



**Medicaid Enterprise**

Iowa Department of Human Services

**Lead Investigation Agency  
Provider Manual**

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**Medicaid Enterprise**

Iowa Department of Human Services

## **III. Provider-Specific Policies**



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Provider

**Lead Investigation Agency**

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May 1, 2007

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## **CHAPTER III. PROVIDER-SPECIFIC POLICIES**

### **A. AGENCIES ELIGIBLE TO PARTICIPATE**

The Iowa Department of Public Health and any lead inspection agency that has been certified by the Iowa Department of Public Health as an elevated blood lead agency pursuant to 641 Iowa Administrative Code 70.5(5) are eligible to participate in the Medicaid program.

### **B. COVERAGE OF SERVICES**

Payment will be made for medically necessary lead inspection services in order to identify the sources of lead poisoning. The service shall be provided for a Medicaid-eligible child who has had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter.

#### **1. Lead Investigation Services**

Investigate all sites where the child may have been exposed to lead. This includes the current residence and all places (baby-sitter, day care, shared custody) where the child currently lives or visits and may include immediate past residences.

This service may include, but is not limited to:

- ◆ X-ray fluorescence analyzer readings.
- ◆ Visual examination of paint location and condition to determine lead hazards of primary or secondary addresses. The determination is made if the child may be exposed to lead-based paint hazards at any or all of these places.
- ◆ Soil samples and dust samples if necessary to determine additional sources of lead.
- ◆ An interview of the family to determine the child's daily schedule, potential sources and habits. Occupational and hobby histories of adults in the household or other places the child spends time help determine whether the child is being exposed to lead from an adult's workplace or hobby.



This service shall include:

- ◆ Ensuring that both the family and the owner of the home clearly understand what work must be done to make the home lead-safe and how to do the work safely.
- ◆ Health education to the child’s family about lead poisoning, the need for follow-up blood lead testing, the importance of good nutrition, and good housekeeping practices. Education should be reinforced during follow-up visits as needed.
- ◆ A written report to the family, the owner of the building, the child’s medical provider, and the local childhood lead poisoning prevention program.
- ◆ Follow-up to ensure that identified hazards are repaired.

**2. Authorization**

To be covered by Medicaid, this service must be recommended by a physician within the physician’s scope of practice under state law.

The Iowa Department of Public Health will provide the authorization. Contact Department of Public Health staff at 1-800-972-2026 to obtain authorization for the service.

**C. BASIS OF PAYMENT**

Elevated blood lead investigation agencies are reimbursed based on a fee schedule. The amount billed should reflect the actual cost of providing the service. The fee schedule amount is the maximum payment allowed.

**D. PROCEDURE CODES AND NOMENCLATURE**

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Claims submitted without a procedure code and ICD-9-CM diagnosis code will be denied. Use the diagnosis code 984.0 inorganic lead compounds or 984.1 organic lead compounds on claims.

The date of service for the Medicaid program should be the date of the elevated blood level investigation. This date should be **either** the date that a lead investigation was completed **or** the date that a verification is made that a home was built on or after January 1, 1978. This should also be the date entered in the IDPH data system as the “date initial inspection completed.”



The procedure code applicable to lead investigation agency services is as follows:

Code	Description
T1029	Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling

## E. INSTRUCTIONS AND CLAIM FORM

### 1. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the CMS-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 member's situation.

*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	<b>REQUIRED</b> Check the applicable program block.
1a.	INSURED'S ID NUMBER	<b>REQUIRED</b> 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	<b>REQUIRED</b> Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	<b>OPTIONAL</b> Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
4.	INSURED'S NAME	<b>OPTIONAL</b> 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	<b>OPTIONAL</b> Enter the address and phone number of the member, if available.
6.	PATIENT RELATIONSHIP TO INSURED	<b>OPTIONAL</b> For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	<b>OPTIONAL</b> For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	<b>REQUIRED, IF KNOWN</b> Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME, ETC.	<b>SITUATIONAL</b> 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.
10.	IS PATIENT'S CONDITION RELATED TO	<b>REQUIRED, IF KNOWN</b> 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	<b>OPTIONAL</b> No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	<b>OPTIONAL</b> For Medicaid purposes, the "insured" is always the same as the patient.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	<p><b>REQUIRED</b> 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 <b>both</b> "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><b>Note:</b> Auditing will be performed on a random basis to ensure correct billing.</p>
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	<b>OPTIONAL</b> No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	<b>OPTIONAL</b> No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	<b>SITUATIONAL</b> Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	<b>SITUATIONAL</b> Chiropractors must enter the current x-ray date as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	<b>OPTIONAL</b> No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	<p><b>SITUATIONAL</b> 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.</p>
17a.		<p><b>SITUATIONAL</b> through May 22, 2007.</p> <p><b>Note:</b> "1D" qualifier must precede any entry in this field.</p> <p>If the patient is a MediPASS member and the MediPASS provider authorized service, enter the seven-digit MediPASS authorization number.</p> <p>If this claim is for consultation, independent laboratory services, or medical equipment, enter the Iowa Medicaid number of the referring or prescribing provider.</p> <p>If the patient is on lock-in and the lock-in provider authorized service, enter the seven-digit authorization number.</p> <p>On May 23, 2007, 17a will no longer be in use.</p>
17b.	NPI	<p><b>OPTIONAL</b> through May 22, 2007.</p> <p>Enter the NPI of the referring provider.</p> <p>On May 23, 2007, the use of the NPI will become mandatory under the following conditions:</p> <ul style="list-style-type: none"> <li>◆ If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring provider.</li> <li>◆ If this claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider.</li> <li>◆ If the patient is on lock-in and the lock-in provider authorized service, enter the NPI.</li> </ul>
18.	HOSPITALIZATION DATES RELATED TO...	<p><b>OPTIONAL</b> No entry required.</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
19.	RESERVED FOR LOCAL USE	<b>OPTIONAL</b> 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."
20.	OUTSIDE LAB	<b>OPTIONAL</b> No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	<b>REQUIRED</b> 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). 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 CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	<b>SITUATIONAL</b> If there is a prior authorization, enter the prior authorization number. Obtain the prior authorization number from the prior authorization form.
24. A	DATE(S) OF SERVICE	<b>REQUIRED</b> Enter the 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, enter 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.  <b>SHADED</b> Required for provider administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	<p><b>REQUIRED</b> 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"> <li>11 Office</li> <li>12 Home</li> <li>21 Inpatient hospital</li> <li>22 Outpatient hospital</li> <li>23 Emergency room – hospital</li> <li>24 Ambulatory surgical center</li> <li>25 Birthing center</li> <li>26 Military treatment facility</li> <li>31 Skilled nursing</li> <li>32 Nursing facility</li> <li>33 Custodial care facility</li> <li>34 Hospice</li> <li>41 Ambulance – land</li> <li>42 Ambulance – air or water</li> <li>51 Inpatient psychiatric facility</li> <li>52 Psychiatric facility – partial hospitalization</li> <li>53 Community mental health center</li> <li>54 Intermediate care facility/mentally retarded</li> <li>55 Residential substance abuse treatment facility</li> <li>56 Psychiatric residential treatment center</li> <li>61 Comprehensive inpatient rehabilitation facility</li> <li>62 Comprehensive outpatient rehabilitation facility</li> <li>65 End-stage renal disease treatment</li> <li>71 State or local public health clinic</li> <li>81 Independent laboratory</li> <li>99 Other unlisted facility</li> </ul>
24. C	EMG	<b>OPTIONAL</b> No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. D	PROCEDURES, SERVICES OR SUPPLIES	<b>REQUIRED</b> Enter the codes for each of the dates of service. <b>Do not</b> list services for which no fees were charged. 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.
24. E	DIAGNOSIS POINTER	<b>REQUIRED</b> Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. <b>Do not</b> 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	<b>REQUIRED</b> Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	<b>REQUIRED</b> 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 <b>total minutes</b> of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	<b>SITUATIONAL</b> 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.	<b>SITUATIONAL</b> through May 22, 2007.  In the shaded portion, enter qualifier "1D" if you are entering a legacy number in field 24.J.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. J	RENDERING PROVIDER ID #	<p><b>SITUATIONAL</b></p> <p>The "rendering provider" is the practitioner who provided, supervised, or ordered the service. This entry identifies the rendering provider when the identifier given in field 33a is that of a group or is not that of the treating provider.</p> <p><b>OPTIONAL</b> through May 22, 2007.</p> <p>In the shaded portion, enter the rendering provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33a does not identify the treating provider. <b>Note:</b> Qualifier "1D" must precede any entry into this field.</p> <p><b>MANDATORY</b> as of May 23, 2007.</p> <p>In the lower portion, enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.</p>
25.	FEDERAL TAX ID NUMBER	<b>OPTIONAL</b> No entry required.
26.	PATIENT'S ACCOUNT NUMBER	<b>FOR PROVIDER USE</b> 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	<b>OPTIONAL</b> No entry required.
28.	TOTAL CLAIM CHARGE	<b>REQUIRED</b> Enter the total of the line item charges. If more than one claim form is used to bill services performed, total each claim form separately. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	<b>SITUATIONAL</b> Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. 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.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
30.	BALANCE DUE	<b>REQUIRED</b> Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	<b>REQUIRED</b> 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.  If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	<b>REQUIRED</b> Enter the name and address associated with the rendering provider.  <b>Note:</b> The zip code must match the zip code confirmed during NPI verification or during enrollment. To view the zip code provided, return to imeservices.org.
32a.	NPI	<b>OPTIONAL</b> Enter the NPI of the facility where services were rendered.
32b.		<b>REQUIRED</b> through May 22, 2007.  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 rendering provider's Iowa Medicaid number must be entered in field 24J for each line.
33.	BILLING PROVIDER INFO AND PHONE #	<b>REQUIRED</b> Enter the complete name and address of the billing provider or service provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered.  <b>Note:</b> The zip code must match the zip code confirmed during NPI verification or during enrollment. To view the zip code provided, return to imeservices.org.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
33a.	NPI	<p><b>OPTIONAL</b> through May 22, 2007 <b>MANDATORY</b> as of May 23, 2007</p> <p>Enter the 10-digit NPI of the billing provider. A provider that does not meet the definition of "health care provider" and therefore does not meet the criteria to receive an NPI should enter the ten-digit provider number assigned by IME (begins with "X00"). If this number identifies a group or an individual provider other than the provider of service, the rendering provider's NPI must be entered in field 24J for each line.</p> <p><b>Note:</b> The NPI must match the NPI confirmed during NPI verification or during enrollment. To view the NPI provided, return to imeservices.org.</p>
33b.		<p><b>OPTIONAL</b> through May 22, 2007 <b>MANDATORY</b> as of May 23, 2007</p> <p>Enter the taxonomy code of the billing provider. <b>Note:</b> Qualifier "ZZ" must precede entry of taxonomy in this field. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the taxonomy code provided, return to imeservices.org.</p>

**2. Facsimile of Claim Form, CMS-1500 (front and back)**

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

**F. REMITTANCE ADVICE AND FIELD DESCRIPTIONS**

**1. 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 (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 IME 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 remittance advice
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



	Field Name	Field Description
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
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"> <li>A Anesthesia</li> <li>B Billed charge</li> <li>C Percentage of charges</li> <li>D Inpatient per diem rate</li> <li>E EAC priced plus dispense fee</li> <li>F Fee schedule</li> <li>G FMAC priced plus dispense fee</li> <li>H Encounter rate</li> <li>I Prior authorization rate</li> <li>K Denied</li> <li>L Maximum suspend ceiling</li> <li>M Manually priced</li> <li>N Provider charge rate</li> <li>O Professional component</li> <li>P Group therapy</li> <li>Q EPSDT total over 17</li> <li>R EPSDT total under 18</li> <li>S EPSDT partial over 17</li> <li>SP Not yet priced</li> <li>T EPSDT partial under 18</li> <li>U Gynecology fee</li> <li>V Obstetrics fee</li> <li>W Child fee</li> <li>X Medicare or coinsurance deductibles</li> <li>Y Immunization replacement</li> <li>Z Batch bill APG</li> <li>0 APG</li> <li>1 No payment APG</li> <li>3 HMO/PHP rate</li> <li>4 System parameter rate</li> <li>5 Statewide per diem</li> <li>6 DRG auth or new</li> <li>7 Inlier/outlier adjust</li> <li>8 DRG ADR inlier</li> <li>9 DRG ADR</li> </ul>
19	EOB	Explanation of benefits denial reason code