - The facility fee for use of the operating room.
  - Supplies and drugs necessary to perform the abortion.
  - Charges associated with routine, uncomplicated preoperative and postoperative visits by the patient.
- Physician charges for administering the anesthesia necessary to induce or perform an abortion.
- Drug charges for medication usually provided to or prescribed for the patient who undergoes an uncomplicated abortion. This incudes:
  - Routinely provided oral analgesics.
  - Antibiotics to prevent septic complication of abortion and Rho-GAM (an immune globulin administered to RH negative women who have an abortion).
- Charges for other laboratory tests performed prior to performing the noncovered abortion to determine the anesthetic and surgical risk of the patient (e.g., CBC, electrolytes, blood typing).
- Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- Uterine ultrasounds performed immediately following an abortion.

D. Sterilizations

Federal regulations provide that payment shall not be made through the Medicaid Program for sterilization of a person under the age of 21 at the time of consent or who is legally mentally incompetent or institutionalized.

"Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment to an operation of the genital urinary tract. For purpose of this definition, mental illness or retardation is not considered an illness or injury.

A "legally mentally incompetent" person is a person who has been declared mentally incompetent by a federal, state or local court for any purpose unless the court declares the person competent for purposes which include the ability to consent to sterilization.

An "institutionalized" person is a person who is involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

The same revision of federal regulations provide that payment may be made through the program for the sterilization of a person aged 21 or over when the consent form is signed, who is mentally competent and noninstitutionalized in accordance with the above definitions under certain conditions.

1. Requirements

The following conditions must be met:

- The person to be sterilized must voluntarily request the services.

- The person to be sterilized must be advised that he/she is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing his or her future care or loss of other project or program benefits to which the patient might otherwise be entitled.

- The person to be sterilized must be given an explanation of the procedures to be performed by a knowledgeable informant upon which he/she can base the consent for sterilization. An "informed consent" is required.

  "Informed consent" means the voluntary knowing assent from the person on whom the sterilization is to be performed after the person has been given a complete explanation of what is involved and has signed a written document to that effect.

  If the person is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. The person to be sterilized may be accompanied by a witness of the person's choice.

  The informed consent shall not be obtained while the person to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substance that affects the person's state of awareness.

  The elements of explanation which must be provided are:

  - A thorough explanation of the procedures to be followed and the benefits to be expected.
  - A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.

- Counseling concerning appropriate alternative methods of family planning and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.
- An offer to answer any inquiries concerning the proposed procedures.

♦ The "informed consent" must be obtained at least 30 days but not more than 180 days before the sterilization is performed except when emergency abdominal surgery or premature delivery occurs.

When emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent form was obtained for the exception to be approved.

When a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained and the documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed for the exception to be approved.

The "informed consent" shall be obtained on form 470-0835, *Consent*, or the Spanish version, form 470-0835S, *Formularo de Consentimiento Requerido*. The individual must be 21 years of age or older at the time of consent.

2. Consent, Form 470-0835 or 470-0835S

The physician's copy of the consent must be completely executed in all aspects (no substitute form is accepted) according to the above directions and attached to the claim in order to receive payment (see page 17 or 18).

When a claim for physician's services for sterilization is denied either due to the failure to have the consent form signed at least 30 days and not more than 180 days before the date service is provided, or failure to use the official consent form, 470-0835 or 470-0835S, any claim submitted by the ambulatory surgical center, hospital, anesthesiologists, assistant surgeon, or associated providers for the same operation or procedure will also be denied.

It is the responsibility of the ambulatory surgical center, hospital, and other providers associated with the sterilization services to obtain a photocopy of the completed consent form which must be attached to their claim when submitted to the fiscal agent for payment.

All names, signatures, and dates on the consent form must be fully, accurately, and legibly completed. The only exceptions to this requirement are that:

- The "Interpreter's Statement" is completed only if an interpreter is actually provided to assist the individual to be sterilized.
- The information requested pertaining to race ethnicity designation is to be supplied voluntarily on the part of the patient, but is not required.

It is the responsibility of the person obtaining the consent form to verify that the patient requesting the sterilization is at least 21 years of age on the date that the patient signs the form. If there is any question pertaining to the true age of the patient, her/his birthdate must be verified.

The "Statement of Person Obtaining Consent" may be completed by any qualified professional capable of clearly explaining all aspects of sterilization and alternate methods of birth control which are available to the patient.

The "Physician's Statement" must be completed fully and signed by the PHYSICIAN PERFORMING THE STERILIZATION and dated when signed. It is important that one of the paragraphs at the bottom of this statement which is not used, be crossed out as per instructions.

Since the physician performing the sterilization will be the last person to sign the consent form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization for which a claim will be submitted; i.e., ambulatory surgical center, hospital, anesthetist, assistant surgeons, etc.

It is the responsibility of all other providers associated with the sterilization to obtain a photocopy of the fully completed consent form from the physician performing the sterilization, to be attached to the provider claim which is submitted to the fiscal agent for payment.

The only signatures which should be on the completed consent form are those of the patient, interpreter (if interpreter services were provided), the person obtaining the consent form, and the physician performing the sterilization.

A supply of the form may be obtained from the fiscal agent upon request.

E. Preprocedure Review

Surgical procedures affect health care expenditures significantly. To ensure that procedures are medically necessary, the Iowa Foundation for Medical Care (IFMC) conducts a preprocedure review program for the Medicaid program. This program entails reviewing selected high-quantity procedures when they are performed on an inpatient basis, in the outpatient unit of a hospital, or in a free-standing surgical unit.

Preprocedure review is performed for all heart, lung, liver, stem cell, and bone marrow transplants and for all gastric bypass procedures, as identified on the preprocedure review list. Reviews are performed for patients with traditional Medicaid and MediPASS coverage.

The following sections explain:

- What procedures are reviewed.
- How reviews are conducted.
- What happens if the review is not obtained until after the patient is discharged.

1. Procedures Subject to Review

The following is a list of the surgical procedures that are subject to preprocedure review. Procedures for which approval must be obtained are listed with CPT and ICD-9 codes.

	Hospital Use Only: ICD-9-CM	Physician and Ambulatory Surgical Center Use Only: CPT-4
Bone marrow transplant	41.00 41.01 41.02 41.03	38240 38241
Stem cell transplant	41.04 41.05	38240 38241
Heart transplant	37.5	33945
Liver transplant auxiliary	50.51	47135
Other transplant of liver	50.59	47135
Lung transplant: Unilateral transplant Bilateral transplant	33.50 33.51 33.52	32851 32852 32853 32854
High gastric bypass (Printen and Mason)	44.31	43846 43847
Gastric stapling (gastroplasty)	44.69	43326 43842 43843 43848
Small bowel bypass	45.91	43846

2. Review Process

The following review process applies to all preprocedure review activities. Preprocedure review is conducted to evaluate the appropriateness of the procedures identified on the preprocedure review list. Requests for review of these elective procedures must be submitted in writing to:

IFMC
6000 Westown Parkway, Suite 350E
West Des Moines, Iowa 50266-7771

The request must provide the following information from the physician, on which the IFMC will base its decision:

- Procedure planned
- Proposed admission date
- Proposed date of procedure
- Hospital or location of intended procedure
- Patient's name, address
- Patient's age
- Patient's Medicaid ID number
- Attending physician's name
- Tentative diagnosis
- Orders
- History and chief complaint (include symptoms and duration of problem)
- Other medical history or problem
- Preadmission treatment
- Outpatient studies performed
- Medication

Preprocedure review is conducted using criteria that have been developed by the applicable physician specialties. Questionable cases are referred to a physician reviewer for a determination of the medical necessity of the procedure. Denial letters are issued if the procedure is determined not to be medically necessary.

The IFMC provides validation numbers on all approved preprocedure reviews. Claims sent to the fiscal agent without an IFMC validation number will be rejected and returned to the hospital. The hospital must notify the IFMC and request a retrospective review to determine the appropriateness of the procedure before receiving payment.

A sample of cases reviewed on a preprocedure basis is selected for retrospective review. The information provided during the preprocedure review is validated during the retrospective review process. A denial may be issued if the information provided during precertification review is not supported by medical record documentation.

3. Procedure Review Obtained Following Discharge

If the provider discovers that preprocedure review was not obtained with the IFMC before or immediately following the procedure and the patient was discharged, the provider must request IFMC review to determine the appropriateness of the procedure before receiving payment.

The provider must complete the form, *Retrospective Certification of Admissions/Procedures for Iowa Medicaid Recipients* (available from IFMC).

In addition, the hospital must send a copy of the complete medical record with the completed form to the IFMC for a retrospective review. Hospital staff are reminded to identify the type of procedure review that is being requested (e.g., gastric stapling review).

IV. BASIS OF PAYMENT FOR AMBULATORY SURGICAL CENTERS

The basis of payment for those services approved by Medicare is the maximum allowable fee established by the Medicare program for the surgery and the geographic area of the ambulatory surgical center. This fee cannot exceed the provider's customary charge.

Medicaid uses the procedure codes and nomenclature from the 4th edition of Current Procedural Terminology. This coding is consistent with that used by Medicare. Surgical procedures not covered by Medicare may be identified as payable by Medicaid. Reimbursement rates are established by the Medicaid Program for those surgical procedures.

Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied.

V. FACSIMILE MEDICAID FORMS

(See the following pages.)

A. Form 470-0836, Certification Regarding Abortion

B. Form 470-0835, Consent Form

C. Form 470-0835S, Formulario de Consentimiento Requerido

Iowa Department of Human Services

Certification Regarding Abortion

CERTIFY TO ONE OF THE FOLLOWING:

I certify that on the basis of my professional judgment:

❑ **Life of the Mother.**

_____
(Name and address of the mother)

suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed, or,

❑ **Fetus Deformed.** The fetus carried by

_____
(Name and address of the mother)

is physically deformed, mentally deficient, or afflicted with a congenital illness based on:

_____

_____
(Medical indications)

❑ **Rape**

I, _____, of _____
(Name of official) (Name of agency)

received a signed form from _____
(Name and address of person reporting)

stating that _____
(Name and address of the mother)

was the victim of an incident of rape. The incident took place on _____
(Date)

and the incident was reported on _____. The report included the name,
(Date)

address and signature of the person making the report.

❑ **Incest**

I, _____, of _____
(Name of official) (Name of agency)

received a signed form from _____
(Name and address of person reporting)

stating that _____
(Name and address of the mother)

was the victim of an incest incident. The incident took place on _____
(Date)

and the incident was reported on _____. The report included the name,
(Date)

address and signature of the person making the report.

I further certify that the mother has been given the opportunity to view an ultrasound image of the fetus as part of the standard care before an abortion is performed, and the mother has been provided information regarding the options relative to a pregnancy including continuing the pregnancy to term and retaining parental rights following the child's birth, continuing the pregnancy to term and placing the child for adoption, and terminating the pregnancy.

Signature of attending provider	Date
Signature of official of law enforcement, public or private health agency which may include a family physician	Date

Conditions for Medicaid Payment for Abortions

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

1. The attending provider certifies in writing that continuing the pregnancy would endanger the life of the pregnant woman. Federal funding is available in these situations only if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

2. The attending provider certifies in writing on the basis of the provider's professional judgment that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.

3. The pregnancy is the result of rape, that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 45 days of the date of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency must so certify in writing.

4. The pregnancy is the result of incest, that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency or physician must so certify in writing.

A copy of the form, *Certification Regarding Abortion* (470-0836), must be attached to any Medicaid claim associated with the abortion. **Payment will not be made to the attending provider or to other providers assisting in the abortion or to the hospital if the required certification is not submitted by the provider with the claim for payment.** It is the responsibility of the attending provider to make a copy of the certification available to the hospital and other providers billing for the services associated with the abortion.

In the case of pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required as set forth above. The member, someone acting in her behalf, or the attending provider is responsible for obtaining the necessary certification from the agency involved. The form, *Certification Regarding Abortion* (470-0836), is to be used for this purpose. It is also the responsibility of the provider to make a copy of the certification available to the hospital and any other provider billing for the service. This will facilitate payment to the hospitals and other providers on abortion claims.

Iowa Department of Human Services

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for the
(doctor or clinic)
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as FIP or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____ hereby consent of my own free will to be sterilized by _____
(doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services or
- Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Month Day Year

You are requested to supply the following race and ethnicity information, but it is not required:

Race and ethnicity designation (please check)*:*

- ❑ American Indian or Alaska Native
- ❑ Asian or Pacific Islander
- ❑ Black (not of Hispanic origin)
- ❑ Hispanic
- ❑ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation, _____the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent Date

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____
_____ on _____
Name of Individual to be sterilized Date of sterilization

_____ , I explained to him/her the nature of the
operation
sterilization operation _____ , the fact that
Specify type of operation
it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control ore available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent con be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the dote of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ❑ Premature delivery; individual's expected date of delivery._____
- ❑ Emergency abdominal surgery: (describe circumstances):

_____
Physician
Date _____

1. White Copy - Patient 2. Canary Copy - Physician 3. Pink Copy – Send to: Consultec, P.O. Box 14422, Des Moines, IA 50306-3422

470-0835 (Rev. 7/97)

FORMULARIO DE CONSENTIMIENTO REQUERIDO

NOTA: Si en cualquier momento decide no hacerse esterilizar ello no resultara en que se le retiren o retengan cualquiera de los beneficios proporcionados por programas o proyectos que reciben fondos del gobierno federal.

CONSENTIMIENTO PARA LA ESTERILIZACIÓN

He pedido y recibido informacion sobre la esterilización de _____. Cuando me informé al respecto,
(doctor o clinica)
se me dijo que la decisión de hacerme esterilizar es absolutamente mía. Me han informado que, si así lo deseo, puedo decidir no hacerme esterilizar. Si decido no hacerme esterilizar, esta decisión no afectará mis derechos a cuidados o tratamiento futuros. No perderé ninguno de los beneficios de programas que reciben fondos federales, como por ejemplo FIP o Medicaid que esté recibiendo en la actualidad o que pueda recibir en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA **PERMANENTE E IRREVOCABLE**. HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, TENER HIJOS O PROCREAR HIJOS.

Se me ha informado acerca de los métodos anticonceptivos que están disponibles y que se me podrán proporcionar, los que sí me permitirán tener un hijo o procrear un hijo en el futuro. He rechazado estas alternativas y he elegido el ser esterilizado(a).

Entiendo que seré esterilizado(a) por medio de una operación conocida bajo el nombre de _____.
Los inconvenientes, riesgos y beneficios asociados con esta operación me han sido explicados. Todas mis preguntas han sido contestadas en forma satisfactoria.

Entiendo que la operación no se hará hasta por lo menos 30 días después de haber firmado este consentimiento. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión de no hacerme esterilizar no resultará en que se me retiren cualquiera de los beneficios o servicios médicos proporcionados por fondos federales.

Tengo por lo menos 21 anõs de edad y naci el _____ _____ _____.
mes *año* *día*

Yo, _____,
por la presente consiento por mi propia voluntad a que me esterilice _____, por el método conocido como
(doctor)
_____.
Mi consentimiento se vence a los 180 días de la fecha de mi firma.

También consiento a que este formulario y otros antecedentes médicos sean puestos a la disposición de:

Representantes del Departamento de Salud, Educación y Bienestar (Department of Health, Education and Welfare) o

Empleados de programas o proyectos que operan con fondos de ese departamento, pero solamente para determinar si se han cumplido las leyes federales.

He recibido una copia de este formulario.

firma	*fecha*	*mes* *día* *año*

Se le pide que proporcione la siguiente información, pero esto no es obligatorio:

Raza y Designación Etnica (haga una marca):

- ❑ Negro (no de orígen hispano)
- ❑ Hispano
- ❑ Asiático o de Islas del Pacifico
- ❑ Indio Norteamericano o Nativo de Alaska
- ❑ Blanco (no de orígen hispano)

DECLARACION DEL INTERPRETE

Si se proporciona un intérprete para asistir a la persona a ser esterilizada:

He traducido la información y consejos incluídos dados en forma oral por la persona que obtiene este consentimiento, a la persona a ser esterilizada. También le he leído el formulario de consentimiento en el idioma _____ y le he explicado su contenido. Según mi mejor entender esta persona ha comprendido esta explicación.

intérprete	*fecha*

DECLARACION DE LA PERSONA QUE OBTIENE ESTE CONSENTIMIENTO

Antes de que _____ firmara este
nombre de la persona
formulario de consentimiento, le he explicado la naturaleza de la operación para la esterilización llamada _____, y el hecho de que se trata de un procedimiento final e irrevocable, habiéndole explicado también los inconvenientes, riesgos y beneficios que la acompañan.

Advertí a la persona a ser esterilizada que existen métodos anticonceptivos alternos, que son temporarios. Le expliqué que la esterilización es diferente porque es permanente.

He informado a la persona a ser esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ninguno de los servicios de salud o cualquier otro beneficio proporcionado con fondos federales.

De acuerdo a mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece tener capacidad mental suficiente. Esta persona ha solicitado en forma voluntaria, con pleno conocimiento de lo que implica, que la esterilicen y parece comprender la naturaleza y consecuencias del procedimiento.

firma de la persona que obtiene el consentimiento	*fecha*
establecimiento	
dirección	

DECLARACION DEL MEDICO

Poco antes de efectuar la operación para la esterilización de _____ el _____
nombre de la persona a ser esterilizada *fecha de la operación*
le expliqué la naturaleza de la operación llamada _____
tipo de operación
así como el hecho de que es un procedimiento final e irrevocable, así como los inconvenientes, riesgos y beneficios derivados del mismo.

He advertido a la persona a ser esterilizada que existen métodos anticonceptivos que son temporarios. Le he explicado que la esterilización es diferente, porque es permanente.

He informado a la persona a ser esterilizada que su consentimiento puede ser retirado en cualquier momento y que por ello no perdera ninguno de los cuidados médicos o beneficios proporcionados por fondos federales.

A mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y tiene la suficiente capacidad mental. Ha pedido voluntariamente y con pleno conocimiento el ser esterilizado(a) y parece comprender la naturaleza y consecuencias del procedimiento.

(**Instruccciones para el uso de párrafos finales alternos:** Utilice el primer párrafo que sigue, excepto en casos de parto prematuro o cirugía abdominal de emergencia, en que la esterilización se efectúa menos de 30 días despúes de la fecha de la firma del formulario de consentimiento. En dichos casos, deberá usarse el segundo párrafo de los que siguen. Tache el párrafo que no utilice.)

(1) Por lo menos treinta días han transcurrido entre la fecha en que la persona firmó el formulario de consentimiento y la fecha en que se efectuó la operación de esterilización.

(2) Esta esterilización fue efectuada menos de 30 días pero mas de 72 horas después de haber firmado la persona el formulario de consentimiento, debido a las circunstancias siguientes (haga una marca donde corresponda y de la información requerida):

- ❑ Parto prematuro
  Fecha en que debiera haber ocurrido el parto: _____
- ❑ Cirugía abdominal de emergencia: (describa las circunstancias)

_____

médico	*fecha*

I. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 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 recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**OPTIONAL** – Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** – Enter the recipient's Medicaid ID number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	**REQUIRED** – Enter the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.

4.	INSURED'S NAME	**CONDITIONAL*** – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident. **Note:** This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	**OPTIONAL** – Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**CONDITIONAL*** – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	**CONDITIONAL*** – Enter the address and phone number of the insured person indicated in field number 4.
8.	PATIENT STATUS	**OPTIONAL** – Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**CONDITIONAL*** – If the recipient carries other insurance, enter the name under which that insurance exists, 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.
10.	IS PATIENT'S CONDITION RELATED TO	**CONDITIONAL*** – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work 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	**CONDITIONAL*** – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**CONDITIONAL** – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29. 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. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
14.	DATE OF CURRENT ILL-NESS, INJURY, PREGNANCY	**CONDITIONAL*** – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS…	**CONDITIONAL** – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK…	**OPTIONAL** – No entry required.

17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL** – Required if the referring physician does not have a Medicaid number.
17a.	ID NUMBER OF REFERRING PHYSICIAN	**CONDITIONAL*** – If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number. If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician. If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.
18.	HOSPITALI-ZATION DATES RELATED TO…	**OPTIONAL** – No entry required.
19.	RESERVED FOR LOCAL USE	**REQUIRED** – If the patient is pregnant, write "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** – No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses.
22.	MEDICAID RESUBMISSION CODE…	**OPTIONAL** – No entry required.
23.	PRIOR AUTHORIZATION NUMBER	**CONDITIONAL*** – Enter the prior authorization number issued by Consultec.

24. A	DATE(S) OF SERVICE	**REQUIRED** – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 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 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility

24. C	TYPE OF SERVICE	**OPTIONAL** – No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged.
24. E	DIAGNOSIS CODE	**REQUIRED** – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 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.
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	**OPTIONAL*** – 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	EMG	**OPTIONAL** – No entry required.
24. J	COB	**OPTIONAL** – No entry required.
24. K	RESERVED FOR LOCAL USE	**CONDITIONAL*** – Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** – No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.

27.	ACCEPT ASSIGNMENT?	**OPTIONAL** – No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**CONDITIONAL*** – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim.
30.	BALANCE DUE	**REQUIRED*** – Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY…	**CONDITIONAL** – If other than a home or office, enter the name and address of the facility where the service(s) were rendered.
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME…	**REQUIRED*** – Enter the complete name and address of the billing physician or service supplier.
	GRP #	**REQUIRED** – Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line.
BACK OF FORM	NOTE	**REQUIRED** – The back of the claim form must be intact on every claim form submitted.

B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

II. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

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.

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 (recipient 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 fiscal agent 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.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following page.)

MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 06/12/97

1. 2. R E M I T T A N C E A D V I C E 4. 5.

TO: [redacted] R.A. NO.: 0000006 3. DATE PAID: 05/19/97 PROVIDER NUMBER: [redacted] PAGE: 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* 6. CLAIM TYPE: HCFA 1500						* 7. CLAIM STATUS: PAID							
ORIGINAL CLAIMS:													
[redacted] 8.	[redacted] 9.	[redacted]	10. 4-96331-00-053-0038-00			11. 38.00	12. 0.00	13. 16.06	14. 0.00	15. 860600608B		16. 900	000
		17. 01	18. 10/3	19. 99212	20. 1	21. 38.00	22. 0.00	23. 16.06	24. 0.00	25. [redacted]			000 00(
[redacted]	[redacted]	[redacted]	4-96348-00-018-0060-00			50.00	0.00	35.26	0.00	860600608B			000 00(
		01	11/15/96	J1055	1	41.00	0.00	33.18	0.00	[redacted]	26.	F	000 00(
		02	11/15/96	9C782	1	9.00	0.00	2.08	0.00	[redacted]		F	000 00(

27.

REMITTANCE T O T A L S

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	---------	88.00	51.32
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					51.32

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

28. 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 14 was intentionally left blank.

C. Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21. Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

B Billed charge
F Fee schedule
M Manually priced
N Provider charge rate
P Group therapy
Q EPSDT total screen over 17 years
R EPSDT total under 18 years
S EPSDT partial over 17 years
T EPSDT partial under 18 years
U Gynecology fee
V Obstetrics fee
W Child fee

27. Remittance totals (found at the end of the *Remittance Advice*):

    - Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
    - Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
    - Number of denied original claims and amount billed by provider.
    - Number of denied adjusted claims and amount billed by provider.
    - Number of pended claims (in process) and amount billed by provider.
    - Amount of check.

28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

III. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

Consultec, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire *Remittance Advice* should be canceled.

Send this form to:

Consultec, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❑ Other pertinent information for possible claim reprocessing.

INQUIRY A

1. **17-DIGIT TCN**
2. **NATURE OF INQUIRY**

(Please do not write below this line)
FOR CONSULTEC RESPONSE

INQUIRY B

1. **17–DIGIT TCN**
2. **NATURE OF INQUIRY**

(Please do not write below this line)
FOR CONSULTEC RESPONSE

Provider Signature/Date:	**MAIL TO: CONSULTEC** **P. O. BOX 14422** **DES MOINES IA 50306-3422**	**Consultec Signature/Date:**

Provider Please Complete:

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR CONSULTEC USE ONLY)

PR Inquiry Log #_____

Received Date Stamp:

470-3744 (Rev. 4/00)

Page 20 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.

❑ **CLAIM ADJUSTMENT**	❑ **CLAIM CREDIT**	❑ **CANCELLATION OF ENTIRE REMITTANCE ADVICE**
♦ Attach a complete copy of claim. (If electronic, use next step.) ♦ Attach a copy of the Remittance Advice with corrections in **red ink**. ♦ Complete Sections B and C.	♦ Attach a copy of the Remittance Advice. ♦ Complete Sections B and C.	♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ♦ Attach the check and Remittance Advice. ♦ Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN

2. Pay-to Provider #:

4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

SECTION C:

Provider/Representative Signature:

Date:

CONSULTEC USE ONLY: REMARKS/STATUS

Return All Requests To:

Consultec
PO Box 14422
Des Moines, IA 50306-3422

470-0040 (Rev. 4/00)