



Medicaid Enterprise

Iowa Department of Human Services

**Maternal Health Center
Provider Manual**

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Iowa Department of Human Services

III. Provider-Specific Policies



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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. MATERNAL HEALTH CENTERS ELIGIBLE TO PARTICIPATE

A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services. Team members must be employed by or under contract with the center. The team must have at least:

- ◆ A physician.
- ◆ A registered nurse.
- ◆ A licensed dietitian.
- ◆ A person with at least a bachelor's degree social work, counseling, sociology, or psychology.

The prenatal and postpartum care shall be in accordance with the latest edition of the Standards for Obstetric-Gynecologic Services published by the American College of Obstetricians and Gynecologists.

Medical services shall be:

- ◆ Provided under the supervision of a physician.
- ◆ Provided by:
 - A physician,
 - A physician assistant, or
 - A nurse practitioner.

These people may be employed by or under contract to the center. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of their profession, as defined by the Code of Iowa. Provide trimester and postpartum reports to the referring physician.

B. COVERAGE OF SERVICES

Services shall be provided as medically necessary. Payment will be made for:

- ◆ Prenatal risk assessment.
- ◆ Prenatal and postpartum medical care.
- ◆ Health education services for patients who are not determined high-risk.
- ◆ Oral health services.
- ◆ "Enhanced" (more intense) prenatal services for patients determined high-risk.



Enhanced services may include:

- ◆ Additional health education,
- ◆ Nutrition counseling,
- ◆ Social services,
- ◆ Additional care coordination, and
- ◆ A Postpartum home visit.

1. Prenatal Risk Assessment

Determine risk for pregnant Medicaid members upon entry into care using form 470-2942, *Medicaid Prenatal Risk Assessment*. To view a sample of this form on line, click [here](#).

When a low-risk pregnancy is reflected, complete a second determination at approximately 28 weeks of care or when an increase in the pregnant woman's risk status is indicated.

The Iowa Departments of Human Services and Public Health have jointly developed the *Medicaid Prenatal Risk Assessment* to help the clinician determine which pregnant clients are in need of supplementary services to complement and support routine medical prenatal care.

The form categorizes the risk factors and assigns a score value related to the seriousness of the risk. In individual cases, the clinician may determine that the value the form assigns is not appropriate and may choose a lesser value.

To determine a woman's risk status during the current pregnancy, add the total score value on the left side and either the B₁ column (initial visit score value) or the B₂ column (re-screen visit between 24-28 weeks gestation score value) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.

When a high-risk pregnancy is reflected, inform the woman and provide enhanced services. (See [Enhanced Services to High-Risk Women](#).) Give a copy of the *Medicaid Prenatal Risk Assessment* to the agency providing enhanced services and keep a copy in the patient's medical records.



a. Risk Factors Related to History

The left side of the *Medicaid Prenatal Risk Assessment* includes medical, dental, historical, environmental, or situational risk factors. A description of many of the risk factors is located on the back of the form. Included are AB first trimester, AB second trimester, uterine anomaly, HX pyelonephritis, illicit drug use, and poor social situation.

Give cigarette smoking a point value if the person smokes one cigarette or more per day. If secondary smoke is a risk factor, indicate it under "Other."

Indicate the risk factor "Last birth within 1 year," when the patient has been pregnant within 12 months of the beginning of the present pregnancy.

b. Risk Factors Related to Current Pregnancy

The right side of the form includes risk factors related to the current pregnancy. These factors are more likely to change during the pregnancy. They may be present during the initial visit or may not appear until the mid to last trimester. For this reason these risk factors are assessed twice during the pregnancy on the form.

A description of the following risk factors is located on the back of the form: bacteriuria, pyelonephritis, bleeding after twelfth week, dilation, and uterine irritability.

Depression has an impact on the development and management of pregnancy related complications. Untreated depression has been associated with unfavorable health behaviors in pregnancy and subsequent fetal growth restrictions, preterm delivery, placental abruption, or newborn irritability.

Using the following two questions to screen for depression may be as effective as more lengthy tools.

- ◆ Over the past two weeks, have you ever felt down, depressed, or hopeless?
- ◆ Over the past two weeks, have you felt little interest or pleasure in doing things?



A positive response to both questions suggests the need for further evaluation. A positive response to one of these questions is sufficient to provide services for a high-risk pregnancy.

(Source: *Psychosocial Risk Factors: Prenatal Screening and Interventions*, ACOG Committee Opinion No 343, American College of Obstetricians and Gynecologists, *Obstet Gynecol* 2006, 108:469-77.)

Use the "Other" box to indicate other risk factors present in the pregnancy, but not reflected in the earlier sections. Examples of other risk factors are listed on the back of the form. These are common examples only and are not meant to be a comprehensive list.

2. Services to Low-Risk Women

The services provided to low-risk woman include:

- ◆ Prenatal and postpartum medical care.
- ◆ Health education services provided by a registered nurse, which includes:
 - Importance of continued prenatal care.
 - Normal changes of pregnancy:
 - Maternal changes
 - Fetal changes
 - Self-care during pregnancy.
 - Comfort measures during pregnancy.
 - Danger signs of pregnancy.
 - Labor and delivery:
 - Normal process of labor
 - Signs of labor
 - Coping skills
 - Danger signs
 - Management of normal labor
 - Preparation for baby:
 - Feeding
 - Equipment
 - Clothing
 - Education on the use of over-the-counter drugs.
 - Education about HIV prevention.



- ◆ Interpretation services.
 - Coverage of services provided either oral or sign.
 - The interpreters must provide only interpretation services for your agency.
 - The services must facilitate access to Medicaid covered services.
- ◆ Postpartum home visits:

A registered nurse shall provide a postpartum home visit within two weeks of the child's discharge from the hospital (ideally in the first week). This visit shall include:

 - An assessment of the mother's health status.
 - Discussion of physical and emotional changes postpartum, including relationships, sexual changes, additional stress, nutritional needs, physical activity, and grief support for unhealthy outcome.
 - Family planning.
 - A review of parenting skills, including nurturing, meeting infant needs, bonding, and parenting of a sick or preterm infant.
 - An assessment of the infant's health.
 - A review of infant care, including feeding and nutritional needs, breast-feeding support, recognition of illness, accident prevention, immunizations, oral health, and well-child care.
 - Identification and referral to community resources as needed.
- ◆ Transportation to receive prenatal and postpartum services that is not otherwise payable under the Medicaid program.
- ◆ Oral health services. Oral health services shall be provided within the scope of practice defined by Iowa Code for dental hygienists, registered nurses, advanced registered nurse practitioners, and physician assistants. Services include:
 - Oral screening: Screenings should be considered for all women, especially those who have indicated they have problems with their teeth or gums, or if a health history indicate that the woman is at risk for tooth decay or gum disease. An oral screening includes:
 - Medical and dental history.
 - Soft and hard tissue evaluation.



- Oral health education (which may include oral hygiene instruction, nutritional counseling, and tobacco counseling) based on the finding of the oral screening and each client's needs.
- Dental referral: Based on findings from the oral screening, determine an appropriate care plan for preventive services and referrals to a dentist. At a minimum, a client should visit the dentist at least once during pregnancy.
- Preventive services: The following services may be provided to prenatal and postpartum clients:
 - Fluoride varnish,
 - Prophylaxis,
 - Radiographs, and
 - Dental sealants.

Encourage clients to enroll in community prenatal classes.

Care coordination related to a direct service is considered part of the direct service. Activities must be considered a part of the direct service if they are included in the pre and post visit services. This direct care related activity should not be considered a care coordination service.

NOTE: Activities that are considered integral to, or an extension of, the specific covered service are included in the rate set for the **direct service**. Therefore they should not be claimed as another service. For example, when an agency provides a medical service, the practitioner should not bill separately for the cost of a referral. These activities are properly paid for as part of the medical service.

3. Enhanced Services to High-Risk Women

Additional services are available to women determined to have high-risk pregnancies. The services included in the Medicaid enhanced services for pregnant women are recommended in a 1989 report of the United States Public Health Services Expert Panel on the Content of Prenatal Care, *Caring for the Future: The Content of Prenatal Care*.

National studies have shown that low-income women who receive these services along with medical prenatal care have better birth outcomes. This package of services is aimed at promoting improved birth outcomes for Medicaid-eligible pregnant women in Iowa.



Maternal health centers that provide enhanced services work with physicians to provide services to higher risk pregnant women. This process allows patients determined to be at high risk to access additional services that Medicaid does not provide under other circumstances. It is expected that the primary medical care provider will continue to provide the medical care.

The enhanced services include:

- ◆ [Health education services](#)
- ◆ [Nutrition services](#)
- ◆ [Psychosocial services](#)

a. Health Education

A registered nurse shall provide health education services. In addition to the education services listed earlier, education on the following topics should be provided as appropriate:

- ◆ High-risk medical conditions related to pregnancy, such as PIH, preterm labor, vaginal bleeding, gestational diabetes, chronic urinary conditions, genetic disorders, and anemia.
- ◆ Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle cell disease, and hypertension.
- ◆ Other medical conditions, such as HIV, hepatitis, and sexually transmitted diseases.
- ◆ Smoking cessation. Refer to Quitline Iowa at 800-784-8669 or on the web at <http://www.quitlineiowa.org/>.
- ◆ Alcohol use.
- ◆ Drug use.
- ◆ Education on environmental and occupational hazards.
- ◆ High-risk sexual behavior.

You may make referrals to:

- ◆ Programs for stopping smoking or the use of alcohol or drugs.
- ◆ Psychosocial services for high-risk parenting issues or home situations, stress management, communication skills and resources, or self esteem.



b. Nutrition Services

A licensed dietitian shall provide nutrition services. Nutrition assessment and counseling shall include:

- ◆ Initial assessment of nutritional risk based on height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information. Discuss the client's attitude about breastfeeding.
- ◆ At least one follow-up nutritional assessment, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.
- ◆ Development of an individualized nutritional care plan.
- ◆ Referral to food assistance programs, if indicated.
- ◆ Nutritional interventions:
 - Nutritional requirements of pregnancy as linked to fetal growth and development.
 - Recommended dietary allowances for pregnancy.
 - Appropriate weight gain.
 - Vitamin and iron supplements.
 - Information to make an informed infant feeding decision.
 - Education to prepare for the proposed feeding method and the support services available for the mother.
 - Infant nutritional needs and feeding practices.

c. Psychosocial Services

Psychosocial assessment and counseling shall include:

- ◆ A psychosocial needs assessment including a profile of the mother's:
 - Demographic factors,
 - Mental and physical health history and concerns,
 - Adjustment to pregnancy and future parenting, and
 - Environmental needs.
- ◆ A profile of the mother's family composition, patterns of functioning, and support systems.
- ◆ An assessment-based plan of care.
- ◆ Risk tracking.



- ◆ Counseling and anticipatory guidance as appropriate.
- ◆ Referral and follow-up services.

Psychosocial services shall be provided by a registered nurse or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.

D. BASIS OF PAYMENT FOR MATERNAL HEALTH CENTERS

Maternal health centers are reimbursed on a fee-for-service basis. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Bill all procedures in whole units of service. For some codes, 15 minutes equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

E. RECORDS

The documentation for each "patient encounter" shall include the following (when appropriate):

- ◆ Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer.
- ◆ Specific procedures or treatments performed.
- ◆ Medications or other supplies.
- ◆ Member's progress, response to and changes in treatment, and revision of diagnosis.
- ◆ Information necessary to support each item of service reported on the Medicaid claim form:
 - Date of service.
 - Place of service.
 - Name of member.
 - Name of provider agency and person providing the service.
 - Nature, content, or units of service.
 - A record of the time to support the units billed. (Time include AM/PM)



The requirements for documenting medical transportation services include the following:

- ◆ Date of service
- ◆ Member's name
- ◆ Address of where member was picked up
- ◆ Destination (medical provider's name and address)
- ◆ Invoice of cost
- ◆ Mileage if the transportation is paid per mile

The requirements for documenting interpretation services include the following:

- ◆ Date and time of the service
- ◆ Member's name
- ◆ Interpreter's name and company
- ◆ Service duration
- ◆ Cost of providing the service

Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.

As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to members' medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.

F. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Services or charges cannot be fragmented for each procedure code billed. Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied.

1. Maternity Care

<u>Code</u>	<u>Description</u>
59425	Antepartum care only; 4 to 6 visits
59426	Antepartum care only; 7 or more visits
99420	Completion of <i>Medicaid Prenatal Risk Assessment</i> , form 470-2942
S9465	Diabetic management program, dietitian visit



<u>Code</u>	<u>Description</u>
90471	Immunization administration
90472	Immunization administration, each additional vaccine
H0046	Mental health services, not otherwise specified, per encounter
S9123	Nursing visit in the home, per hour
S9470	Nutrition counseling dietitian visit
59025	Fetal non-stress test
59430	Postpartum care only (separate procedure)
H1003	Prenatal care, at risk enhanced service education, 15-minute unit
S9127	Social work visit in the home (encounter code)
81025	Urine pregnancy test, by visual color comparison
T1001	Nursing assessment or evaluation, per 15 minutes

New Patient

<u>Code</u>	<u>Description</u>
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> ◆ A problem-focused history; ◆ A problem focused examination; and ◆ Straightforward medical decision-making. <p>Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family.</p>
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> ◆ An expanded problem-focused history; ◆ An expanded problem-focused examination; and ◆ Straightforward medical decision-making. <p>Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient or family.</p>
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:



Code

Description

- ◆ A detailed history;
- ◆ A detailed examination; and
- ◆ Medical decision making of low complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems) and the patient's and family's needs. Usually, the presenting problems are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient or family.

99204

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- ◆ A comprehensive history;
- ◆ A comprehensive examination; and
- ◆ Medical decision making of moderate complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient or family.

99205

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- ◆ A comprehensive history;
- ◆ A comprehensive examination; and
- ◆ Medical decision making of high complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient or family.



Established Patient

<u>Code</u>	<u>Description</u>
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99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
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99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
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- ◆ a problem-focused history;
- ◆ a problem-focused examination;
- ◆ straightforward medical decision-making.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family.

99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
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- ◆ an expanded problem-focused history;
- ◆ an expanded problem-focused examination;
- ◆ medical decision making of low complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and family's needs. Usually, the presenting problems are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient or family.



<u>Code</u>	<u>Description</u>
99214	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> ◆ a detailed history; ◆ a detailed examination; ◆ medical decision making of moderate complexity. <p>Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient or family.</p>
99215	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> ◆ a comprehensive history; ◆ a comprehensive examination; ◆ medical decision making of high complexity. <p>Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problems and the patient's and family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient or family.</p>

Do not submit a copy of the *Medicaid Prenatal Risk Assessment*, 470-2942. Maintain the form in the medical file.

2. Injections

Immunizations are usually given in conjunction with a medical service. Bill the vaccine administration codes in addition to the CPT code.

You **must** provide Medicaid immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are found at http://www.idph.state.ia.us/adper/vaccines_for_children.asp or at 1-800-831-6293.



For VFC vaccine, bill code 90471, 90472, or 90473 for vaccine administration in addition to the CPT code. Charge your usual and customary charge for the administration 90471 and 90472. The charges in box 24F should be "0" for the vaccine.

NOTE: 90473 (immunization administration by oral or nasal route) cannot be used with 90471.

When a member receives a vaccine outside of VFC coverage, Medicaid will provide reimbursement for the vaccine. Codes for other injections:

<u>Code</u>	<u>Description</u>
90782	Injection of medication
J2788	RHO D immune globulin 50 mcg
J2790	Rhogam, RHO D immune globulin 300 mcg
J1055	Injection, Medroxyprogesterone acetate for contraceptive use

3. Interpretation Services

<u>Code</u>	<u>Description</u>	<u>Unit</u>
T1013	Sign language or oral interpretive services	15 minute unit
W5023	Telephonic oral interpretive services	1 minute unit

4. Local Transportation

In the diagnosis code area of the claim form, use diagnosis code V68.9.

<u>Code</u>	<u>Description</u>	<u>Unit</u>
A0080	Non-emergency transportation; vehicle provided by volunteer (individual or organization), with no vested interest	Per round trip
A0100	Non-emergency transportation; taxi	Per round trip
A0110	Non-emergency transportation; bus, intra or interstate carrier	Per round trip
A0130	Non-emergency transportation; wheelchair van	Per round trip
A0160	Non-emergency transportation, by caseworker or social worker	Per round trip
A0170	Transportation; parking fees, tolls, other	



5. Oral Health Services

In the diagnosis area of the claim form, use diagnosis code 528.9.

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D0150	Initial screening evaluation	One time per patient (Also allowed when provider has not seen patient within three-year period)
D0120	Screening evaluation (periodic)	Once every six months
D1110	Adult prophylaxis (Age 13 and older)	Once every six months
D1120	Child prophylaxis (Age 12 and younger)	Once every six months
D1206	Topical fluoride varnish	Three times a year, at least 90 days apart
D1310	Nutritional counseling for the control and prevention of oral disease	15-minute unit
D1320	Tobacco counseling for the control and prevention of oral disease	15-minute unit
D1330	Oral hygiene instructions (home care, tooth brushing, flossing and special hygiene aids)	15-minute unit
D1351	Sealant, per tooth	One time per tooth (Replacement sealants may be covered when patient record documents medical necessity.)
D0270	Bitewing radiograph, single film*	
D0272f	Bitewing radiograph, two films*	
D0274	Bitewing radiograph, four films*	

* Before radiographs are taken, standing orders must be in place with a specific dentist who will read the radiographs, provide an examination, and establish a treatment plan.



G. CLAIM FORMS

Bill for maternal health center services on the *Health Insurance Claim Form*, CMS-1500. To view a sample of this form on line, click [here](#).

Providers interested in billing electronically can contact EDISS (Electronic Data Interchange Support Services) at 800-967-7902 or by e-mail at edi@noridian.com.

Electronic media claim (EMC) submitters should also refer to your EMC specifications for claim completion instructions.

1. Instructions for Completing the CMS-1500 Claim Form

The table below follows the CMS-1500 claim form by field number and name, and gives 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.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	REQUIRED. Check the applicable program block.
1a.	INSURED'S ID NUMBER	REQUIRED. Enter the Medicaid member's Medicaid number, found on the <i>Medical Assistance Eligibility Card</i> . The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	REQUIRED. Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	OPTIONAL. Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
4.	INSURED'S NAME	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	OPTIONAL. Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	REQUIRED, IF KNOWN. Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	SITUATIONAL. Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	REQUIRED, IF KNOWN. Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER	OPTIONAL. 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>REQUIRED. If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed.</p> <p>If there is no other insurance, check "no."</p> <p>If you have received a denial of payment from another insurance, check both "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record.</p> <p>Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.</p> <p>NOTE: Auditing will be performed on a random basis to ensure correct billing.</p>
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	SITUATIONAL. 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...	SITUATIONAL. Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	CONDITIONAL. Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		LEAVE BLANK. The claim will be returned if any information is entered in this field.
17b.	NPI	SITUATIONAL. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.
18.	HOSPITALIZATION DATES RELATED TO...	OPTIONAL. No entry required.
19.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
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. Do not enter descriptions If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
23.	PRIOR AUTHORIZATION NUMBER	SITUATIONAL. If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC TOP SHADED PORTION LOWER PORTION	<p>SITUATIONAL. 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.</p> <p>REQUIRED. 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.</p> <p>Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.</p>
24. B	PLACE OF SERVICE	<p>REQUIRED. Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		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	EMG	OPTIONAL. No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	<p>REQUIRED. Enter the codes for each of the dates of service. Do not list services for which no fees were charged. Do not enter the description.</p> <p>Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.</p>
24. E	DIAGNOSIS POINTER	<p>REQUIRED. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. Do not write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.</p>
24. F	\$ CHARGES	<p>REQUIRED. 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.</p>
24. G	DAYS OR UNITS	<p>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.</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. H	EPSDT/FAMILY PLANNING	SITUATIONAL. Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	LEAVE BLANK. The claim will be returned if any information is entered in this field.
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	LEAVE BLANK REQUIRED. Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	OPTIONAL. No entry required.
26.	PATIENT'S ACCOUNT NUMBER	FOR PROVIDER USE. Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or 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	SITUATIONAL. 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.
30.	BALANCE DUE	REQUIRED. Enter the amount of total charges less the amount entered in field 29.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	REQUIRED. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of the claim 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	OPTIONAL. Enter the name and address associated with the rendering provider.
32a.	NPI	OPTIONAL. Enter the NPI of the facility where services were rendered.
32b.		LEAVE BLANK. The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	REQUIRED. Enter the complete name and address of the billing provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. The address must contain the ZIP code associated with the billing provider's NPI. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org .
33a.	NPI	REQUIRED. Enter the ten-digit NPI of the billing provider.
33b.		REQUIRED. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, access imeservices.org .



2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ **Staple** the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click [here](#).)
- ◆ Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- ◆ **Do not** attach a paper claim.
- ◆ Mail the *Claim Attachment Control* with attachments to:

Iowa Medicaid Enterprise
PO Box 150001
Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

H. REMITTANCE ADVICE

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 follow. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

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



2. Remittance Advice Samples and Field Descriptions

Two different remittance advice formats may be issued, depending on whether the claims are for members and items that are also covered by Medicare Part B.

To view a sample of the standard RA-1500 remittance advice on line, click [here](#). The fields are described as follows:

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



	Field Name	Field Description
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status

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



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



To view a sample of the Medicare Part B crossover remittance advice format on line, click [here](#). The fields are described as follows:

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



Field Name		Field Description
T	Deductible	Total deductible amount within same claim type or status
U	Coins. Amt.	Total coinsurance amount within same claim type or status
V	Copay	Total copayment amount within same claim type or status
X	Mcaid Paid Amt	Total Medicaid payment within same claim type or status

1	Patient	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Mcare Paid Amt	Total paid by Medicare on claim
5	Mcare Apprd	Total amount Medicare approved
6	Deductible	Total Medicare deductible on claim
7	Coins Amt.	Total Medicare coinsurance on claim
8	Copay	Total Iowa Medicaid copayment on claim
9	Mcaid Paid Amt	Total amount paid by Medicaid on claim
10	Med Rcd Num	Medical record number OR patient account number
11	Line	Line number
12	Svc-Date	Date of service on line
13	Proc Mods	CPT or HCPCS code and modifier billed
14	Units	Number of units billed
15	Mcare Paid Amt	Medicare paid amount on line item
16	Mcare Apprd	Medicare approved amount on line item
17	Deductible	Medicare deductible amount on line item
18	Coins. Amt.	Medicare coinsurance amount on line item
19	Copay	Iowa Medicaid copayment on line item
20	Mcaid Paid Amt	Total amount paid by Medicaid on line



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