

**ALL PROVIDERS**

**IV. BILLING IOWA MEDICAID**





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## Preamble

This provider manual is intended to provide general coverage guidelines for members that are currently Medicaid Fee-for-Service (FFS) eligible. Verifying a member's eligibility is crucial to ensure correct coverage of services and limitations. Once an assignment to the IA Health Link Managed Care Organization (MCO) has been completed, please refer to the provider manual for the IA Health Link MCO assigned.

## CHAPTER IV. BILLING IOWA MEDICAID

### A. INTRODUCTION

The Iowa Medicaid Billing Manual is a comprehensive explanation of billing instructions for each type of claim form used by the Iowa Medicaid Enterprise (IME). This chapter offers step-by-step instructions on claim form completion, remittance advice guides, and other supplemental information to allow for faster and more accurate claims adjudication.

The IME used the following claim forms:

- ◆ [UB-04 Claim Form](#)
- ◆ [CMS-1500 Claim Form](#)
- ◆ [American Dental Association \(ADA\) 2012 Claim](#)
- ◆ [Medicare Crossover Invoice](#)
- ◆ [Claim for Targeted Medical Care Claim Form](#)

### B. TIMELY FILING REQUIREMENTS

The Iowa Medicaid Enterprise (IME) policy on timely filing requirements for resubmitting a claim for payment is as follows:

- ◆ Providers have 365 days from the date of service to submit a claim.
- ◆ A claim may be resubmitted or adjusted if it is submitted within 365 days from the last date of adjudication.
- ◆ No claim will be paid past two years from the date of service.



A copy of the Medicaid remittance advice is not required to show an original claim submission. The IME will research to verify that the original claim was received within the original submission guidelines. The resubmitted claim must be received at the IME within 365 days of the Medicaid remittance advice date of denial. If the claim is submitted within that year and denies for a second time, providers have up to one year from the date of the last adjudication to make corrections, not exceeding the two years from the date of service. As of January 1, 2009, Iowa Medicaid providers may resubmit claims electronically since remittance advices to prove the original filing dates are no longer required.

Claims should not be sent to the Department of Human Services. This will delay the processing of these claims. Resubmitted claims for services past 365 days from the last date of service should be sent to the regular IME claims address (listed below) and will be processed according to the timeline described above.

Two exceptions exist to the 365-day timely filing guideline: retroactive eligibility and third-party related delays. Each of these must be billed on paper with the proper attachment.

## **1. Paper Claims Addresses**

### **a. Regular Claims, Resubmissions, and Third-Party Related Delays**

Third-party related delays must be accompanied by a copy of the TPL explanation of benefits and must be received at the IME within 365 days of the TPL process date.

Medicaid Claims  
PO Box 150001  
Des Moines, IA 50315

### **b. Exception to Policy Claims (PAPER CLAIMS) and Retroactive Eligibility Claims**

Retroactive eligibility claims must be accompanied by the DHS *Notice of Decision* and must be received at the IME within 365 days of the notice date.

Iowa Medicaid  
Attn: Exception Processing  
1305 East Walnut Street, Room 112  
Des Moines, IA 50319-0112

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**c. Exception to Policy Claims (ELECTRONIC CLAIMS)**

Providers can now submit claims electronically for services approved under an Exception to Policy. To do so, these directions must be followed:

- ◆ When completing the claim form, enter the Exception to Policy number in the Attachment Control Number (ACN) field. The ETP number is located near the top of the ETP letter from DHS. When completing the ACN field the ETP number must be preceded with the letters "ETP." Example: 08-E1234 would be entered as ETP08-E1234. Failure to enter this number exactly may result in the claim denial. The ACN field is loop 2300 segment PWK05-06.
  - If using software other than PC-ACE Pro32, please contact your software vendor to determine where to complete the ACN field.
  - If using PC-ACE Pro 32, the ACN box is located on the Institutional claim on the Extended General tab and for the Professional claim use the EXT Pat/Gen (2) tab. For both claim form types put the ETP number in the box marked 'Attachment Control Number'. Use the drop down boxes to complete both the Type and Trans boxes.
- ◆ If the approved Exception to Policy letter states that additional attachments are required with the claim, these attachments must be faxed to (515) 725-1318. Additional attachments will be itemized in the ETP letter. The ETP letter is not considered an additional attachment and does not need to be faxed to the IME. Attachments that cannot be faxed will require that the claim be submitted on paper according to [Informational Letter 637](#).

The faxed documentation must include the *Claim Attachment Control*, form 470-3969, as the first page of documentation after the fax cover sheet. The Attachment Control Number must be the letters "ETP" plus the Exception to Policy number and must match the ACN that was entered on the claim. Failure to do so will result in the claim denying for lack of required documentation. To view a sample of the *Claim Attachment Control*, form 470-3969, click [here](#).

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## 2. Electronic Billing

Providers that wish to begin electronic filing can contact EDISS at <http://www.edissweb.com/med/index.html> or email [support@edissweb.com](mailto:support@edissweb.com). Electronic claims submission is a much cleaner and faster method to bill claims.

### C. INSTRUCTIONS FOR COMPLETING THE UB-04 CLAIM FORM

The following Iowa Medicaid provider types bill for services on the UB-04 claim form:

- ◆ Hospitals
- ◆ Rehabilitation agencies
- ◆ Home health
- ◆ Skilled nursing facilities
- ◆ Hospice
- ◆ Psychiatric medical institution for children
- ◆ Nursing facilities for the mentally ill
- ◆ Mental health institutes
- ◆ Nursing facilities
- ◆ Residential facilities

To view a sample of the UB-04 claim form on line, click [here](#).

The table below contains information that will aid in the completion of the UB-04 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.

The IME provides software for electronic claims submission at no charge. For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions. For assistance with setting up or questions related to electronic billing, contact EDI Support Services at (800) 967-7902, email [support@edissweb.com](mailto:support@edissweb.com), or visit <http://www.edissweb.com/med/>.



When submitting a paper claim to Iowa Medicaid, the claim form must be typed or handwritten legibly in dark blue or black ink. Mail to:

Medicaid Claims  
PO Box 150001  
Des Moines, IA 50315

Field No.	Field Name/Description	Requirements	Instructions
1	(Untitled) Provider Name, Address, and Telephone Number	<b>REQUIRED</b>	Enter the name, address, and phone number of the billing facility or service supplier.  <b>NOTE:</b> The zip code must match the zip code confirmed during NPI verification or during enrollment.
2	(Untitled) Pay-to Name, Address, and Secondary Identification Fields	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the pay-to name and address information is different than billing provider information in field 1.
3a	Member Control Number	OPTIONAL	Enter the account number assigned to the member by the provider of service. This field is limited to 20 alpha/numeric characters and will be reflected on the remittance advice statement as "Medical Record Number."
3b	Member Record Number	OPTIONAL	Enter the number assigned to the member's medical or health record by the provider. This field is limited to 20 alpha/numeric characters and will be reflected on the remittance advice statement as "Medical Record Number" only if the field 3a is blank.



Field No.	Field Name/Description	Requirements	Instructions
4	Type of Bill	<b>REQUIRED</b>	<p>Enter a three-digit number consisting of one digit from each of the following categories in this sequence:</p> <p>First digit    Type of facility            Second digit    Bill classification            Third digit    Frequency</p> <p>Type of Facility</p> <p>1    Hospital or psychiatric medical institution for children (PMIC)            2    Skilled nursing facility            3    Home health agency            7    Rehabilitation agency            8    Hospice</p> <p>Bill Classification</p> <p>1    Inpatient hospital, inpatient SNF or hospice (nonhospital-based)            2    Hospice (hospital-based)            3    Outpatient hospital, outpatient SNF or hospice (hospital-based)            4    Hospital-referenced laboratory services, home health agency, rehabilitation agency</p> <p>Frequency</p> <p>1    Admit through discharge claim            2    Interim – first claim            3    Interim – continuing claim            4    Interim – last claim</p>
5	Federal Tax Number	OPTIONAL	<p>No entry required.</p> <p><b>NOTE:</b> Changes to the tax ID must be reported through IME Provider Services Unit at (800) 338-7909 or (515) 256-4609 (in Des Moines).</p>
6	Statement Covers Period (From-Through)	<b>REQUIRED</b>	<p>Enter the month, day, and year (MMDDYY format) under both the From and Through categories for the period.</p>



Field No.	Field Name/Description	Requirements	Instructions
7	(Untitled) Not Used	OPTIONAL	No entry required. <b>NOTE:</b> Covered and non-covered days are reported using value codes in fields 39a-41d.
<b>Patient Name</b>			
8a	Last Name	<b>REQUIRED</b>	Enter the last name of the member.
8a	First Name	<b>REQUIRED</b>	Enter the first name and middle initial of the member.
<b>Patient Address</b>			
9a	Street Address	OPTIONAL	Enter the street address of the member.
9b	City	OPTIONAL	Enter the city for the member's address.
9c	State	OPTIONAL	Enter the state for the member's address.
9d	Zip Code	OPTIONAL	Enter the zip code for the member's address.
9e		OPTIONAL	No entry required.
10	Member's Birth Date	OPTIONAL	Enter the member's birth date as month, day, and year.
11	Sex	<b>REQUIRED</b>	Enter the member's sex: "M" for male or "F" for female.
12	Admission Date	<b>REQUIRED</b>	Enter in MMDDYY format. Inpatient, PMIC, and SNF: Enter the date of admission for inpatient services. Outpatient: Enter the dates of service. Home health agency and hospice: Enter the date of admission for care. Rehabilitation agency: No entry required.



Field No.	Field Name/Description	Requirements	Instructions																																																												
13	Admission Hour	<i>SITUATIONAL</i>	<p><b>REQUIRED FOR INPATIENT/PMIC/SNF</b></p> <p>The following chart consists of possible admission times and a corresponding code.</p> <p>Enter the code times and a corresponding code.</p> <p>Enter the code that corresponds to the hour the member was admitted for inpatient care.</p> <table border="1"> <thead> <tr> <th colspan="2">Code Time: AM</th> <th colspan="2">Code Time: PM</th> </tr> <tr> <th colspan="2">Midnight</th> <th colspan="2">Noon</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00 - 12:59</td> <td>12</td> <td>12:00 - 12:59</td> </tr> <tr> <td>01</td> <td>1:00 - 1:59</td> <td>13</td> <td>1:00 - 1:59</td> </tr> <tr> <td>02</td> <td>2:00 - 2:59</td> <td>14</td> <td>2:00 - 2:59</td> </tr> <tr> <td>03</td> <td>3:00 - 3:59</td> <td>15</td> <td>3:00 - 3:59</td> </tr> <tr> <td>04</td> <td>4:00 - 4:59</td> <td>16</td> <td>4:00 - 4:59</td> </tr> <tr> <td>05</td> <td>5:00 - 5:59</td> <td>17</td> <td>5:00 - 5:59</td> </tr> <tr> <td>06</td> <td>6:00 - 6:59</td> <td>18</td> <td>6:00 - 6:59</td> </tr> <tr> <td>07</td> <td>7:00 - 7:59</td> <td>19</td> <td>7:00 - 7:59</td> </tr> <tr> <td>08</td> <td>8:00 - 8:59</td> <td>20</td> <td>8:00 - 8:59</td> </tr> <tr> <td>09</td> <td>9:00 - 9:59</td> <td>21</td> <td>9:00 - 9:59</td> </tr> <tr> <td>10</td> <td>10:00 - 10:59</td> <td>22</td> <td>10:00 - 10:59</td> </tr> <tr> <td>11</td> <td>11:00 - 11:59</td> <td>23</td> <td>11:00 - 11:59</td> </tr> <tr> <td>99</td> <td>Hour unknown</td> <td></td> <td></td> </tr> </tbody> </table>	Code Time: AM		Code Time: PM		Midnight		Noon		00	12:00 - 12:59	12	12:00 - 12:59	01	1:00 - 1:59	13	1:00 - 1:59	02	2:00 - 2:59	14	2:00 - 2:59	03	3:00 - 3:59	15	3:00 - 3:59	04	4:00 - 4:59	16	4:00 - 4:59	05	5:00 - 5:59	17	5:00 - 5:59	06	6:00 - 6:59	18	6:00 - 6:59	07	7:00 - 7:59	19	7:00 - 7:59	08	8:00 - 8:59	20	8:00 - 8:59	09	9:00 - 9:59	21	9:00 - 9:59	10	10:00 - 10:59	22	10:00 - 10:59	11	11:00 - 11:59	23	11:00 - 11:59	99	Hour unknown		
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14	Admission Type/Visit	<i>SITUATIONAL</i>	<p><b>REQUIRED FOR INPATIENT/PMIC/SNF</b></p> <p>Enter the code corresponding to the priority level of this inpatient admission:</p> <ul style="list-style-type: none"> <li>1 Emergency</li> <li>2 Urgent</li> <li>3 Elective</li> <li>4 Newborn</li> <li>9 Information unavailable</li> </ul>																																																												



Field No.	Field Name/Description	Requirements	Instructions
15	SRC (Source of Admission)	<i>SITUATIONAL</i>	<p><b>REQUIRED FOR INPATIENT/PMIC/SNF</b></p> <p>Enter the code that corresponds to the source of this admission.</p> <ul style="list-style-type: none"> <li>1 Non-health care facility point of origin</li> <li>2 Clinic or physician's office</li> <li>4 Transfer from a hospital</li> <li>5 Born inside the hospital</li> <li>6 Born outside of this hospital facility</li> <li>8 Court/law enforcement</li> <li>9 Information unavailable</li> </ul>
16	DHR (Discharge Hour)	<i>SITUATIONAL</i>	<p>Enter the code that corresponds to the hour member was discharged from inpatient care.</p> <p>See <a href="#">Field 13, Admission Hour</a>, for instructions for accepted discharge hour codes.</p>
17	STAT (Member Status)	<i>SITUATIONAL</i>	<p><b>REQUIRED FOR INPATIENT/PMIC/SNF</b></p> <p>Enter the code that corresponds to the status of the member at the end of service.</p> <ul style="list-style-type: none"> <li>01 Discharged to home or self-care (routine discharge)</li> <li>02 Discharged or transferred to other short-term general hospital for inpatient care</li> <li>03 Discharged or transferred to a skilled nursing facility (SNF)</li> <li>04 Discharged or transferred to an intermediate care facility (ICF)</li> <li>05 Discharged or transferred to another type of institution for inpatient care or outpatient services</li> <li>06 Discharged or transferred to home with care of organized home health services</li> <li>07 Left care against medical advice or otherwise discontinued own care</li> </ul>



Field No.	Field Name/Description	Requirements	Instructions
			08 Discharged or transferred to home with care of home IV provider 10 Discharged or transferred to mental health care 11 Discharged or transferred to Medicaid-certified rehabilitation unit 12 Discharged or transferred to Medicaid-certified substance abuse unit 13 Discharged or transferred to Medicaid-certified psychiatric unit 20 Expired 30 Remains a member or is expected to return for outpatient services (valid only for non-DRG claims) 40 Hospice patient died at home 41 Hospice patient died at hospital 42 Hospice patient died unknown 43 Discharged or transferred to federally qualified health center 50 Hospice home 51 Hospice medical facility 61 Transferred to swing-bed 62 Transferred to rehabilitation facility 64 Transferred to nursing facility 65 Discharged or transferred to psychiatric hospital 71 Transferred for another outpatient facility 72 Transferred for outpatient service
18-28	Condition Codes	<i>SITUATIONAL</i>	Enter corresponding codes to indicate whether or not treatment billed on this claim is related to any condition listed below.  Up to seven codes may be used to describe the conditions surrounding a member's treatment.  <i>General</i> 01 Military service related 02 Condition is employment related 04 HMO enrollee 05 Lien has been filed



Field No.	Field Name/Description	Requirements	Instructions
			<p><i>Inpatient Only</i></p> <p>4V Neonatal level II or III unit            4W Physical rehabilitation unit            4X Substance abuse unit            4Y Psychiatric unit            X3 IFMC approved lower level of care, ICF            X4 IFMC approved lower level of care, SNF            91 Respite care</p> <p><i>Outpatient Only</i></p> <p>84 Cardiac rehabilitation program            85 Eating disorder program            86 Mental health program            87 Substance abuse program            88 Pain management program            89 Diabetic education program            90 Pulmonary rehabilitation program            98 Pregnancy indicator – outpatient or rehabilitation agency</p> <p><i>Special Program Indicator</i></p> <p>A1 EPSDT            A2 Physically handicapped children’s program            A3 Special federal funding            A4 Family planning            A5 Disability            A6 Vaccine/Medicare 100% payment            A7 Induced abortion – danger to life            A8 Induced abortion – victim rape/incest            A9 Second opinion surgery</p> <p><i>Home Health Agency</i>            (Medicare not applicable)</p> <p>XA Condition stable            XB Not homebound            XC Maintenance care            XD No skilled service</p>



Field No.	Field Name/Description	Requirements	Instructions
29	Accident State	OPTIONAL	No entry required.
30	Untitled	OPTIONAL	No entry required.
31-34	Occurrence Codes and Dates	<i>SITUATIONAL</i>	<p><b>REQUIRED</b> if any of the occurrences listed below are applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence.</p> <p><i>Accident Related</i></p> <p>01 Auto accident            02 No fault insurance involved, including auto accident/other            03 Accident/tort liability            04 Accident/employment related            05 Other accident            06 Crime victim</p> <p><i>Insurance Related</i></p> <p>17 Date outpatient occupational plan established or reviewed            24 Date insurance denied            25 Date benefits terminated by primary payer            27 Date home health plan was established or last reviewed            A3 Medicare benefits exhausted</p> <p><i>Other</i></p> <p>11 Date of onset</p>
35-36	Occurrence Span Codes and Dates	OPTIONAL	No entry required.
37	Untitled	OPTIONAL	No entry required.
38	Untitled (Responsible Party Name and Address)	OPTIONAL	No entry required.



Field No.	Field Name/Description	Requirements	Instructions
39-41	Value Codes and Amounts	<b>REQUIRED</b>	<p>Enter the value code, followed by the NUMBER of covered or non-covered days that are included in the billing period. <b>(NOTE: There should not be a dollar amount in this field.)</b></p> <p>If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence.</p> <p>80 Covered days 81 Non-covered days</p>
42	Revenue Code	<b>REQUIRED</b>	<p>Enter the revenue code that corresponds to each item or service billed.</p> <p><i>A list of valid <a href="#">revenue codes</a> can be found at the end of these UB-04 claim form instructions.</i></p> <p><b>NOTE:</b> Not all listed revenue codes are payable by Medicaid.</p>
43	Revenue Description	<i>SITUATIONAL</i>	<p><b>REQUIRED</b> if the provider enters a HCPCs "J-code" for a drug that has been administered. Enter the National Drug Code (NDC) that corresponds to the J-code entered in field 44. The NDC must be preceded with a "N4" qualifier. NDC should be entered in NNNNN-NNNN-NN format. <b>No other entries should be made in this field.</b></p>
43 Line 23	Page ___ of ___	<i>SITUATIONAL</i>	<p><b>REQUIRED</b> if claim is more than one page. Enter the page number and the total number of pages for the claim.</p> <p><b>NOTE:</b> The "PAGE ___ OF ___" and CREATION DATE on line 23 should be reported on all pages of the UB-04</p>



Field No.	Field Name/Description	Requirements	Instructions
44	HCPCS/Rate/HIPPS Codes	<i>SITUATIONAL</i>	<p><b>REQUIRED</b> for outpatient hospital, inpatient SNF, and home health agencies.</p> <p>Outpatient hospital: Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APG.</p> <p>Inpatient SNF: Enter the HCPCS code W0511 for ventilator-dependent members; otherwise leave blank.</p> <p>Home health agencies: Enter the appropriate HCPCS code from the prior authorization when billing for EPSDT-related services.</p> <p>All others: Leave blank.</p> <p><b>Do not</b> enter rates in this field.</p> <p><i>*When applicable, a procedure code modifier should be displayed after the procedure code.</i></p>
45	Service Dates	<i>SITUATIONAL</i>	<p><b>REQUIRED</b> for outpatient claims.</p> <p>Outpatient: Enter the service date for outpatient service referenced in <a href="#">field 42</a> or <a href="#">field 44</a>. Note that one entry is required for each date in which the service was performed.</p>
46	Service Units	<i>SITUATIONAL</i>	<p><b>REQUIRED</b> for inpatient, outpatient and home health agencies.</p> <p>Inpatient: Enter the appropriate units of service for accommodation days.</p> <p>Outpatient: Enter the appropriate units of service provided per CPT/revenue code. (Batch-bill APGs require one unit for every 15 minutes of service time.)</p> <p>Home health agencies: Enter the appropriate units for each service billed. A unit of service equals a visit.</p> <p>For prior authorization private-duty nursing or personal care, one unit equals an hour.</p>



Field No.	Field Name/Description	Requirements	Instructions
			ALL units should be entered using whole numbers only (1). Do not indicate partial units (1.5) or anything after the decimal (1.0).
47	Total Charges	<b>REQUIRED</b>	Enter the total charges for each line billed. The total must include both dollars and cents.
47 Line 23	Totals	<b>REQUIRED</b>	Enter the sum of the total charges for all lines billed (all of 47). This field should be completed on the last page of the claim only. The total must include both dollars and cents.
48	Non-Covered Charges	<b>REQUIRED</b>	Enter the non-covered charges for each applicable line.  <i>*** The total must include both dollars and cents.</i>
48 Line 23	Totals	<b>REQUIRED</b>	Enter the sum of the total non-covered charges for all lines billed (all of 48). This field should be completed on the last page of the claim only. The total must include both dollars and cents.
49	Untitled	NA	Not used.
50 A-C	Payer Name	<b>REQUIRED</b>	Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill. When indicating Iowa Medicaid as a payer, enter "Medicaid."
51 A-C *	Health Plan ID	LEAVE BLANK	This field must be left <b>blank</b> . Entering information in this field will cause the claim to be returned.



Field No.	Field Name/Description	Requirements	Instructions
52 A-C	Release of Information Certification Indicator	OPTIONAL	By submitting the claim, the provider has agreed to all information on the back of the claim form, including release of information.
53 A-C	Assignment of Benefits Certification Indicator	OPTIONAL	No entry required.
54 A-C	Prior Payments	OPTIONAL	<b>REQUIRED</b> if prior payments were made by a payer <i>other</i> than Medicaid. If applicable, enter the amount paid by a payer other than Medicaid.  Do not enter previous Medicaid payments.  The total must include both dollars and cents.
55 A-C	Estimated Amount Due From Member	OPTIONAL	No entry required.
56 *	National Provider ID (NPI)	<b>REQUIRED</b>	Enter the NPI of the billing entity.
57A *	Untitled	LEAVE BLANK	This field must be left <b>blank</b> . Entering information in this field will cause the claim to be returned.
57B *	Other	LEAVE BLANK	This field must be left <b>blank</b> . Entering information in this field will cause the claim to be returned.
57C *	Provider ID	LEAVE BLANK	This field must be left <b>blank</b> . Entering information in this field will cause the claim to be returned.
58	Insured's Name	<b>REQUIRED</b>	Enter the last name, first name, and middle initial of the Medicaid member on the line (A, B, or C) that corresponds to Medicaid from <a href="#">field 50</a> .



Field No.	Field Name/Description	Requirements	Instructions
59	Patient's Relationship to Insured	OPTIONAL	No entry required.
60 A-C	Insured's Unique ID	<b>REQUIRED</b>	Enter the member's Medicaid identification number found on the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, i.e., 1234567A.  Enter the Medicaid ID on the line (A, B, or C) that corresponds to Medicaid from <a href="#">field 50</a> .
61	Group Name	OPTIONAL	No entry required.
62 A-C	Insurance Group Number	OPTIONAL	No entry required.
63	Treatment Authorization Codes	<i>SITUATIONAL</i>	Enter prior authorization number if applicable.  <b>NOTE:</b> <i>This field is no longer used to report the MediPASS referral. Refer to <a href="#">field 79</a> to enter the MediPASS referral.</i>  <b>NOTE:</b> <i>Lock-in moved to <a href="#">field 78</a>.</i>
64	Document Control Number (DCN)	OPTIONAL	No entry required.
65	Employer Name	OPTIONAL	No entry required.
66	Diagnosis and Procedure code Qualifier (ICD Version Indicator)	<b>REQUIRED</b>	Enter the appropriate diagnosis and procedure code qualifier:  For ICD-9 enter "9." For ICD-10 enter "0."



Field No.	Field Name/Description	Requirements	Instructions
67	Principal Diagnosis Code	<b>REQUIRED</b>	Enter the ICD-9-CM code for the principal diagnosis.
	Present on Admission (POA)	<b>REQUIRED</b>	<p>POA indicator is the eighth digit of <a href="#">field 67 A-Q</a>. POA indicates if a condition was present or incubating at the time the order for inpatient admission occurs.</p> <p>Code Reason for Code</p> <p>Y Diagnosis was present at inpatient admission.</p> <p>U Documentation insufficient to determine if present at admission.</p> <p>W Unable to clinically determine if present at time of admission.</p> <p>(blank) Diagnosis is exempt from POA reporting.</p> <p>1 Invalid indicator – do not submit!</p>
67 A-Q	Other Diagnosis Codes	<i>SITUATIONAL</i>	<b>REQUIRED</b> if a diagnosis other than the principal is made. Enter the ICD-9-CM codes for additional diagnosis.
68	Untitled	OPTIONAL	No entry required.
69	Admitting Diagnosis	<i>SITUATIONAL</i>	<b>REQUIRED</b> for inpatient hospital claims. Inpatient hospital: The admitting diagnosis is required.
70 a-c	Member's Reason for Visit	<i>SITUATIONAL</i>	<b>REQUIRED</b> if visit is unscheduled. Member's reason for visit is required for all unscheduled outpatient visits for outpatient bills.
71	PPS (Prospective Payment System) Code	OPTIONAL	No entry required.
72	ECI (External Cause of Injury Codes)	OPTIONAL	No entry required.



Field No.	Field Name/Description	Requirements	Instructions
73	Untitled	OPTIONAL	No entry required.
74	Principal Procedure Code and Date	<i>SITUATIONAL</i>	<b>REQUIRED</b> for the principal surgical procedure. Enter the appropriate ICD-CM procedure code and surgery date, when applicable.
74 a-e	Other Procedure Codes and Dates	<i>SITUATIONAL</i>	<b>REQUIRED</b> for additional surgical procedures. Enter the appropriate ICD-CM procedure codes and surgery dates.
75	Untitled	OPTIONAL	No entry required.
<b><i>Attending Provider Name and Identifiers</i></b>			
76 *	NPI	<b>REQUIRED</b>	Enter the NPI of the attending physician. <b>REQUIRED</b> when claim/encounter contains any services other than nonscheduled transportation services. <i>The attending provider is the individual who has overall responsibility for the member's medical care and treatment reported in this claim/ encounter. If not required, do not send.</i>
	Qual	LEAVE BLANK	This field must be left <b>blank</b> . Entering information in this field will cause the claim to be returned.
	Last	<b>REQUIRED</b>	Enter the last name of the referring physician.
	First	<b>REQUIRED</b>	Enter the first name of the referring physician.



Field No.	Field Name/Description	Requirements	Instructions
<b><i>Operating Provider Name and Identifiers</i></b>			
77 *	NPI	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the physician performing the principal procedure is different than the attending physician. Enter the NPI of the operating physician.
	Qual	LEAVE BLANK	This field must be left <b>blank</b> . Entering information in this field will cause the claim to be returned.
	Last	<i>SITUATIONAL</i>	Enter the last name of the operating physician.
	First	<i>SITUATIONAL</i>	Enter the first name of the operating physician.
<b><i>Other Provider Name and Identifiers</i></b>			
78 *	NPI	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member is in the Lock-In program. Enter the NPI of the member's lock-in provider.
	Qual	LEAVE BLANK	This field must be left <b>blank</b> . Entering information in this field will cause the claim to be returned.
	Last	<i>SITUATIONAL</i>	Enter the last name of the member's lock-in provider.
	First	<i>SITUATIONAL</i>	Enter the first name of the member's lock-in provider.



Field No.	Field Name/Description	Requirements	Instructions
<b>Other Provider Name and Identifiers</b>			
79 *	NPI	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member is in the MediPASS program or if non-MediPASS and claim is outpatient. Enter the NPI of the referring physician. This area should not be completed if the primary physician did not give the referral.
	Qual	LEAVE BLANK	This field must be left <b>blank</b> . Entering information in this field will cause the claim to be returned.
	Last	<i>SITUATIONAL</i>	Enter the last name of the <i>referring</i> MediPASS physician.
	First	<i>SITUATIONAL</i>	Enter the first name of the <i>referring</i> MediPASS physician.
80 *	Remarks	<i>SITUATIONAL</i>	<b>REQUIRED</b> if a diagnosis other than the principal is made.  When applicable enter one of the following: <ul style="list-style-type: none"> <li>• "Not a Medicare benefit."</li> <li>• "Resubmit" (and list the original filing date).</li> <li>• Member is "Retro-Eligible and NOD is attached." (Notice of Decision)</li> </ul>
81*	Code-Code Fields	<b>REQUIRED</b>	Enter taxonomy code associated with the NPI of the billing entity ( <a href="#">field 56</a> ). Precede taxonomy code with qualifier "B3" (healthcare provider taxonomy code).  <b>NOTE:</b> The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment.



<b>Revenue Codes Field 42</b>		
<b>Code</b>	<b>Defined</b>	<b>Subcategories</b>
<b>11X</b> <b>Room &amp; Board Private</b> (medical or general)	Charges for accommodations with a single bed.	0 General classifications 1 Medical/surgical/GYN 2 OB 3 Pediatric 4 Psychiatric 6 Detoxification 7 Oncology 8 Rehabilitation 9 Other
<b>12X</b> <b>Room &amp; Board Semi-Private Two Bed</b> (medical or general)	Charges for accommodations with two beds.	0 General classifications 4 Sterile environment 7 Self care 9 Other
<b>13X</b> <b>Room &amp; Board Semi-Private Three and Four Beds</b> (medical or general)	Charges for accommodations with three and four beds.	0 General classifications 4 Sterile environment 7 Self care 9 Other
<b>14X</b> <b>Private</b> (deluxe)	Charges for accommodations with amenities substantially in excess of those provided to other members.	0 General classifications 4 Sterile environment 7 Self care 9 Other
<b>15X</b> <b>Room &amp; Board Ward</b> (medical or general)	Charges for accommodations with five or more beds.	0 General classifications 4 Sterile environment 7 Self care 9 Other
<b>16X</b> <b>Other Room &amp; Board</b>	Charges for accommodations that cannot be included in the specific revenue center codes.  Hospitals that are separating this charge for billing sterile environment is to be used.	0 General classifications 4 Sterile environment 7 Self care 9 Other



<b>Code</b>	<b>Defined</b>	<b>Subcategories</b>
<b>17X Nursery</b>	Charges for nursing care for newborn and premature infants in nurseries.	0 General classification 1 Newborn 2 Premature 5 Neonatal ICU 9 Other
<b>18X Leave of Absence</b>	Charges for holding a room or bed for a member while they are temporarily away from the provider.	5 Nursing home (for hospitalization)
<b>20X Intensive Care</b>	Charges for medical or surgical care provided to members who require a more intensive level of care than is rendered in the general medical or surgical unit.	0 General classification 1 Surgical 2 Medical 3 Pediatric 4 Psychiatric 6 Post ICU 7 Burn care 8 Trauma 9 Other intensive care
<b>21X Coronary Care</b>	Charges for medical care provided to members with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit.	0 General classification 1 Myocardial infarction 2 Pulmonary care 3 Heart transplant 4 Post CCU 9 Other coronary care
<b>22X Special Charges</b>	Charges incurred during an inpatient stay or on a daily basis for certain services.	0 General classification 1 Admission charge 2 Technical support charge 3 U.R. service charge 4 Late discharge, medically necessary 9 Other special charges
<b>23X Incremental Nursing Charge Rate</b>		0 General classification 1 Nursery 2 OB 3 ICU 4 CCU 9 Other



Code	Defined	Subcategories
<b>24X</b> <b>All Inclusive Ancillary</b>	A flat rate charge incurred on either a daily or total stay basis for ancillary services only.	0 General classification 9 Other inclusive ancillary
<b>25X</b> <b>Pharmacy</b>	Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies.	0 General classification 1 Generic drugs 2 Non-generic drugs 3 Take-home drugs 4 Drugs incident to other diagnostic services 5 Drugs incident to radiology 6 Experimental drugs 7 Nonprescription 8 IV solutions 9 Other pharmacy
<b>26X</b> <b>IV Therapy</b>	Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.	0 General classification 1 Infusion pump 2 IV therapy/pharmacy services 3 IV therapy/drug/supply delivery 4 IV therapy/supplies 9 Other IV therapy
<b>27X</b> <b>Medical/Surgical Supplies and Devices</b>  (also see <a href="#">62X</a> , an extension of 27X)	Charges for supply items required for member care.	0 General classification 1 Nonsterile supply 2 Sterile supply 3 Take-home supplies 4 Prosthetic/orthotic devices 5 Pacemaker 6 Intraocular lens 7 Oxygen – take home 8 Other implants 9 Other supplies/devices
<b>28X</b> <b>Oncology</b>	Charges for the treatment of tumors and related diseases.	0 General classification 9 Other oncology



Code	Defined	Subcategories
<b>29X</b> <b>Durable Medical Equipment</b> (other than renal)	Charges for medical equipment that can withstand repeated use (excluding renal equipment).	0 General classification 1 Rental 2 Purchase of new DME 3 Purchase of used DME 4 Supplies/drugs for DME effectiveness (home health agency only) 9 Other equipment
<b>30X</b> <b>Laboratory</b>	Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, be sure to indicate the code for each lab charge in UB-04 form field number 44.	0 General classification 1 Chemistry 2 Immunology 3 Renal patient (home) 4 Nonroutine dialysis 5 Hematology 6 Bacteriology and microbiology 9 Other laboratory
<b>31X</b> <b>Laboratory Pathological</b>	Charges for diagnostic and routine laboratory tests on tissues and cultures. For outpatient services, indicate the CPT code for each lab charge in UB-04 form field number 44.	0 General classification 1 Cytology 2 Histology 4 Biopsy 9 Other
<b>32X</b> <b>Radiology Diagnostic</b>	Charges for diagnostic radiology services provided for the examination and care of members. Includes taking, processing, examining and interpreting of radiographs and fluorographs.	0 General classification 1 Angiocardiology 2 Arthrography 3 Arteriography 4 Chest x-ray 9 Other
<b>33X</b> <b>Radiology Therapeutic</b>	Charges for therapeutic radiology services and chemotherapy required for care and treatment of members. Includes therapy by injection or ingestion of radioactive substances.	0 General classification 1 Chemotherapy – injected 2 Chemotherapy – oral 3 Radiation therapy 5 Chemotherapy – IV 9 Other



Code	Defined	Subcategories
<p><b>34X</b> <b>Nuclear Medicine</b></p>	<p>Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of members.</p>	<p>0 General classification 1 Diagnostic 2 Therapeutic 9 Other</p>
<p><b>35X</b> <b>CT Scan</b></p>	<p>Charges for computed tomographic scans of the head and other parts of the body.</p>	<p>0 General classification 1 Head scan 2 Body scan 9 Other CT scans</p>
<p><b>36X</b> <b>Operating Room Services</b></p>	<p>Charges for services provided to member by specifically trained nursing personnel who assisted physicians in surgical or related procedures during and immediately following surgery.</p>	<p>0 General classification 1 Minor surgery 2 Organ transplant – other than kidney 7 Kidney transplant 9 Other operating room services</p>
<p><b>37X</b> <b>Anesthesia</b></p>	<p>Charges for anesthesia services in the hospital.</p>	<p>0 General classification 1 Anesthesia incident to radiology 2 Anesthesia incident to other diagnostic services 4 Acupuncture 9 Other anesthesia</p>
<p><b>38X</b> <b>Blood</b></p>	<p>Charges for blood must be separately identified for private payer purposes.</p>	<p>0 General classification 1 Packed red cells 2 Whole blood 3 Plasma 4 Platelets 5 Leukocytes 6 Other components 7 Other derivatives (cryoprecipitates) 9 Other blood</p>



Code	Defined	Subcategories
<b>39X Blood Storage and Processing</b>	Charges for the storage and processing of whole blood.	0 General classification 1 Blood administration 9 Other blood storage and processing
<b>40X Other Imaging Services</b>		0 General classification 1 Diagnostic mammography 2 Ultrasound 3 Screening mammography 4 Positron emission tomography 9 Other imaging services
<b>41X Respiratory Services</b>	Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the member's ability to exchange oxygen and other gases.	0 General classification 1 Inhalation services 3 Hyperbaric oxygen therapy 9 Other respiratory services
<b>42X Physical Therapy</b>	Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of members who have neuromuscular, orthopedic, and other disabilities.	0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other occupational therapy or trial occupational therapy – rehab agency



<b>Code</b>	<b>Defined</b>	<b>Subcategories</b>
<b>43X Occupational Therapy</b>	Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of members.	0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other occupational therapy or trial occupational therapy – rehab agency
<b>44X Speech Language Pathology</b>	Charges for services provided to those with impaired functional communication skills.	0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other speech-language pathology or trial speech therapy – rehab agency
<b>45X Emergency Room</b>	Charges for emergency treatment to ill and injured requiring immediate unscheduled medical or surgical care.	0 General classification 9 Other emergency room
<b>46X Pulmonary Function</b>	Charges for tests measuring inhaled and exhaled gases, the analysis of blood and for tests evaluating the member's ability to exchange oxygen and other gases.	0 General classification 9 Other pulmonary function
<b>47X Audiology</b>	Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.	0 General classification 1 Diagnosis 2 Treatment 9 Other audiology



<b>Code</b>	<b>Defined</b>	<b>Subcategories</b>
<b>48X Cardiology</b>	Charges for cardiac procedures rendered in a separate unit within the hospital. Procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, exercise stress tests.	0 General classification 1 Cardiac cath lab 2 Stress test
<b>49X Ambulatory Surgical Care</b>	Charges for ambulatory surgery not covered by other categories.	0 General classification 9 Other ambulatory surgical care
<b>50X Outpatient Services</b>	Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service.	0 General classification 9 Other outpatient services
<b>51X Clinic</b>	Clinic (nonemergency, scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services on a scheduled basis to ambulatory members.	0 General classification 1 Chronic pain center 2 Dental clinic 3 Psychiatric clinic 4 OB-GYN clinic 5 Pediatric clinic 9 Other clinic
<b>52X Free-Standing Clinic</b>		0 General classification 1 Rural health – clinic 2 Rural health – home 3 Family practice 9 Other free-standing clinic
<b>53X Osteopathic Services</b>	Charges for a structural evaluation of the cranium, entire cervical, dorsal, and lumbar spine by a doctor of osteopathy.	0 General classification 1 Osteopathic therapy 9 Other osteopathic services



Code	Defined	Subcategories
<p><b>54X</b> <b>Ambulance</b></p>	<p>Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention. Ambulance is payable on the UB-04 form only in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form. Documentation of medical necessity must be provided for ambulance transport. The diagnosis and documentation must reflect that the member was nonambulatory and the trip was to the nearest adequate facility.</p>	<p>0 General classification 1 Supplies 2 Medical transport 3 Heart mobile 4 Oxygen 5 Air ambulance 6 Neonatal ambulance services 7 Pharmacy</p>
<p><b>55X</b> <b>Skilled Nursing</b> (home health agency only)</p>	<p>Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the member and achieving the medically desired result.</p>	<p>0 General classification 1 Visit charge 2 Hourly charge 9 Other skilled nursing</p>
<p><b>56X</b> <b>Medical Social Services</b> (home health agency only)</p>	<p>Charges for services provided to patients on any basis, such as counseling, interviewing, and interpreting social situations problems.</p>	<p>0 General classification 1 Visit charge 2 Hourly charge 9 Other medical social services</p>
<p><b>57X</b> <b>Home Health Aide</b> (home health agency only)</p>	<p>Charges made by a home health agency for personnel primarily responsible for the personal care of the member.</p>	<p>0 General classification 1 Visit charge 2 Hourly charge 9 Other home health aide services</p>



Code	Defined	Subcategories
<p><b>61X MRI</b></p>	<p>Charges for Magnetic Resonance Imaging of the brain and other body parts.</p>	<p>0 General classification 1 Brain (including brainstem) 2 Spinal cord (including spine) 9 Other MRI</p>
<p><b>62X Medical/Surgical Supplies</b>  (extension of <a href="#">27X</a>)</p>	<p>Charges for supply items required for member care. The category is an extension of 27X for reporting additional breakdown where needed. Sub code 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Sub code 2 is for providers that cannot bill supplies used for other diagnostic procedures.</p>	<p>0 Supplies incident to radiology 2 Supplies incident to other diagnostic services</p>
<p><b>63X Drugs Requiring Specific Identification</b></p>	<p>Charges for drugs and biologicals requiring specific identification as required by the payer.  If HCPCS is used to describe the drug, enter the HCPCS code in UB-04 form field number 44.</p>	<p>0 General classification 1 Single source drug 2 Multiple source drug 3 Restrictive prescription 4 Erythropoietin (EPO), less than 10,000 units 5 Erythropoietin (EPO), 10,000 or more units 6 Drugs requiring detailed coding</p>



Code	Defined	Subcategories
<p><b>64X</b> <b>Home IV Therapy Services</b></p>	<p>Charges for intravenous drug therapy services performed in the member's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy.</p>	<p>0 General classification 1 Nonroutine nursing, central line 2 IV site care, central line 3 IV site/change, peripheral line 4 Nonroutine nursing, peripheral line 5 Training member/caregiver, central line 6 Training, disabled member, central line 7 Training, member/caregiver, peripheral line 8 Training, disabled member, peripheral line 9 Other IV therapy services</p>
<p><b>65X</b> <b>Hospice Services</b> (hospice only)</p>	<p>Charges for hospice care services for a terminally ill member if the member elects these services in lieu of other services for the terminal condition.</p>	<p>1 Routine home care 2 Continuous home care (hourly) 5 Inpatient respite care 6 General inpatient care 8 Care in an ICF or SNF</p>
<p><b>70X</b> <b>Cast Room</b></p>	<p>Charges for services related to the application, maintenance, and removal of casts.</p>	<p>0 General classification 9 Other cast room</p>
<p><b>71X</b> <b>Recovery Room</b></p>		<p>0 General classification 9 Other recovery room</p>
<p><b>72X</b> <b>Labor Room/Delivery</b></p>	<p>Charges for labor and delivery room services provided by specially trained nursing personnel to members. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite.</p>	<p>0 General classification 1 Labor 2 Delivery 3 Circumcision 4 Birthing center 9 Other labor room/delivery</p>



Code	Defined	Subcategories
<p><b>73X</b> <b>EKG/ECG</b> (electro-cardiogram)</p>	<p>Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments.</p>	<p>0 General classification 1 Holter monitor 2 Telemetry 9 Other EKG/ECG</p>
<p><b>74X</b> <b>EEG</b> (electro-encephalogram)</p>	<p>Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders.</p>	<p>0 General classification 9 Other EEG</p>
<p><b>75X</b> <b>Gastro-Intestinal Services</b></p>	<p>Procedure room charges for endoscopic procedures not performed in the operating room.</p>	<p>0 General classification 9 Other gastro-intestinal</p>
<p><b>76X</b> <b>Treatment or Observation Room</b></p>	<p>Charges for the use of a treatment room or the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes on outpatient claims.</p>	<p>0 General classification 1 Treatment room 2 Observation room 9 Other treatment/observation room</p>
<p><b>79X</b> <b>Lithotripsy</b></p>	<p>Charges for the use of lithotripsy in the treatment of kidney stones.</p>	<p>0 General classification 9 Other lithotripsy</p>
<p><b>80X</b> <b>Inpatient Renal Dialysis</b></p>	<p>A waste removal process performed in an inpatient setting using an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue.</p>	<p>0 General classification 1 Inpatient hemodialysis 2 Inpatient peritoneal (non-CAPD) 3 Inpatient continuous ambulatory peritoneal dialysis 4 Inpatient continuous cycling peritoneal dialysis (CCPD) 9 Other inpatient dialysis</p>



Code	Defined	Subcategories
<p><b>81X</b> <b>Organ Acquisition</b> (see <a href="#">89X</a>)</p>	<p>The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.)</p>	<p>0 General classification 1 Living donor – kidney 2 Cadaver donor – kidney 3 Unknown donor – kidney 4 Other kidney acquisition 5 Cadaver donor – heart 6 Other heart acquisition 7 Donor – liver 9 Other organ acquisition</p>
<p><b>82X</b> <b>Hemodialysis</b> (outpatient or home)</p>	<p>A waste removal process, performed in an outpatient or home setting, necessary when the body’s own kidneys have failed. Waste is removed directly from the blood.</p>	<p>0 General classification 1 Hemodialysis/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient hemodialysis</p>
<p><b>83X</b> <b>Peritoneal Dialysis</b> (outpatient or home)</p>	<p>A waste removal process, performed in an outpatient or home setting, necessary when the body’s own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.</p>	<p>0 General classification 1 Peritoneal/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient peritoneal dialysis</p>
<p><b>84X</b> <b>Continuous Ambulatory Peritoneal Dialysis (CCPD)</b> (outpatient or home)</p>	<p>A continuous dialysis process performed in an outpatient or home setting using the member peritoneal membrane as a dialyzer.</p>	<p>0 General classification 1 CAPD/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient CAPD</p>



Code	Defined	Subcategories
<p><b>85X</b> <b>Continuous Cycling Peritoneal Dialysis (CCPD)</b> (outpatient or home)</p>	<p>A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night.</p>	<p>0 General classification 1 CCPD/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient CCPD</p>
<p><b>88X</b> <b>Miscellaneous Dialysis</b></p>	<p>Charges for dialysis services not identified elsewhere.</p>	<p>0 General classification 1 Ultrafiltration 2 Home dialysis aid visit 9 Miscellaneous dialysis other</p>
<p><b>89X</b> <b>Other Donor Bank</b> (extension of <a href="#">81X</a>)</p>	<p>Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts – see 81X).</p>	<p>0 General classification 1 Bone 2 Organ (other than kidney) 3 Skin 9 Other donor bank</p>
<p><b>92X</b> <b>Other Diagnostic Services</b></p>		<p>0 General classification 1 Peripheral vascular lab 2 Electromyogram 3 Pap smear 4 Allergy test 5 Pregnancy test 9 Other diagnostic services</p>
<p><b>94X</b> <b>Other Therapeutic Services</b></p>	<p>Charges for other therapeutic services not otherwise categorized.</p>	<p>0 General classification 1 Recreational therapy 2 Education/training 3 Cardiac rehabilitation 4 Drug rehabilitation 5 Alcohol rehabilitation 6 Complex medical equipment – routine 7 Complex medical equipment – ancillary 9 Other therapeutic services</p>



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<b>Code</b>	<b>Defined</b>	<b>Subcategories</b>
<b>99X</b> <b>Member</b> <b>Convenience Items</b>	Charges for items generally considered by the third party payers to be strictly convenience items, and, therefore, are not covered.	0 General classification 1 Cafeteria or guest tray 2 Private linen service 3 Telephone or telegraph 4 TV or radio 5 Nonmember room rentals 6 Late discharge charge 7 Admission kits 8 Beauty shop or barber 9 Other member convenience items

\*\* If you have any questions about this information, please contact Provider Services at (800) 338-7909; locally in the Des Moines area at (515) 256-4609.



## D. INSTRUCTIONS FOR COMPLETING THE CMS-1500 CLAIM FORM

The following Iowa Medicaid provider types bill for services on the CMS-1500 claim form:

- ◆ Ambulance
- ◆ Ambulatory surgical center
- ◆ Area education agencies
- ◆ Audiologist
- ◆ Birthing centers
- ◆ Certified registered nurse anesthetists
- ◆ Chiropractors
- ◆ Clinics
- ◆ Community mental health clinics
- ◆ Family planning clinics
- ◆ Federally qualifying health centers
- ◆ Hearing aid dealers
- ◆ Independently practicing physical therapists
- ◆ Lead investigation agency
- ◆ Maternal health centers
- ◆ Medical equipment and supply dealers
- ◆ Nurse midwives
- ◆ Opticians/optometrists
- ◆ Orthopedic shoe dealers
- ◆ Physicians
- ◆ Rural health clinics
- ◆ Screening centers

Click [here](#) to view a sample of the CMS-1500 claim form online.

The billing instructions below contain information that will aid in the completion of the CMS-1500 claim form. The table follows the claim 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.

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

If you have any questions about this form or instructions, please contact IME Provider Services at (800) 338-7909, or if within the local Des Moines area, call (515) 256-4609.



Field No.	Field Name/Description	Requirements	Instructions
1	Check One	<b>REQUIRED</b>	Check the applicable program.
1a	Insured's ID Number	<b>REQUIRED</b>	<p>Enter the Medicaid member's Medicaid number found on the <i>Medical Assistance Eligibility Card</i>. The Medicaid member is defined as the recipient of services who has Iowa Medicaid coverage.</p> <p>The Medicaid number consists of seven digits followed by a letter, i.e., 1234567A.</p> <p>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.</p> <p>To establish a web portal account, call (800) 967-7902.</p>
2	Patient's Name	<b>REQUIRED</b>	Enter the last name, first name, and middle initial of the Medicaid member.
3	Patient's Birth Date	OPTIONAL	Enter the birth date and sex of the member.
4	Insured's Name	OPTIONAL	For Medicaid purposes, this will always be the same as the member. The insured: For Iowa Medicaid purposes, the member is the insured. If the member is covered through other insurance, the policyholder is the "other insured."
5	Patient's Address	OPTIONAL	Enter the address and phone number of the member, if available.
6	Patient Relationship to Insured	OPTIONAL	For Medicaid purposes, the insured will always be the same as the member.
7	Insured's Address		



Field No.	Field Name/Description	Requirements	Instructions
8	Reserved for NUCC Use	<i>SITUATIONAL</i>	If you are billing with unlisted CPT/HCPCS codes, please clearly identify those by listing a description of the item or service.
9	Other Insured's Name	<i>SITUATIONAL</i>	<b>REQUIRED</b> 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," this field must be completed.
9a	Other Insured's Name, etc.	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the Medicaid member is covered under other additional insurance, enter the name of the policyholder of that insurance. <b>NOTE:</b> If 11d is "Yes," this field must be completed.
9b-c	Reserved for NUCC Use	LEAVE BLANK	This field must be left blank.
9d	Insurance Plan Name or Program Name	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the Medicaid member is covered under other additional insurance. Enter the name of the plan or program. <b>NOTE:</b> If 11d is "Yes," this field must be completed.
10	<b><i>Is Member's Condition Related to:</i></b>		
10a	Employment?	<i>SITUATIONAL</i>	<b>REQUIRED</b> if known. 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 member's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes. The provider also needs to include the appropriate postal abbreviation for the PLACE (State) associated with the auto accident.
10b	Auto Accident?		
10c	Other Accident?		



Field No.	Field Name/Description	Requirements	Instructions
10d	Claim Codes (Designated by NUCC)	OPTIONAL	No entry required.
11	Insured's Policy Group or FECA Number	OPTIONAL	For Medicaid purposes, the insured will always be the same as the member.
11a	Insured's Date of Birth & Gender	OPTIONAL	Enter date of birth in MM/DD/YY format. Select appropriate gender box.
11b	Other Claim ID (Designated by NUCC)	OPTIONAL	No entry required.
11c	Insurance Plan Name or Program Name	OPTIONAL	For Medicaid purposes, the insured will always be the same as the member.
11d	Is There Another Health Benefit Plan?	<b>REQUIRED</b>	<p><b>REQUIRED</b> if the Medicaid member has other insurance, check "YES" and enter payment amount in field 29. If "YES," then fields 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 member 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>



Field No.	Field Name/Description	Requirements	Instructions
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 Onset or Pregnancy (LMP) and Qualifier	<i>SITUATIONAL</i>	Entry should be made in MM/DD/YY format. <b>REQUIRED</b> for chiropractors. Chiropractors use the date of onset of current symptoms or illness. For pregnancy, use the date of the last menstrual period (LMP). This field is not required for preventative care. Qualifier 484 should be used when entering date of last menstrual period (LMP). Qualifier 431 should be used when entering the date for onset of current symptoms or illness.
15	Other Date and Qualifier	<i>SITUATIONAL</i>	<b>REQUIRED</b> for chiropractors. Chiropractors <b>must</b> enter the date of the most current x-ray. Entry should be made in MM/DD/YY format. Qualifier 455 must be used when indicating x-ray date.
16	Dates Patient Unable to Work in Current Occupation	OPTIONAL	No entry required.



Field No.	Field Name/Description	Requirements	Instructions
17	Name of Referring Provider or Other Source	OPTIONAL	Enter the name (first name, middle initial, last name) followed by the credentials of the MediPASS provider or lock-in provider.
17a	Untitled	LEAVE BLANK	This field must be left <b>blank</b> .
17b	NPI	<i>SITUATIONAL</i>	<b>REQUIRED</b> if The member is a MediPASS member and the MediPASS provider authorized the service, enter the 10-digit NPI of the referring MediPASS provider.  If the member is on lock-in and the lock-in provider authorized service, enter the 10-digit NPI of the lock-in Primary Care Provider (PCP).
18	Hospitalization Dates Related to Current Services	OPTIONAL	No entry required.
19	Additional Claim Information (Designated by NUCC)	<i>SITUATIONAL</i>	Enter the NPI number of the referring or prescribing provider.  If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider.  This field is <b>Required</b> if the referring or prescribing provider is <u>NOT</u> the same as the MediPASS provider or lock-in PCP.  For MediPASS members, if the referring or prescribing provider is also the MediPASS provider or lock-in PCP, then this field is <u>NOT</u> required.



Field No.	Field Name/Description	Requirements	Instructions
20	Outside Lab	OPTIONAL	No entry required.
21	Diagnosis or Nature of Illness or Injury and ICD Indicator	<b>REQUIRED</b>	<p>Indicate the applicable ICD-CM diagnosis codes in order of importance (A-primary; B-secondary; C-tertiary; D – quaternary) to a maximum of twelve diagnoses.</p> <p>If the patient is pregnant, one of the diagnosis codes <b>must</b> indicate pregnancy. The pregnancy diagnosis codes are as follows:</p> <p><b>ICD-9-CM:</b> 640.00 through 648.93; 670.00 through 676.93; V22.0; V23.9</p> <p><b>ICD-10-CM:</b> Any diagnosis code to indicate pregnancy. Example: Z33.1</p> <p>Indicate a 9 for the ICD Ind. when submitting ICD-9-CM diagnosis codes. Indicate a 0 for the ICD Ind. when submitting ICD-10-CM.</p>
22	Resubmission Code	OPTIONAL	No entry required.
23	Prior Authorization Number	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a prior authorization, enter the prior authorization number. Obtain the prior authorization number from the prior authorization form.
24A Top Shaded Portion	Date(s) of Service/NDC	<i>SITUATIONAL</i>	<p><b>REQUIRED</b> for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs).</p> <p>No spaces or symbols should be used in reporting this information.</p>
24A Lower Portion	Date(s) of Service	<b>REQUIRED</b>	<p>Enter month, day, and year under both the From and To categories for each procedure, service, or supply.</p> <p>Entry should be made in MM/DD/YY format.</p>



Field No.	Field Name/Description	Requirements	Instructions
24B	Place of Service	<b>REQUIRED</b>	<p>Using the chart below, enter the number corresponding to the place service was provide. <b>Do not</b> 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/ intellectually disabled</li> <li>55 Psychiatric residential treatment center</li> <li>61 Comprehensive inpatient rehabilitation facility</li> <li>62 Comprehensive outpatient</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>



Field No.	Field Name/Description	Requirements	Instructions
24C	EMG	OPTIONAL	No entry required.
24D	Procedures, Services, or Supplies	<b>REQUIRED</b>	<p>Enter the codes for each of the dates of service.</p> <p><b>Do not</b> list services for which no fees were charged.</p> <p><b>Do not</b> enter the description.</p> <p>Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) or valid Current Procedural Terminology (CPT). When applicable, show HCPCS code modifiers with the HCPCS code.</p>
24E	Diagnosis Pointer	<b>REQUIRED</b>	<p>Indicate the corresponding diagnosis code from <a href="#">field 21</a> by entering the number of its position, i.e., C.</p> <p><b>Do not</b> enter the actual diagnosis code in this field. Doing so will cause the claim to deny.</p> <p><b>NOTE:</b> There is a maximum of four diagnosis codes per claim.</p>
24F	\$ Charges	<b>REQUIRED</b>	Enter the <u>usual</u> and <u>customary</u> charge for each line item billed. The charge must include both dollars and cents.
24G	Days or Units	<b>REQUIRED</b>	<p>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."</p> <p>When billing general anesthesia, the units of service must reflect the <u>total minutes</u> of general anesthesia.</p>



Field No.	Field Name/Description	Requirements	Instructions
24H	EPSDT/Family Planning	<i>SITUATIONAL</i>	<b>REQUIRED</b> if services are a result of an EPSDT Care for Kids screen or are for family planning services.  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.
24I	ID Qual.	LEAVE BLANK	This field must be left <b>blank</b> .
24J Top shaded portion	Rendering Provider ID #	LEAVE BLANK	This field must be left <b>blank</b> .
24J Bottom portion	NPI	<b>REQUIRED</b>	Enter the NPI of the provider rendering the service.
25	Federal Tax I.D. Number	OPTIONAL	No entry required.
26	Patient's Account No.	OPTIONAL	Enter the member account number assigned to the member by the provider of service. This field is limited to 10 alphabetical or numeric characters.
27	Accept Assignment?	OPTIONAL	No entry required.
28	Total Charge	<b>REQUIRED</b>	Enter the total of the line item charges on the LAST page of the claim.  If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Total Charge. The pages prior to the last page should have "continued" or "page 1 of ___" in field 28.



Field No.	Field Name/Description	Requirements	Instructions
29	Amount Paid	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance and the insurance has made a payment on the claim. Enter only the amount paid by other insurance. Member copayments, Medicare payments or previous Medicaid payments are not listed on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denials must be included in the member record.  If more than once claim form is used to bill services performed and a prior payment was made, the third-party payment should be entered on <i>each page</i> of the claim in field 29.
30	Reserved for NUCC/Local Use	LEAVE BLANK	This field must be left <b>blank</b> .
31	Signature of Physician or Supplier	<b>REQUIRED</b>	Enter the signature of either the physician or authorized representative and the original filing date. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.  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.
32	Service Facility Location Information	OPTIONAL	Enter the complete address of the treating or rendering provider.
32a	NPI	OPTIONAL	Enter the NPI of the facility where services were rendered.



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Field No.	Field Name/Description	Requirements	Instructions
32b	Untitled	LEAVE BLANK	This field must be left <b>blank</b> .
33	Billing Provider Info and Phone #	<b>REQUIRED</b>	Enter the name and complete address of the billing provider. <b>NOTE:</b> The address must contain the zip code associated with the billing provider's NPI.
33a	NPI	<b>REQUIRED</b>	Enter the NPI of the billing provider.
33b	Untitled	<b>REQUIRED</b>	Enter the taxonomy code associated with the <b>billing provider's NPI</b> . A " <b>ZZ</b> " qualifier must precede the taxonomy code.



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## E. INSTRUCTIONS FOR COMPLETING THE ADA 2012 CLAIM FORM

Iowa Medicaid dentists bill for Medicaid-covered services using the 2012 *Dental Claim Form* published by the American Dental Association.

Click [here](#) to view a sample of the ADA 2012 claim form.

The billing instructions below contain information that will aid in the completion of the ADA 2012 claim form. The table follows the claim 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.

The IME provides software for electronic claims submission at no charge. For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions. For assistance with setting up or questions related to electronic billing, contact EDI Support Services at (800) 967-7902, email [support@edissweb.com](mailto:support@edissweb.com), or visit <http://www.edissweb.com/med/>.

When submitting a paper claim to Iowa Medicaid, the claim form must be typed or handwritten legibly in dark blue or black ink. Mail to:

Medicaid Claims  
PO Box 150001  
Des Moines, IA 50315



Field No.	Field Name/Description	Requirements	Instructions
1	Type of Transaction	<b>REQUIRED</b>	<p>Check "Statement of Actual Services" if the statement is for actual services.</p> <p>Check "EPSDT/Title XIX" if the services are a result of a referral from an EPSDT Care for Kids screening examination.</p> <p><b>NOTE:</b> Requests for predetermination/preauthorization should be completed using the prior authorization form.</p>
2	Predetermination/Pre-authorization Number	<i>SITUATIONAL</i>	<b>REQUIRED</b> if Medicaid has assigned a predetermination/prior authorization number for the services. Enter the prior authorization number for the services.
3	Company/Plan Name, Address, City, State, Zip Code	OPTIONAL	No entry required.
4	Other Coverage	<b>REQUIRED</b>	<p>Check if the member has other medical or dental insurance. If box 4 is checked, an amount must be entered in field 31a. If carrier denied, "\$0.00" must be entered.</p> <p><b>NOTE:</b> Medicaid should be billed only after the other insurance plans have been billed.</p> <p>If one box is checked, fields 5-11 must be completed. If both of the boxes for dental and medical coverage are checked, enter only the other dental carrier information in fields 5-11.</p>
5	Name of Policyholder	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance. Enter the last name, first name, and middle initial of the primary subscriber.



Field No.	Field Name/Description	Requirements	Instructions
6	Date of Birth	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance. Enter the date of birth of the primary subscriber.  Entry should be made in MM/DD/YYYY format.
7	Gender	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance. Check the appropriate box for the primary subscriber's gender.
8	Policyholder	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance. Enter the other insurance identification number or the social security number of the primary subscriber.
9	Plan/Group Number	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance. Enter the plan or group number for the other insurance of the primary subscriber.
10	Patient's Relationship to Person Named in #5	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance. Check the appropriate box to reflect the relationship the member has with the policyholder named in field 5.
11	Other Insurance Company/ Dental Benefit Plan Name, Address, City, State, Zip Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance. Enter the name, address, city, state, and zip code of the other insurance company or dental benefit plan.
12	Policyholder/ Subscriber Name, Address, City, State, Zip Code	<b>REQUIRED</b>	Enter last name, first name, and middle initial of the Medicaid member.  Use the <i>Medical Assistance Eligibility Card</i> for verification.



Field No.	Field Name/Description	Requirements	Instructions
13	Date of Birth	<b>REQUIRED</b>	Enter the date of birth if the member. Entry should be made in MM/DD/YYYY format.
14	Gender	<b>REQUIRED</b>	Check the appropriate box for the member's gender.
15	Policyholder/Subscriber ID	<b>REQUIRED</b>	Enter the Medicaid identification number of the member. This number consists of seven numbers and a letter, i.e., 1234567A. This number can be found on the <i>Medical Assistance Eligibility Card</i> .
16	Plan/Group Number	OPTIONAL	No entry required.
17	Employer Name	OPTIONAL	No entry required.
18	Relationship to Policyholder/Subscriber in #12	OPTIONAL	No entry required.
19	Reserved for Future Use	OPTIONAL	No entry required.
20	Name, Address, City, State, Zip Code	OPTIONAL	No entry required.
21	Date of Birth	OPTIONAL	No entry required.
22	Gender	OPTIONAL	No entry required.



Field No.	Field Name/Description	Requirements	Instructions
23	Patient ID/ Account #	OPTIONAL	Enter the number assigned by the dentist's office relating to the member's account or the record number.  This field is limited to 20 characters.
24	Procedure Date	<b>REQUIRED</b>	Enter the date of service.  Entry should be made in MM/DD/YYYY format.  <b>NOTE:</b> One entry is required for each line billed.
25	Area of Oral Cavity	<i>SITUATIONAL</i>	Report the area of the oral cavity unless one of the following conditions in field 29 (procedure code) exists: <ul style="list-style-type: none"> <li>• The procedure identified in field 29 requires the identification of a tooth or a range of teeth.</li> <li>• The procedure identified in field 29 incorporates a specific area of the oral cavity (for example: D5110 complete denture – maxillary).</li> <li>• The procedure identified in field 29 does not relate to any portion of the oral cavity (for example: D9220 deep sedation/general anesthesia – first 30 minutes).</li> </ul> <p><b>NOTE:</b> <i>The ANSI/ADA/ISO Specification No. 3950 – 1984 Dentistry Designation System for Teeth and Areas of the Oral Cavity</i> should be used in reporting the area of oral cavity. Valid entries are:</p> <ul style="list-style-type: none"> <li>00 Whole of the oral cavity</li> <li>01 Maxillary area</li> <li>02 Mandibular area</li> <li>10 Upper right quadrant</li> <li>20 Upper left quadrant</li> <li>30 Lower left quadrant</li> <li>40 Lower right quadrant</li> </ul>



Field No.	Field Name/Description	Requirements	Instructions
26	Tooth System	OPTIONAL	No entry required.
27	Tooth Number(s) or Letter(s)	<i>SITUATIONAL</i>	<p>When billing an applicable procedure code. Enter the tooth number (permanent teeth) or tooth letter (deciduous teeth).</p> <p><b>NOTE:</b> <i>The ADA's Universal/National Tooth Designation System is to be used in reporting tooth number or letter.</i></p> <p>If the same procedure is performed on more than one tooth, on the same date of service, report each procedure and tooth designation on <i>separate lines</i> on the claim form.</p> <p>If billing for partial dentures, <i>one</i> tooth number from the area of the denture is required. If the area contains both anterior and posterior teeth, an anterior tooth number should be used.</p>
28	Tooth Surface	<i>SITUATIONAL</i>	<p>When billing an applicable procedure code.</p> <p>Enter the standard ADA designation of the tooth surfaces.</p>
29	Procedure Code	<i>REQUIRED</i>	Enter the appropriate procedure code found in the version of the code on dental procedures and nomenclature in effect on the "procedure date" (field 24).
29a	Diag. Pointer	<i>SITUATIONAL</i>	<p>REQUIRED if a diagnosis code is entered in field 34a.</p> <p>Indicate the corresponding diagnosis code from field 34a by entering the letter of its position, i.e., "A."</p> <p>Do not enter the actual diagnosis code in this field. Doing so will cause the claim to deny.</p>



Field No.	Field Name/Description	Requirements	Instructions
29b	Qty.	<b>REQUIRED</b>	Enter the number of units provided.
30	Description	<b>REQUIRED</b>	Enter a description of the procedure.
31	Fee	<b>REQUIRED</b>	Enter the usual and customary charge for each line item billed. <b>NOTE:</b> The total must include both dollars and cents. Do not enter the fee from the Medicaid fee schedule.
31a	Other Fees	<i>SITUATIONAL</i>	Must be left blank, unless the member has other insurance. Enter the payment amount received from other insurance in relation to the claim. If the other insurance denied the claim or applied the full allowed amount to the coinsurance or deductible, enter "0.00." Do not include the member's copayment amount in this field. <b>NOTE:</b> The total must include both dollars and cents.
32	Total Fee	<b>REQUIRED</b>	Enter the sum of the charges listed in field 31 (Fee). This field should be completed on the last page of the claim only. <b>NOTE:</b> Do not subtract any amounts paid by other insurance.
33	Missing Teeth Information	<i>SITUATIONAL</i>	Place an "X" on the missing tooth letter or number. <b>NOTE:</b> The <i>ADA's Universal/National Tooth Designation System</i> is used to name teeth on the form.



Field No.	Field Name/Description	Requirements	Instructions
34	Diagnosis Code List Qualifier	<i>SITUATIONAL</i>	<b>REQUIRED</b> if a diagnosis code is entered in field 29a. Indicate whether the claim reflects ICD-9 or ICD-10 diagnosis codes.  For ICD-9 enter "B." For ICD-10 enter "AB."
34a	Diagnosis Code(s)	<i>SITUATIONAL</i>	Only <b>REQUIRED</b> if the member is pregnant at the time of service or received preventive services due to a physical or mental condition that impairs their ability to maintain adequate oral hygiene.  If the member is pregnant, enter ICD-9 diagnosis code "V22.2" or any ICD-10 diagnosis code indicating pregnancy, e.g., "Z33.1." This will indicate that the member is pregnant and exempt from the copay requirement.  If the member is disabled, enter ICD-9 diagnosis code "V49.89" or ICD-10 diagnosis code "Z78.9" or "Z74.09." This will allow for reimbursement of preventive services otherwise limited.  <b>Do not</b> enter descriptions.
35	Remarks	<i>SITUATIONAL</i>	Enter the reason for replacement if crowns, partial or complete dentures are being replaced. Enter a brief description if treatment is the result of an occupational illness or injury, auto accident or other accident.  <b>NOTE:</b> This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth.  It can also be used to convey additional information believed necessary to process the claim.  Remarks should be concise and pertinent to the claim submission.  Pregnancy is now indicated in field 34a.



<b>Field No.</b>	<b>Field Name/ Description</b>	<b>Requirements</b>	<b>Instructions</b>
36	Patient/ Guardian Signature	OPTIONAL	No entry required.
37	Subscriber Signature	OPTIONAL	No entry required.
38	Place of Treatment	REQUIRED	Enter the two-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services.  Frequently used codes are:  03 School 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 31 Skilled nursing facility 32 Nursing facility
39	Enclosures (Y or N)	<i>SITUATIONAL</i>	Check the box if the claim includes enclosures, such as radiographs, oral images or study models.
40	Is Treatment for Orthodontics?	OPTIONAL	No entry required.
41	Date Appliance Placed	OPTIONAL	No entry required.
42	Months of Treatment Remaining	OPTIONAL	No entry required.



Field No.	Field Name/Description	Requirements	Instructions
43	Replacement of Prosthesis	<i>SITUATIONAL</i>	<b>REQUIRED</b> when billing for crowns, partial or complete dentures. Check the applicable box.  If "YES" is checked, then indicate the reason for replacement under "Remarks" in field 35.
44	Date Prior Placement	<i>SITUATIONAL</i>	<b>REQUIRED</b> if "YES" is checked in field 43, and if prior placement is less than 5 years ago. Enter the date of prior placement.  Entry should be made in MM/DD/YYYY format.  To verify the date of prior placement contact ELVS at (800) 338-7752, or in the local Des Moines area at (515) 323-9639.
45	Treatment Resulting From	<i>SITUATIONAL</i>	<b>REQUIRED</b> only if treatment is result of occupational illness or injury, auto accident or other accident.  Check the applicable box and enter a brief description in field 35.
46	Date of Accident	<i>SITUATIONAL</i>	<b>REQUIRED</b> only if treatment is result of occupational illness or injury, auto accident or other accident.  Enter the date of the accident.  Entry should be made in MM/DD/YYYY format.
47	Auto Accident State	<i>SITUATIONAL</i>	<b>REQUIRED</b> only if treatment is result of occupational illness or injury, auto accident or other accident.  Enter the two letter postal state code for the state in which the auto accident occurred.



Field No.	Field Name/Description	Requirements	Instructions
48	Name, Address, City, State, Zip Code	<b>REQUIRED</b>	Enter the name and complete address of the billing dentist or the dental entity (corporation, group, etc.).  <b>NOTE:</b> The address must contain the zip code associated with the billing dentist or dental entity's NPI.  The zip code must match the zip code confirmed during NPI verification.
49	NPI	<b>REQUIRED</b>	Enter the NPI of the billing entity.
50	License Number	OPTIONAL	No entry required.
51	SSN or TIN	OPTIONAL	No entry required.
52	Phone Number	OPTIONAL	No entry required.
52a	Additional Provider ID	LEAVE BLANK	This field must be left <b>blank</b> . The claim will be returned if information is submitted in this field.
53	Treating Dentist Signature	<b>REQUIRED</b>	Enter the name of the treating dentist and the date the form is signed.
54	NPI	<b>REQUIRED</b>	Enter the NPI of the treating dentist.
55	License Number	<b>REQUIRED</b>	Enter the license number of the treating dentist.
56	Address, City, State, Zip Code	<b>REQUIRED</b>	Enter the complete address of the treating dentist.  <b>NOTE:</b> The address must contain the zip code associated with the treating provider's NPI.  The zip code must match the zip code confirmed during NPI verification.



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Field No.	Field Name/Description	Requirements	Instructions
56a	Provider Specialty Code	<b>REQUIRED</b>	Enter the taxonomy code associated with the billing entity's NPI. <b>NOTE:</b> The taxonomy code must match the taxonomy code confirmed during NPI verification.
57	Phone Number	OPTIONAL	No entry required.
58	Additional Provider ID	LEAVE BLANK	This field must be left <b>blank</b> . The claim will be returned if information is submitted in this field.

\*\* If you have any questions about this information, please contact Provider Services at (800) 338-7909; locally in the Des Moines area at (515) 256-4609.



## **F. INSTRUCTIONS FOR COMPLETING THE IOWA MEDICAID LONG TERM CARE CLAIM FORM**

Iowa Medicaid enrolled nursing facilities and residential care facilities bill for services electronically as an institutional claim on a monthly basis. The IME offers free electronic billing software; PC-ACE Pro 32, available through <http://edissweb.com/med/index.html>. Click [here](#) for more information on how to obtain PC-ACE software or to view help resources.

## **G. INSTRUCTIONS FOR SUBMITTING MEDICARE CROSSOVER INVOICES**

All providers enrolled with the IME are required to use a *Medicare Crossover Invoice* and attach a copy of the Medicare Explanation of Benefits (EOMB) when it is necessary to send a paper crossover billing to the IME. This requirement is pursuant to 441 Iowa Administrative Code (IAC) 80.2(2)“h.”

There are two different crossover invoice forms depending on which provider and claim types you use to bill Medicare:

- ◆ The *Medicare Crossover Invoice (Professional)*, form 470-4708. Click [here](#) to view the form online.
- ◆ The *Medicare Crossover Invoice (Institutional)*, form 470-4707. Click [here](#) to view the form online.

Submit these forms only after Medicare has paid and established a coinsurance or deductible. These forms are not for submission of a claim where Medicare has denied the charges. Continue to attach the denied EOMB from Medicare to the CMS-1500 and UB-04 claim forms when submitting for denied or non-covered charges.



## 1. Submitting Medicare Professional Charges

To bill professional services to Iowa Medicaid that were originally billed to Medicare on a CMS-1500 claim form that did not electronically cross over from Medicare, submit **both**:

- ◆ Form 470-4708, *Medicare Crossover Invoice (Professional)*, and
- ◆ A copy of the *Explanation of Medicare Benefits (EOMB)*.

If you have access to a computer you must use the printable version of the invoice.

If you do not have access to a computer to type in the needed fields, contact Provider Services at (800) 338-7909, or locally (in the Des Moines area) at (515) 256-4609 to order blank forms. Please print legibly and use only blue or black ink.

Mail the completed crossover invoice along with the EOMB to:

Medicaid Claims  
PO Box 150001  
Des Moines, Iowa 50315



If you have questions, please contact IME Provider Services at (800) 338-7909, locally in Des Moines at (515) 256-4609 or via email to [imeproviderservices@dhs.state.ia.us](mailto:imeproviderservices@dhs.state.ia.us).

The following table contains information that will aid in the completion of the invoice.

Field No.	Field Name/Description	Requirements	Instructions
<b>Medicare Information</b>			
1	Medicare's ICN	<i>SITUATIONAL</i>	If available, enter the ICN number from the Medicare Explanation of Benefits. For Medicare HMO crossovers, please enter the HMO claim transaction number.  If the ICN number is not available, leave blank.
2	Medicare Payment Date	<b>REQUIRED</b>	Enter the date from the Medicare Explanation of Benefits that Medicare paid for the services.  Entries should be made in a MM/DD/YY format.
<b>Member Information</b>			
3	Member's Name	<b>REQUIRED</b>	Enter the last name, first name, and middle initial of the member.
4	Member's Medicaid ID #	<b>REQUIRED</b>	Enter the member's Medicaid identification number found on the <i>Iowa Medicaid Eligibility Card</i> .  The identification number consists of seven digits followed by a letter, i.e., 1234567A.
5	Patient Account #	OPTIONAL	Enter the account number assigned to the member by the provider of service. This field is limited to 10 characters.



Field No.	Field Name/Description	Requirements	Instructions
<b><i>Provider Information</i></b>			
6	Billing Provider NPI	<b>REQUIRED</b>	Enter the NPI associated with the billing provider.
7	Billing Provider Name	<b>REQUIRED</b>	Enter the name of the billing provider.
8	Billing Provider Address	<b>REQUIRED</b>	Enter the address, city, and state of the billing provider.
9	Billing Provider Zip	<b>REQUIRED</b>	Enter the zip code associated with the billing provider's address.
10	Taxonomy Code	<b>REQUIRED</b>	Enter the taxonomy code associated with the billing provider.
11	Rendering Phys NPI	OPTIONAL	Enter the NPI associated with the rendering provider.
12	Referring Phys NPI	OPTIONAL	Enter the NPI associated with the referring provider.
<b><i>Other Health Insurance Information</i></b>			
13	Did Other Insurance/ TPL Deny Coverage	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has insurance other than Medicare and Medicaid that has denied payment. Check if the member's other insurance has denied payment.  If no, leave blank.
14	Other Insurance/ TPL Amount Pd	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has insurance other than Medicare and Medicaid that has made a payment. Enter only the total amount paid by a third party.  If none, leave blank.  Member copayments, Medicare payments or previous Medicaid payments are not to be listed in this field.



Field No.	Field Name/Description	Requirements	Instructions
<b><i>Diagnosis or Nature of Injury or Illness</i></b>			
15	ICD Ver Ind	<b>REQUIRED</b>	Indicate whether the claim reflects ICD-9 or ICD-10 diagnosis codes.  For ICD-9 enter "9." For ICD-10 enter "0."
16	Prim Diag Code	<b>REQUIRED</b>	Indicate the applicable primary ICD-CM diagnosis code (without a decimal point).
17	Other Diag	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an additional diagnosis code.  Enter the ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
18	Other Diag	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an additional diagnosis code.  Enter the ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
<b><i>Service Information Transferred From Medicare Explanation of Benefits</i></b>			
19	From Date	<b>REQUIRED</b>	Enter the "From" date of service from the Medicare Explanation of Benefits.  Entries should be made in a MM/DD/YY format.
20	To Date	<b>REQUIRED</b>	Enter the "To" date of service from the Medicare Explanation of Benefits.  Entries should be made in a MM/DD/YY format.



Field No.	Field Name/Description	Requirements	Instructions
21	POS	<b>REQUIRED</b>	<p>Enter the two-digit place of service code from the Medicare Explanation of Benefits. The place of service code must be converted to one of the following codes if the code from the Medicare Explanation of Benefits is not on the list below:</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/ intellectually disabled</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>72 Rural health clinic</li> <li>81 Independent laboratory</li> <li>99 Other unlisted facility</li> </ul>



Field No.	Field Name/Description	Requirements	Instructions
22	Qty	<b>REQUIRED</b>	Enter the number of times this procedure was performed or number of supply items dispensed from the Medicare Explanation of Benefits.
23	Proc Code & Mods	<b>REQUIRED</b>	Enter the appropriate five-digit procedure code and any necessary modifier (up to two modifiers allowed) for each of the dates of service from the Medicare Explanation of Benefits. <b>Do not</b> list services for which Medicare did not cover.
24	NDC	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the procedure code is a J-code.  Enter the eleven-digit NDC (without dashes or spaces) associated with the procedure code.
25	Billed Amt	<b>REQUIRED</b>	Enter the billed amount for each procedure code from the Medicare Explanation of Benefits.
26	Allowed Amt	<b>REQUIRED</b>	Enter the amount allowed by Medicare for each procedure code from the Medicare Explanation of Benefits.
27	Copay	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a copay amount indicated on the Medicare Explanation of Benefits.  Enter the copay amount for each procedure code from the Medicare Explanation of Benefits.
28	Coinsurance	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a coinsurance amount indicated on the Medicare Explanation of Benefits.  Enter the coinsurance amount for each procedure code from the Medicare Explanation of Benefits.



Field No.	Field Name/Description	Requirements	Instructions
29	Deductible	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a deductible amount indicated on the Medicare Explanation of Benefits.  Enter the deductible amount for each procedure code from the Medicare Explanation of Benefits.
30	Psych Reduction	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a psychiatric reduction amount (PR-122) indicated on the Medicare Explanation of Benefits.  Enter the psychiatric reduction amount (PR-122) for each procedure code from the Medicare Explanation of Benefits.
31	Medicare Pd	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a Medicare payment indicated on the Medicare Explanation of Benefits.  Enter the amount paid by Medicare for each procedure code from the Medicare Explanation of Benefits.
32	Total Billed Amt	<b>REQUIRED</b>	Enter the total of the line item billed amounts (field 25) on the LAST page of the claim.  If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Total Billed Amount. The pages prior to the last page should have "continued" or "page 1 of _" in field 32.
<b><i>Signature of Physician or Supplier</i></b>			
33	Signature	<b>REQUIRED</b>	The provider or an authorized representative must sign the claim.
34	Date	<b>REQUIRED</b>	The provider or authorized representative must indicate the original filing date.



## 2. Submitting Medicare Institutional Charges

To bill institutional services to Iowa Medicaid that were originally billed to Medicare on a UB-04 claim form that did not electronically crossover from Medicare, submit both:

- ◆ Form 470-4707, *Medicare Crossover Invoice (Institutional)*, and
- ◆ A copy of the *Explanation Medicare of Benefits (EOMB)*.

If you have access to a computer, you **must** use the printable version of the invoice.

If you do not have access to a computer to type in the needed fields, contact Provider Services at (800) 338-7909, or locally (in the Des Moines area) at (515) 256-4609 to order blank forms. Please print legibly and use only blue or black ink.

Mail the completed crossover invoice along with the EOMB to:

Medicaid Claims  
PO Box 150001  
Des Moines, Iowa 50315

If you have questions, please contact IME Provider Services at (800) 338-7909, locally in Des Moines at (515) 256-4609 or via email to [imeproviderservices@dhs.state.ia.us](mailto:imeproviderservices@dhs.state.ia.us).

The following table contains information that will aid in the completion of the invoice.



Field No.	Field Name/Description	Requirements	Instructions
<b>Medicare Information</b>			
1	Medicare's ICN	<i>SITUATIONAL</i>	If available, enter the ICN number from the Medicare Explanation of Benefits.  For Medicare HMO crossovers, please enter the HMO claim transaction number. If the ICN number is not available, leave blank.
2	Medicare Payment Date	<b>REQUIRED</b>	Enter the date from the Medicare Explanation of Benefits that Medicare paid for the services.  Entries should be made in a MM/DD/YY format.
<b>Member Information</b>			
3	Member's Name	<b>REQUIRED</b>	Enter the last name, first name, and middle initial of the member.
4	Member's Medicaid ID #	<b>REQUIRED</b>	Enter the member's Medicaid identification number found on the <i>Iowa Medicaid Eligibility Card</i> .  The identification number consists of seven digits followed by a letter, i.e., 1234567A.
5	Patient Account #	OPTIONAL	Enter the account number assigned to the member by the provider of service. This field is limited to 10 characters.
<b>Provider Information</b>			
6	Billing Provider NPI	<b>REQUIRED</b>	Enter the NPI associated with the billing provider.
7	Billing Provider Name	<b>REQUIRED</b>	Enter the name of the billing provider.
8	Billing Provider Address	<b>REQUIRED</b>	Enter the address, city, and state of the billing provider.



Field No.	Field Name/Description	Requirements	Instructions
9	Billing Provider Zip	<b>REQUIRED</b>	Enter the zip code associated with the billing provider's address.
10	Taxonomy Code	<b>REQUIRED</b>	Enter the taxonomy code associated with the billing provider.
11	Attending Phys NPI	OPTIONAL	Enter the NPI associated with the attending provider.
12	Referring Phys NPI	OPTIONAL	Enter the NPI associated with the referring provider.
<b><i>Other Health Insurance Information</i></b>			
13	Did the Other Insurance/ TPL Deny Coverage	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has insurance other than Medicare and Medicaid that has denied payment.  Check if the member's other insurance has denied payment.  If no, leave blank.
14	Other Insurance/ TPL Amount Paid	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has insurance other than Medicare and Medicaid that has made a payment. Enter only the total amount paid by a third party.  If none, leave blank.  Member copayments, Medicare payments or previous Medicaid payments are not to be listed in this field.
<b><i>Diagnosis or Nature of Injury or Illness</i></b>			
15	ICD Ver Ind	<b>REQUIRED</b>	Indicate whether the claim reflects ICD-9 or ICD-10 diagnosis codes.  For ICD-9 enter "9." For ICD-10 enter "0."
16	Diag Code	<b>REQUIRED</b>	Indicate the applicable primary ICD-CM diagnosis code (without a decimal point).



Field No.	Field Name/Description	Requirements	Instructions
17	Other Diag Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an additional diagnosis code.  Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
18	Other Diag Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an additional diagnosis code.  Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
19	Other Diag Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an additional diagnosis code.  Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
20	Other Diag Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an additional diagnosis code.  Enter the appropriate ICD-CM code (without a decimal point), other than primary, for additional diagnosis in order of importance.
21	Proc Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> for the principal surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
21A	Date	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an ICD-CM principal surgical procedure code entered in field 21, enter the date associated with the principal surgical procedure code.
22	Other Proc Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.



Field No.	Field Name/Description	Requirements	Instructions
22A	Date	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an ICD-CM additional surgical procedure code entered in field 22, enter the date associated with the additional surgical procedure code.
23	Other Proc Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
23A	Date	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an ICD-CM additional surgical procedure code entered in field 23, enter the date associated with the additional surgical procedure code.
24	Other Proc Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
24A	Date	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an ICD-CM additional surgical procedure code entered in field 24, enter the date associated with the additional surgical procedure code.
25	Other Proc Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.
25A	Date	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an ICD-CM additional surgical procedure code entered in field 25, enter the date associated with the additional surgical procedure code.
26	Other Proc Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> for additional surgical procedure, enter the appropriate ICD-CM procedure code, when applicable.



Field No.	Field Name/Description	Requirements	Instructions
26A	Date	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is an ICD-CM additional surgical procedure code entered in field 26, enter the date associated with the additional surgical procedure code.
<b><i>Service Information Transferred From Medicare Explanation of Benefits</i></b>			
27	Covered Days	<i>SITUATIONAL</i>	<b>REQUIRED FOR NURSING FACILITIES</b> Enter the number of covered days. Do not use the day of discharge in your calculations.
28	TOB	<b>REQUIRED</b>	Enter a three-digit type of bill consisting of one digit from each of the following categories in this sequence: First digit: Type of facility Second digit: Bill classification Third digit: Frequency  Type of Facility 1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice  Bill Classification 1 Inpatient hospital, inpatient skilled nursing facility or hospice (nonhospital-based) 2 Hospice (hospital based) 3 Outpatient hospital, outpatient skilled nursing facility or hospice (hospital-based) 4 Hospital-referenced laboratory services, home health agency, rehabilitation agency



Field No.	Field Name/Description	Requirements	Instructions
			Frequency 1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim
29	From Date	<b>REQUIRED</b>	Enter the “From” date of service from the Medicare Explanation of Benefits.  Entries should be made in a MM/DD/YY format.
30	To Date	<b>REQUIRED</b>	Enter the “To” date of service from the Medicare Explanation of Benefits.  Entries should be made in a MM/DD/YY format.
31	Covered Chgs	<b>REQUIRED</b>	Enter the total covered charges from the Medicare Explanation of Benefits.
32	Non-Cov Chgs	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there are total non-covered charges indicated on the Medicare Explanation of Benefits.  Enter the total non-covered charges from the Medicare Explanation of Benefits.
33	Blood Deduct	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a blood deductible amount indicated on the Medicare Explanation of Benefits.  Enter the total blood deductible amount from the Medicare Explanation of Benefits.
34	Reserved	LEAVE BLANK	This field must be left <b>blank</b> .
35	Deductible	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a deductible amount indicated on the Medicare Explanation of Benefits.  Enter the total deductible amount from the Medicare Explanation of Benefits.



Field No.	Field Name/Description	Requirements	Instructions
36	Coinsurance	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a coinsurance amount indicated on the Medicare Explanation of Benefits.  Enter the total coinsurance amount from the Medicare Explanation of Benefits.
37	Copay	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a copay amount indicated on the Medicare Explanation of Benefits.  Enter the total copay amount from the Medicare Explanation of Benefits.
38	Medicare Paid	<i>SITUATIONAL</i>	<b>REQUIRED</b> if there is a Medicare payment indicated on the Medicare Explanation of Benefits.  Enter the total amount paid by Medicare from the Medicare Explanation of Benefits.
<b>Part B (Bundling)</b>			
39	Deductible	LEAVE BLANK	This field must be left <b>blank</b> .
40	Coinsurance	LEAVE BLANK	This field must be left <b>blank</b> .
<b>Signature of Physician or Supplier</b>			
41	Signature	<b>REQUIRED</b>	The provider or an authorized representative must sign the claim.
42	Date	<b>REQUIRED</b>	The provider or an authorized representative must indicate the original filing date.



## H. SUBMITTING MEDICARE-DENIED CHARGES TO IOWA MEDICAID

When **Medicare denies** a charge, it can be submitted to Iowa Medicaid for payment consideration. In order for Iowa Medicaid to process the claim, the following information must be submitted to Iowa Medicaid:

### 1. Claim Form (CMS-1500 or UB-04)

- ◆ The claim form must be completed correctly according to the billing instructions.
- ◆ Only the procedure codes that Medicare denied should be listed on the claim form.
- ◆ Medicare allowed or paid charges should not be listed as these codes are submitted separately on the Medicare EOMB.
- ◆ If Medicare requires a specific CPT/HCPCS code that Iowa Medicaid does not recognize, please find an appropriate CPT/HCPCS code and place on the claim form to bill Iowa Medicaid. You will still attach the Medicare EOB as proof of the denial.
- ◆ Medicare payment amount should never be reflected on the claim form itself.
- ◆ Write or type "*NOT A MEDICARE COVERED BENEFIT*" on the claim form

### 2. Attach Medicare (or Medicare HMO) EOB

If multiple claims are listed on the EOB, please clearly indicate which claim is being submitted. (Circle or star the correct claim OR black out all other claims on page.)

## I. SUBMITTING TO IOWA MEDICAID WHEN MEDICARE DENIES AND PAYS THE SAME CLAIM

When Medicare pays on part of the claim and denies other lines, **two** claims must be sent to the IME in order to receive proper reimbursement.

- ◆ *Step 1:* Submit the Medicare EOB with the required information for the Medicare covered charges (see instructions above).
- ◆ *Step 2:* Submit a claim form listing only the Medicare **non-covered** charges and attach the Medicare EOB to the claim form to show the Medicare denial. Follow the instructions above for submitting Medicare non-covered charges.



**J. INSTRUCTIONS FOR SUBMITTING A CLAIM FOR TARGETED MEDICAL CARE**

The following Iowa Medicaid provider types bill for services on the *Claim for Targeted Medical Care* claim form:

- ◆ Case Management
- ◆ Consumer-Directed Attendant Care (CDAC)
- ◆ Waiver

The table below follows the revised *Claim for Targeted Medical Care* by field number, field name/description, whether or not that field is required, and a brief description of the information that needs to be entered in that field, and how it needs to be entered.

Use the original claim form or the downloadable version available on the IME website. Click [here](#) to view a sample of the form.

If you have any questions about this form or to order blank forms, contact Provider Services at (800) 338-7909, or locally (in the Des Moines area) at (515) 256-4609.

When submitting a paper claim to the IME, the claim form must be typed or handwritten legibly in dark blue or black ink. Mail to:

Medicaid Claims  
PO Box 150001  
Des Moines, IA 50315

Field No.	Field Name/Description	Requirements	Instructions
<b><i>Member Information</i></b>			
1	Medicaid ID Number	<b>REQUIRED</b>	Enter the member's Medicaid identification number found on the <i>Iowa Medical Assistance Eligibility Card</i> .  The identification number consists of seven digits followed by a letter ( <i>Example: 1234567A</i> ).



Field No.	Field Name/Description	Requirements	Instructions
2	Member's Name	<b>REQUIRED</b>	Enter the member's last name, first name, and middle initial.
<b><i>Provider Information</i></b>			
3	NPI Provider Number	<b>REQUIRED</b>	Enter the NPI of the provider.
4	Provider's Name	<b>REQUIRED</b>	Enter the name of the provider.
5	Provider Address	<b>REQUIRED</b>	Enter the address of the provider.
6	Zip Code	<b>REQUIRED</b>	Enter the zip code associated with the provider's address.
7	Taxonomy Code	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the NPI reported in field 3 does not begin with an "X." In this case, enter the taxonomy code associated with the provider.  If NPI starts with "X00," leave this field blank.
<b><i>Other Information</i></b>			
8	Other Health Insurance	<b>REQUIRED</b>	Indicate whether or not the member has other insurance that covers the services billed, by checking "yes" or "no."
9	Other Health Insurance Denied	<i>SITUATIONAL</i>	<b>REQUIRED</b> if the member has other insurance that has denied payment. Check "yes" if the member's other insurance has denied payment.  Check "no" if the other insurance paid for the services billed.



Field No.	Field Name/Description	Requirements	Instructions
10	Other Health Insurance Payment	<i>SITUATIONAL</i>	<b>REQUIRED</b> if a payment was made by other insurance (other than Iowa Medicaid) for the services billed.  Enter the total amount of payments paid by other insurance (if applicable). If none, leave blank.  If more than one claim form is used to bill for services and a prior payment was made by another insurance (other than Iowa Medicaid), the prior payment should be entered on each page of the claim in field 10.  <b>NOTE:</b> The total must include both dollars and cents (Example: \$150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.
11	Client Participation Amount	<i>SITUATIONAL</i>	Enter the amount that the member is contributing. If none, leave blank.  If more than one claim form is used to bill for services and the member owes member participation (CP), the CP should be entered on each page of the claim in field 11.  <b>NOTE:</b> The total must include both dollars and cents (Example: \$150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.
<b>Services</b>			
12	Procedure Code	<b>REQUIRED</b>	Enter the five-digit service code for each service being billed on the claim.
13	Modifier	<i>SITUATIONAL</i>	When applicable, enter the procedure code modifier.



Field No.	Field Name/Description	Requirements	Instructions
14	Place of Service	<b>REQUIRED</b>	Enter the two-digit place of service code of each service being billed on the claim.
15	First Date	<b>REQUIRED</b>	Enter the FIRST date that services were provided for the month being billed in MM/DD/YY format.  <b>NOTE:</b> Please wait until the month following the month that services were provided to bill the claim.  (Example: Date of service is 1/1/12-1/31/12; do not complete the claim or mail until 2/1/12.)
16	Last Date	<b>REQUIRED</b>	Enter the LAST date that services were provided for the month being billed in MM/DD/YY format.  <b>NOTE:</b> A line can only contain services that took place in a single month. If service took place in multiple months, you must list the services provided in each month on separate lines. (Example: Line 1: DOS 1/1/12-1/31/12; Line 2: DOS 2/1/12-2/29/12.)
17	Units	<b>REQUIRED</b>	Enter the total number of units being billed for each line.  <b>NOTE:</b> All units should be entered using whole numbers only (i.e., 1). Do not indicate partial units or anything after a decimal (i.e., 1.5).
18	Total Line Charge	<b>REQUIRED</b>	Enter the total charge for each line.  <b>NOTE:</b> The total must include both dollars and cents (Example: \$150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.



Field No.	Field Name/Description	Requirements	Instructions
19	Total Claim Charges	<b>REQUIRED</b>	<p>Enter the sum of the total line charges (column 18).</p> <p>If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Total Charge. The pages prior to the last page should have "continued" or "page ___ of ___" in field 19.</p> <p><b>NOTE:</b> The total must include both dollars and cents (Example: \$150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.</p>
<b>Authorized Signature(s)</b>			
	Provider Signature & Date	<b>REQUIRED</b>	The provider must sign and date the claim.
	Member/Guardian Signature & Date	<i>SITUATIONAL</i>	<p><b>REQUIRED</b> if any procedure billed is for Consumer-Directed Attended Care (CDAC). The member or member's guardian must sign and date the claim when CDAC services are billed.</p> <p><b>NOTE:</b> If the member's guardian is signing the claim, the guardian must sign their own name, and indicate that they are the guardian. A guardian should not sign the member's name.</p>

\*\* If you have any questions about this information, please contact Provider Services at (800) 338-7909; locally in the Des Moines area at (515) 256-4609.



## K. SERVICES PROVIDED TO MEDICARE BENEFICIARIES

To obtain Medicaid reimbursement for services provided to Medicare beneficiaries, observe the following special conditions:

- ◆ Always bill the Part A or Part B Medicare intermediary first for any Medicare-covered services. Use the Medicare billing form.
- ◆ Following payment of Medicare-covered services, the Medicare intermediary transfers the claim to the IME for payment of deductibles, coinsurance, and any Medicaid-covered services beyond the scope of Medicare (if there is Medicaid coverage **at that time**).
- ◆ If the member has been denied benefits through Medicare on the basis that the benefits were not medically necessary, the member is not eligible to receive these benefits under the Medicaid program for the same reason.
- ◆ Medicaid payment for Medicare deductibles and coinsurance amounts is limited to the maximum allowable charge under the Medicare program for that particular service.
- ◆ When parts of the services are covered by Medicare Part A or Part B and others are covered only by Medicaid, submit **separate** billings to the Medicare intermediary and to the IME.
- ◆ The Medicaid program pays in its usual manner for services that Medicaid covers but Medicare does not. Submit claims for these services separately to the IME on the regular Medicaid billing form.

### Medicare with Other Insurance

If a member has Medicare coverage and other insurance, bill the other sources before submitting a bill to Medicaid. If you receive a payment, but the other resource has not paid your full charge, the central Medicare contractor will send your claim to the IME.

You may submit the bill to Medicaid for consideration if the payment is not made within 60 days of the Explanation of Medicare Benefits (EOMB).

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## L. PRIOR AUTHORIZATION

When Medicaid requires an item or service to have prior authorization, providers must also submit a request for prior authorization to Medicaid before billing.

Some medical equipment items, services, and supplies are the responsibility of health maintenance organizations (HMOs). When a member is enrolled in an HMO, contact the HMO before requesting a prior authorization from IME. Prior authorization by IME does not override the fact that the item or service is the responsibility of the HMO.

### 1. Procedure for Requesting Authorization

For items requiring prior authorization, make the request on form 470-0829, *Request for Prior Authorization*. Click [here](#) to view the form online.

You may also submit this form if you are unsure whether an item meets coverage criteria. See [Instructions for Completing Request for Prior Authorization](#).

Include a practitioner's written order or prescription and sufficient medical documentation (certificate of medical necessity, manufacturer's invoice, physical therapy evaluation, etc.) to permit an independent conclusion that:

- ◆ The requirements for the equipment or device are met, and
- ◆ The item is medically necessary and reasonable.

The IME Medical Services Unit will review the request and make a determination of coverage. When a determination has been made, the form will be returned to you.

If the service is approved for coverage, you may then submit your claim for reimbursement. Place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, IME will verify that the service has been approved for payment.

**IMPORTANT:** Do not return the prior authorization form.

Remember, Medicaid is the payer of last resort. You are responsible for determining whether the member is on Medicare or has other insurance. Providers must bill Medicare and other third-party insurance before submitting claims to Medicaid.



Prior authorization is not a guarantee of payment. Approval of a request does not indicate that the member continues to be eligible for Medicaid. You are responsible for verifying Medicaid eligibility for the dates of service.

You can verify eligibility by checking the Eligibility Verification System (ELVS) hotline, which is available 24 hours a day, 7 days a week at phone (800) 338-7752, locally in Des Moines at (515) 323-9639, or by accessing the IME Provider Web Portal Services at:

<https://ime-ediss5010.noridian.com/iowaxchange5010/LogonDisplay.do>

## 2. Instructions for Completing Request for Prior Authorization

- ◆ **Patient Name.** Complete the last name, first name, and middle initial of the member. Use the *Medical Assistance Eligibility Card* for verification.
- ◆ **Patient Medicaid Identification No.** Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven digits and one letter).
- ◆ **Date of Birth.** Copy the member's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).
- ◆ **Provider Taxonomy No.** Enter the taxonomy number used in your Medicaid agreement.
- ◆ **Provider Phone No.** This area is optional. Completing it may expedite the processing of your *Request for Prior Authorization*.
- ◆ **Provider Fax.** This area is optional. Completing it may expedite the processing of your *Request for Prior Authorization*.
- ◆ **Provider NPI.** Enter the ten-digit National Provider Identifier (NPI) of the dispensing provider.
- ◆ **Dates Covered by Request.** Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM, DD, YY). If this request is approved, it will be valid only for this period.
- ◆ **Dispensing Provider Name.** Enter the name of the provider that will provide and submit claims for the services.
- ◆ **Service Location Street Address.** Enter the street address of the dispensing provider requesting prior authorization.



- ◆ **Service Location City, State, Zip.** Enter the city, state, and zip code of the dispensing provider requesting prior authorization.
- ◆ **Prior Authorization No.** Leave blank. The IME will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.
- ◆ **Reasons for Request.** Provide the required information for the type of approval being requested in this area along with the “Services to Be Authorized” area.

Refer to the coverage sections of this manual. Include all items identified as required treatment plan information. For enteral products, enter a short description of the reason for the request.

#### **Services to Be Authorized**

- ◆ **Line No.** No entry is required.
- ◆ **Procedure, Supply, Drug to be Provided or NDC if Applicable.** Enter the description of the service or services to be authorized. For enteral products, enter the product name and NDC number.
- ◆ **Code, HCPCS, CPT or CDT.** Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.
- ◆ **Units of Service.** Complete with the amount or number of times the service is to be performed. For enteral products, enter the number of cans or packets dispensed for the time span requested.
- ◆ **Authorized Units.** Leave blank. The IME will indicate the number of authorized units.
- ◆ **Amount Requested.** Enter the amount that will be charged for this line item.
- ◆ **Authorized Amount.** Leave blank. The IME will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.
- ◆ **Status.** Leave blank. The IME will indicate “A” for approved or “D” for denied.



- ◆ **IMPORTANT NOTE.** This is information to the benefit of the provider completing this form. Please read this carefully. This section explains that the prior authorization request is approved from the standpoint of medical necessity only. The provider continues to be responsible to establish the member's eligibility at the time of service. Directions are included on how to access this information.
- ◆ **Requesting Provider.** Enter the signature of the provider or authorized representative requesting prior authorization and indicate the date the request was signed.

#### **Prior Authorization Reviewer Use Only**

- ◆ **Medicaid services are hereby.** Do not complete. The IME will complete this item after evaluating the request.
- ◆ **Comments or Reasons for Denial of Services.** Do not complete. The IME will complete this section if this request is denied.
- ◆ **Signature.** Do not complete. The IME staff making the final decision on this request will sign and date.

### **3. Attachments for Electronic Requests**

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for prior authorization requests (278 transaction).

However, there is no standard to use in submitting additional documentation electronically. Therefore, if you want to submit a prior authorization request electronically, the additional documentation must be submitted on paper using the following procedure:

- ◆ **Complete** form 470-3970, *Prior Authorization Attachment Control*. Click [here](#) to view a sample of this form online.
- ◆ Complete the "attachment control number" with the same number submitted on the electronic prior authorization request. IME will accept up to 20 characters (letters or digits) in this field. If you do not know the attachment control number for the request, contact the person in your office responsible for electronic claims billing.
- ◆ **Staple** the additional information to the *Prior Authorization Attachment Control*.

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**Fax** the form with attachments to the Prior Authorization Unit at (800) 574-2515, **or mail** the information to:

IME Medical Services Unit  
 PO Box 36478  
 Des Moines, IA 50319

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

### M. PROVIDER INQUIRY

The *Provider Inquiry*, form 470-3744, should be submitted along with an original claim form and supporting documentation to initiate an investigation into a claim denial, or to request review by the IME Medical Services unit. Click [here](#) to view the form online. The *Provider Inquiry* will be responded to in writing.

A *Provider Inquiry* is not appropriate in the following situations:

- ◆ To add documentation to a denied claim. In this situation the claim may be resubmitted through the regular claim submission process with the added documentation for review.
- ◆ To update, change, or correct a paid claim. In this situation, the claim needs to be adjusted or recouped using either the *Adjustment Request*, form 470-0040, or the *Recoupment Request*, form 470-4987.

For instructions on completing these forms, please refer to [ADJUSTMENT AND RECOUPMENT REQUESTS](#).

Attach an original claim form and any supporting documentation you want to have considered, such as additional medical records.

Send these forms to:

IME Provider Services Unit  
 PO Box 36450  
 Des Moines, IA 50315



## N. ADJUSTMENT AND RECOUPMENT REQUESTS

Adjustment or recoupment requests may be submitted to correct a claim following receipt of the *Remittance Advice*.

Use the *Adjustment Request*, form 470-0040, to notify the IME to take an action against a paid claim when a paid claim amount needs to be changed. Click [here](#) to view a sample of the *Adjustment Request* online.

Use the *Recoupment Request*, form 470-4987, to notify the IME to take an action against a paid claim when money needs to be credited back. Click [here](#) to view a sample of the *Recoupment Request* online.

**NOTE:** Do not use the *Adjustment Request* when a claim has been denied. Denied claims must be resubmitted.

### 1. Electronic Adjustment or Recoupment Requests

The IME is able to fully process adjustment and recoupment requests that are submitted electronically (via HIPAA 837 transaction).

#### a. For Direct Medicaid Submissions

An **adjustment** is a request for Medicaid to make a change to a previously paid claim. When submitting an **adjustment**, providers must enter the REF01 value "**F8**" in the 2300 REF segment with the Payer Claim Internal Control Number. The Payer Claim Internal Control Number is the 17-digit Medicaid TCN number of the claim that needs adjusted.

The frequency code of "**7**" must be entered in the 2300 Loop CLM Segment. *It is important to include all charges that need to be processed, not just the line that needs to be corrected. If previously paid lines are **not** submitted on the adjustment request, they will be recouped from the original request but not repaid on the adjustment, likely resulting in an unintentional credit balance.*



A **recoupment** is a request for Medicaid to take back the entire, original claim payment. When submitting a **recoupment**, providers must enter the REF01 value “**F8**” in the 2300 REF segment with the Payer Claim Internal Control Number. The Payer Claim Internal Control Number is the 17-digit Medicaid TCN number of the claim that needs to be recouped.

The frequency code of “**8**” must be entered in the 2300 Loop CLM Segment.

#### **b. For Medicare Crossover Claims**

When Medicare processes adjustment requests from providers, the *adjustment* from the Coordination of Benefits Contractor (COBC) will *now* be accepted by the IME and processed accordingly just as the *original claim submissions* to Medicare have been forwarded in the past. Providers will no longer need to submit the adjustments on the paper adjustment or recoupment forms if the original claim was received from the COBC and settled by Medicaid and the related adjustment is sent by Medicare through the COBC.

Denied claims must be resubmitted in the normal claim submission process. Denied claims cannot be adjusted or recouped.

### **2. Paper Adjustment or Recoupment Requests**

To request a paper adjustment or recoupment request use the *Adjustment Request*, form 470-0040, or the *Recoupment Request*, form 470-4987. See [ADJUSTMENT AND RECOUPMENT REQUESTS](#) for instructions.

### **3. Requesting an Adjustment on Paper**

Request an adjustment to a paid claim, if you need to make a correction to the original submission. This will result in a corrected claim payment. *For example*, if a claim was originally billed with one unit of service and should have been billed as two units, an *Adjustment Request*, form 470-0040, should be submitted with a corrected claim or corrected remittance advice attached.



Send form 470-0040 and required attachments to:

IME Provider Services Unit  
PO Box 36450  
Des Moines, IA 50315

**NOTE:** Requests for adjustments on paid claims will not be processed if more than 365 days have elapsed between the date of payment of the claim in question and the date the IME receives the request for adjustment.

#### 4. Requesting a Recoupment on Paper

Request a credit, by completing and attaching the *Recoupment Request*, form 470-4987, to a paid claim if the entire claim was billed in error. This will result in the entire claim being recouped. For example, if the incorrect member identification number was submitted on the claim resulting in a payment for the incorrect member.

Send form 470-4987 and required attachments to:

IME Provider Services Unit  
PO Box 36450  
Des Moines, IA 50315

## O. REMITTANCE ADVICE INSTRUCTIONS

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.

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 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.

Claim-type specific remittance advice guides provided in this manual are listed below:

- ◆ [UB-04 \(Inpatient\)](#)
- ◆ [UB-04 \(Outpatient\)](#)
- ◆ [CMS-1500](#)
- ◆ [Dental](#)
- ◆ [Long-Term Care](#)
- ◆ [Medicare Crossover \(Inpatient\)](#)
- ◆ [Medicare Crossover \(Outpatient\)](#)
- ◆ [Medicare Part B Crossover](#)
- ◆ [Pharmacy](#)
- ◆ [Waiver Provider](#)
- ◆ [Capitation and Administrative Fees](#)



## 1. UB-04 (Inpatient) Remittance Advice Guide

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [UB-04 \(Inpatient\) Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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



Field	Field Name	Field Description
Q	Number of Claims	Total number of claims within same claim type or status
R	Billed Amt.	Total billed amount of all claims within same claim type or status
S	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Non Cov Charges	Total non-covered charges within same claim type or status

1	Member Name	Name of the member as shown on the Medicaid identification card
2	Recipient ID Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Covered Period (From To)	First to last date of service on claim
5	DRG Code	Diagnosis-related group code (inpatient hospital claims ONLY)
6	Cover Days	Number of covered days billed on claim
7	Billed Amt.	Total billed amount on claim
8	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
9	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
10	Non Cov Charges	Amount of non-covered charges on claim
11	Medical Record Num	Medical record number or patient account number
12	Subm/Reimb Diff	Difference between the amount billed and amount paid



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Date

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**b. UB-04 (Inpatient) Remittance Advice Sample**

R.A. NO.: 00000000

A

WARRANT NUMBER: 00000000

B

PROVIDER NAME  
PROVIDER ADDRESS  
PO BOX XXX  
ANYTOWN IA 00000-0000

C

D

----- NEWSLETTER UPDATE -----

E  
\*\*\*\*\* IMPORTANT INFO INFORMATION \*\*\*\*\*  
IMPORTANT INFORMATION AND REMINDERS FROM IHE WILL BE POSTED IN THIS SECTION  
OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES  
MOINES AREA AT 515-256-4609. E-MAIL: IMPROVIDERSERVICES@DES.STATE.IA.US



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Date

May 1, 2014

IAMC8000-R001 (CP-O-12)  
AS OF XX/XX/XX

C

TO: PROVIDER NAME [ ] R.A. NO.: [00000000] A

WARR NO.: [00000000] B DATE PAID: [XX/XX/XX] G

PROV. NUMBER: [ ] H

PAGE: 1 I

RUN DATE [XX/XX/XX] F

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
R E M I T T A N C E A D V I C E

\*PATIENT NAME\* RECIPIENT TRANS-CONTROL-NUMBER COVERED PERIOD DRG COVER BILLED OTHER PAID BY NON COV  
LAST FIRST M ID NDM FROM TO CODE DAYS AMT. SOURCES MOAID CHARGES EOB EOB

\*\*\* CLAIM TYPE: INPATIENT

\*\*\* CLAIM STATUS: PAID

ORIGINAL CLAIMS: 2 3 4 5 6 7 8 9 10

DOE J [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

MEDICAL RECORD NDM: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

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MEDICAL RECORD NDM: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

2 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS... R S T X



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Date

October 1, 2013

TO: PROVIDER NAME **C** R.A. NO.: 000000000 **A** WARR. NO.: 00000000 **B** DATE PAID: MM/DD/YY **G** PROV. NUMBER: 00000000000 **H** PAGE: **I**

REMITTANCE TOTALS  
 PAID ORIGINAL CLAIMS: 0 NUMBER OF CLAIMS 0,000.00 **K**  
 PAID ADJUSTMENT CLAIMS: 0 NUMBER OF CLAIMS 0.00 **L**  
 DENIED ORIGINAL CLAIMS: 0 NUMBER OF CLAIMS 0.00  
 DENIED ADJUSTMENT CLAIMS: 0 NUMBER OF CLAIMS 0.00  
 PENDING CLAIMS (IN PROCESS): 0 NUMBER OF CLAIMS 0.00  
 AMOUNT OF EFT DEPOSIT: 0,000.00 **M**

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

**N** 000 EXPLANATION (EOB) OF DENIAL CODE **O** **P** 1



## 2. UB-04 (Outpatient) Remittance Advice Guide

This section covers the following material:

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Allowed Charge Source Codes](#)
- ◆ [UB-04 \(Outpatient\) Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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



Field	Field Name	Field Description
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 "other sources" on claim (for example: TPL, spenddown)
T	Total Non Cov Charges	Total non-covered charges within same claim type or status
U	Total Allowed Charge	Total dollar amount allowed by Medicaid within same claim type or status
X	Total Paid by Mcaid	Total dollar amount paid within same claim type or status

1	Member Name	Name of the member as shown on the Medicaid identification card (last name and first initial)
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	Non Cov Charges	Total non-covered charges on claim
7	Allowed Charge	Allowed charge for claim
8	Paid by Mcaid	Dollar amount paid by Medicaid for claim
9	Medical Rec. No.	Medical record number assigned by provider
10	EOB	Explanation of Benefits denial code for claim



Field	Field Name	Field Description
11	Line	Line number on claim
12	Svc-Date	Date of service as billed on claim
13	Proc	CPT or HCPCS code billed on claim
14	APG/APC	APC code that line item is grouping to
15	Units	Number of units billed for each line item on claim
16	Billed Amt.	Billed amount for each line item on claim
17	Other Sources	Other sources for each line item on claim (for example: TPL)
18	Non Cov Charges	Non-covered charges for each line item on claim
19	Allowed Charge	Allowed charges for each line item billed on claim
20	APC-ST/DIS/PK/Weight	APC status indicator, discount formula, packaging flag, and weight.
21	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
22	EOB	Explanation of Benefits denial reason code for each line



**b. Allowed Charge Source Codes**

Source Code	Description
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 fee
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

Source Code	Description
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



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Date

October 1, 2013

**c. UB-04 (Outpatient) Remittance Advice Sample**

R.A. NO.: 00000000

A

WARRANT NUMBER: 00000000

B

PROVIDER NAME  
PROVIDER ADDRESS  
PO BOX XXX  
ANYTOWN IA 00000-0000

C

D

----- NEWSLETTER UPDATE -----

E

\*\*\*\*\*IMPORTANT IPE INFORMATION\*\*\*\*\*  
IMPORTANT INFORMATION AND REMINDERS FROM IPE WILL BE POSTED IN THIS SECTION  
OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES  
MOINES AREA AT 515-256-4609. E-MAIL: IMPROVIDERSERVICES@DES.STATE.IA.US



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Date

May 1, 2014

IAMC8000-R001 (CP-0-12)  
AS OF 07/12/10

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 07/09/10

TO: PROVIDER NAME

R.A. NO.:

TIN:

WAR NO.:

DTE PD:

07/12/10

PROV:

PAYD BY

PAGE: 1

000 000

\*\*\*\*\* PATIENT NAME \*\*\*\*\*  
LINE SVC-DATE PROC AFG/APC UNITS

BILLED AMT.

OTHER SOURCES

NON COV CHARGES

ALLOWED CHARGE

PAID BY MCAID

MEDICAL REC. NO.

S EOB EOB

\*\*\* CLAIM TYPE: OUTPATIENT

\*\*\* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

MED AFG: FROM 06/10/10 TO 06/10/10 MED EDUC ADD:

01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10
80053	82055	84484	85025	85610	70450	71275	86374	86376	99284	12060	09967	93005	93005	99285	93010						
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1						
44.50	115.50	116.50	32.00	26.00	498.00	1024.00	216.00	71.75	900.00	85.40	85.00	185.00	609.00	35.50							
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00							
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00							
14.67	14.99	13.65	10.78	4.85	623.40	0.00	0.00	20.19	221.37	0.00	0.00	26.34	327.06	0.00							
A	A	A	A	A	S	N	A	V	N	N	N	S	V	B							
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1							
0.00000	0.00000	0.00000	0.00000	0.00000	9.32400	0.00000	0.55550	0.00000	3.31090	0.00000	0.00000	0.39400	4.89170	0.00000							
F	F	F	F	F	O	K	F	F	O	O	O	O	O	O							
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							

1 CLAIMS-THIS CLAIM TYPE/CLAIM STATUS. TOTALS..



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Date  
October 1, 2013

TO: **C** PROVIDER NAME: [REDACTED] R.A. NO.: **A** 000000000 WARR. NO.: **B** 00000000 DATE PAID: **G** MM/DD/YY PROV. NUMBER: **H** 000000000000 PAGE: **I** 2

REMITTANCE TOTALS  
 PAID ORIGINAL CLAIMS: 0  
 PAID ADJUSTMENT CLAIMS: 0  
 DENIED ORIGINAL CLAIMS: 0  
 DENIED ADJUSTMENT CLAIMS: 0  
 PENDING CLAIMS (IN PROCESS): 0  
 AMOUNT OF EFT DEPOSIT: 0

NUMBER OF CLAIMS: **J** 0  
 NUMBER OF CLAIMS: 0  
 NUMBER OF CLAIMS: 0  
 NUMBER OF CLAIMS: 0  
 NUMBER OF CLAIMS: 0

DATE PAID: **K** 0,000.00  
 0.00  
 0.00  
 0.00  
 0.00

PROV. NUMBER: **L** 0,000.00  
 0.00  
 0.00  
 0.00  
 0.00

AMOUNT OF EFT DEPOSIT: **M** 0,000.00

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

**N** 000 EXPLANATION (EOB) OF DENIAL CODE **O** [REDACTED] **P** 1



### 3. CMS-1500 Remittance Advice Guide

This section covers the following material:

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Allowed Charge Source Codes](#)
- ◆ [CMS-1500 Remittance Advice Sample](#)

#### a. Remittance Advice Field Descriptions

Field	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



Field	Field Name	Field Description
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status

1	Member Name	Last, first name or initial of the member as shown on the Medicaid identification 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 copayment on claim
8	Med Rcd Num	Medical record number or member 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.)



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Date

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Field	Field Name	Field Description
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
18	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
19	EOB	Explanation of Benefits denial reason code



**b. Allowed Charge Source Codes**

Source Code	Description
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 fee
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

Source Code	Description
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



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**c. CMS-1500 Remittance Advice Sample**

R.A. NO. : 00000000 **A**

WARRANT NUMBER: 00000000 **B**

**C**  
PROVIDER NAME  
PROVIDER ADDRESS  
PO BOX XXX  
ANYTOWN IA 00000-0000  
**D**

----- NEWSLETTER UPDATE -----

**E**  
\*\*\*\*\*IMPORTANT IHE INFORMATION\*\*\*\*\*  
IMPORTANT INFORMATION AND REMINDERS FROM IHE WILL BE POSTED IN THIS SECTION  
OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-388-7909 OR IN THE DES  
MOINES AREA AT 515-256-4609. E-MAIL: IHEPROVIDERSERVICES@DHS.STATE.IA.US



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Date

May 1, 2014

IAN000-R001 (CP-0-12) IOWA DEPARTMENT OF HUMAN SERVICES  
 AS OF XX/XX/XX MEDICAID MANAGEMENT INFORMATION SYSTEM  
 R E N T I A N C E A D V I S E  
 RUN DATE XX/XX/XX **P**

TO: PROVIDER NAME **C** R.A. NO.: 0000000 **A** MAPD NO.: 0000000 **B** DATE PAID: XX/XX/XX **C** PROV. NUMBER: **H** PAGE: 1 **I**  
 \*\*\*\* PATIENT NAME \*\*\*\* RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY  
 LAST FIRST MI LINE SVC-DATE PROC/NOBS UNITS AMT. SOURCES MEDID  
 \*\*\* CLAIM TYPE: HCFM 1500 \*\*\* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9
ERRR	LAST	0-00000-00-000-0000-00	100.00	0.00	55.00	3.00		000 000
		01 XX/XX/XX	00.00		0.00	0.00		000 000
		02 XX/XX/XX	70.00		50.00	0.00		000 000
		03 XX/XX/XX	30.00		15.00	3.00		000 000
		11 XX/XX/XX						
		12 XX/XX/XX						
		13						
		14						
		15						
		16						
		17						
		18						
		19						

**Q** 01 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS.:  
**R** 100.00 **S** 0.00 **T** 55.00 **X** 3.00



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Date

October 1, 2013

TO: PROVIDER NAME DDS **C** R.A. NO.: 00000000 **A** WARR. NO.: 00000000 **B** DATE PAID: MM/DD/YY **G** PROV. NUMBER: 0000000000 **H** PAGE: **I**

REMITTANCE TOTALS

	NUMBER OF CLAIMS	AMOUNT
PAID ORIGINAL CLAIMS:	0	0,000.00 <b>J</b>
PAID ADJUSTMENT CLAIMS:	0	0.00 <b>K</b>
DENIED ORIGINAL CLAIMS:	0	0.00 <b>L</b>
DENIED ADJUSTMENT CLAIMS:	0	0.00 <b>M</b>
PENDED CLAIMS (IN PROCESS):	0	0.00
AMOUNT OF EFT DEPOSIT:	0	0,000.00

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

COUNT:

**N** 000 EXPLANATION (EOB) OF DENIAL CODE **O** **1** **P**



#### 4. Dental Remittance Advice Guide

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Allowed Charge Source Codes](#)
- ◆ [Dental Claim Remittance Advice Sample](#)

##### a. Remittance Advice Field Descriptions

Field	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



Field	Field Name	Field Description
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount

1	Member Name	Last, first name or initial of the member as shown on the Medicaid identification 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
7	Copay Amt.	Total copayment on claim
8	Med Rcd Num	Member account number assigned by the provider
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	Line number
11	Svc-Date	Date of service
12	Proc/Mods	ADA or CPT code and modifier billed



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Field	Field Name	Field Description
13	Units	Number of units billed
14	Billed Amt.	Billed amount for line item
15	Paid by Mcaid	Amount paid by Iowa Medicaid on line
16	Copay Amt.	Copayment amount applied to line item
17	Perf. Prov.	Treating provider number billed
18	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
19	EOB	Explanation of Benefits denial reason code for line item (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



**b. Allowed Charge Source Codes**

Source Code	Description
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 fee
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

Source Code	Description
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



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**c. Dental Claim Remittance Advice Sample**

R.A. NO. : 00000000

A

WARRANT NUMBER: 00000000

B

PROVIDER NAME  
PROVIDER ADDRESS  
PO BOX XXX  
ANYTOWN IA 00000-0000

C

D

----- NEWSLETTER UPDATE -----

\*\*\*\*\*IMPORTANT IVE INFORMATION\*\*\*\*\*

IMPORTANT INFORMATION AND REMINDERS FROM IVE WILL BE POSTED IN THIS SECTION  
OF THE REMITTANCE ADVICE.

E

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-388-7909 OR IN THE DES  
MOINES AREA AT 515-256-4609. E-MAIL: IVEPROVIDERSERVICES@IHS.STATE.IA.US



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Date

May 1, 2014

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE

TO: DENTAL PROVIDER NAME  R.A. NO.:  A WARR NO.:  B DATE PAID:  G PROV. NUMBER:  H PACE:  I

\*\*\* PATIENT NAME \*\*\* RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /  
LAST FIRST MI LINE SVC-DATE PROC/MODS UNITS AMT. SOURCES MCALID WCAID PERM. PROV. S EOB EOB

\*\*\* CLAIM TYPE: DENIAL

\*\*\* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9
<input type="text" value="01"/>	<input type="text" value="02"/>	<input type="text" value="XX/XX/XX"/>	<input type="text" value="D00000"/>	<input type="text" value="1"/>	<input type="text" value="50.00"/>	<input type="text" value="30.00"/>	<input type="text" value="0.00"/>	<input type="text" value="1111111111"/>
<input type="text" value="10"/>	<input type="text" value="11"/>	<input type="text" value="XX/XX/XX"/>	<input type="text" value="D00000"/>	<input type="text" value="1"/>	<input type="text" value="50.00"/>	<input type="text" value="30.00"/>	<input type="text" value="0.00"/>	<input type="text" value="1111111111"/>
<input type="text" value="13"/>	<input type="text" value="14"/>	<input type="text" value="1"/>	<input type="text" value="100.00"/>	<input type="text" value="0.00"/>	<input type="text" value="60.00"/>	<input type="text" value="0.00"/>	<input type="text" value="1111111111"/>	<input type="text" value="R 521 940"/>
<input type="text" value="18"/>	<input type="text" value="19"/>	<input type="text" value="1"/>	<input type="text" value="100.00"/>	<input type="text" value="0.00"/>	<input type="text" value="60.00"/>	<input type="text" value="0.00"/>	<input type="text" value="1111111111"/>	<input type="text" value="F 000 000"/>

CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..



TO: DENTAL PROVIDER NAME DDS **C** R.A. NO.: 000000000 **A** MARR NO.: 00000000 **B** DATE PAID: MM/DD/YY **G** PROV. NUMBER: 0000000000 **H** PAGE: **I**  
**2**

REMITTANCE TOTALS  
 PAID ORIGINAL CLAIMS: 1  
 PAID ADJUSTMENT CLAIMS: 0  
 DENIED ORIGINAL CLAIMS: 0  
 DENIED ADJUSTMENT CLAIMS: 0  
 PENDING CLAIMS (IN PROCESS): 0  
 AMOUNT OF EFT DEPOSIT: 0

NUMBER OF CLAIMS: 1  
 NUMBER OF CLAIMS: 0  
 NUMBER OF CLAIMS: 0  
 NUMBER OF CLAIMS: 0  
 NUMBER OF CLAIMS: 0

60.00 **K** 60.00 **L**  
 0.00 0.00  
 0.00 0.00  
 0.00 0.00  
 0.00 0.00  
 0.00 0.00 **M**

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

EOB CODE	EXPLANATION (EOB) OF DENIAL CODE	COUNT
000	EXPLANATION (EOB) OF DENIAL CODE	1
921	THE ITEM/SERVICE BILLED IS NOT A MEDICAID BENEFIT.	1
940	THE BILLING INSTRUCTIONS ON THE DHS EXCEPTION LETTER WERE NOT FOLLOWED.	1

**N**

**O**

**P**



## 5. Long-Term Care Remittance Advice Guide

This section covers the following material:

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Long-Term Care Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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



Field	Field Name	Field Description
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status

1	Member Name	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Svc Date	Date of service
5	Covd Days	Number of days billed
6	Hosp Days	Number of hospital leave days billed
7	Ncov Days	Number of non-covered days billed
8	Visit Days	Number of leave days billed
9	Billed Amt.	Total amount billed to Iowa Medicaid
10	Other Sources	Third-party insurance payment or spenddown amount applied
11	Paid by Mcaid	Total amount paid by Medicaid
12	EOB	Explanation of Benefits (EOB) code, if denied. A description of the code can be found on the summary page of the <i>Remittance Advice</i> (field O).



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Date

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Field	Field Name	Field Description
13	Previous-Date-Paid	Claim was previously paid on the given <i>Remittance Advice</i> date
14	Conflicting-TCN	TCN of previously paid claim
15	Claim Credit	Claim being credited or recouped
16	Claim Adjustment	Claim being adjusted or reprocessed
17	Net	Difference paid or recouped from claim credit or adjustment
18	ADJ-R	Reason code indicating the reason for the adjustment
19	TCN-to-Credit	17-digit TCN number of the claim being credited or recouped



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Date

October 1, 2013

**b. Long-Term Care Remittance Advice Sample**

R.A. NO.: 00000000

A

WARRANT NUMBER: 00000000

B

PROVIDER NAME  
PROVIDER ADDRESS  
PO BOX XXX  
ANYTOWN IA 00000-0000

C

D

----- NEWSLETTER UPDATE -----

\*\*\*\*\*IMPORTANT IHE INFORMATION\*\*\*\*\*

IMPORTANT INFORMATION AND REMINDERS FROM IHE WILL BE POSTED IN THIS SECTION  
OF THE REMITTANCE ADVICE.

E

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES  
MOINES AREA AT 515-256-4609. E-MAIL: IHEPROVIDERSERVICES@DHS.STATE.IA.US



RUN DATE: MM/DD/YY F

TO: PROVIDER NAME C R.A. NO.: A MAOR NO.: B DATE PAID: G ENOV. NUMBER: H PAGE: I

\*\*\* PATIENT NAME \*\*\* RECEIPT FIRST LAST COVID MOSP NCOV VISIT BILLED OTHER PAID BY

LAST FI MI IDENT NUM TRANS-CONTROL-NUMBER SVC DATE SVC DATE DAYS DAYS DAYS AMT. SOURCES WCALD EOB EOB

\* \* \* CLAIM TYPE: LONG TERM CASE \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1 2 3 4 5 6 7 8 9 10 11 12

00000008 0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 31 0 0 0 0000.00 0.00 0.00

PREVIOUS-DATE-PAID: MM/DD/YY 13

CONFLICTING-ICN: 14

ADJUSTMENT CLAIMS:

0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 28 0 0 0 0000.00- 0000.00- 0000.00- 15

0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 28 0 0 0 0000.00 00.00 0000.00 16

ADD-R: 94 ICN-TO-CREDIT: 19

4 CLAIMS = THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS... R S T

0 0000.00 0000.00 0000.00 17



Iowa  
Department  
of Human  
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Date

October 1, 2013

TO: PROVIDER NAME **C** R.A. NO.: 00000000 **A** MARK NO.: 00000000 **B** DATE PAID: MM/DD/YY **G** PROV. NUMBER: 000000000000 **H** PAGE: **I**

REMITTANCE T O T A L S

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	0,000.00	0,000.00
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 EFT DEPOSIT:	NUMBER OF CLAIMS	0	0.00	0,000.00

**J** **K** **L** **M**

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

COUNT:

**N** 000 EXPLANATION (EOB) OF DENIAL CODE **O** **P** 1



## 6. Medicare Crossover (Inpatient) Remittance Advice Guide

This section covers the following material:

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Medicare Crossover \(Inpatient\) Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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



Field	Field Name	Field Description
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	Medicare Paid Amt	Total dollar amount of Medicare payment
S	Deductible	Total deductible paid amount within same claim type or status
T	Coins. Amt.	Total coinsurance paid amount within same claim type or status
U	TIN	Total dollar amount allowed by Medicaid within same claim type or status
X	Mcaid Paid Amt	Total amount Medicaid paid within same claim type or status

1	Member Nme	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dates of Service (first and last)	First and last date of service
5	Medicare Paid Amt	Total paid by Medicare on claim
6	Deductible	Total Medicare deductible on claim
7	Coins. Amt.	Total Medicare coinsurance on claim
8	Mcaid Paid Amt	Total amount paid by Medicaid on claim
9	Medical Record No.	Medical record number or member account number
10	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.)



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Date

October 1, 2013

b. Medicare Crossover (Inpatient) Remittance Advice Sample

R.A. NO. : 00000000

A

WARRANT NUMBER: 0000000

B

PROVIDER NAME  
PROVIDER ADDRESS  
PO BOX XXX ANYTOWN IA 00000-0000

C

D

----- NEWSLETTER UPDATE -----

\*\*\*\*\* IMPORTANT IVE INFORMATION\*\*\*\*\*

IMPORTANT INFORMATION AND REMINDERS FROM IVE WILL BE POSTED IN THIS SECTION OF THE REMITTANCE ADVICE.

E

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-256-4609. E-MAIL: IVEPROVIDERSERVICES@DHS.STATE.IA.US



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Date

May 1, 2014

IAMC8000-R001 (CP-0-12)  
AS OF 07/12/10

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 07/09/10

TO: PROVIDER NAME [C] R.A. NO.: [A] 00000006 TIN: [U] XXXXXXXXXX MAR NO: [B] 999999991 DTE PD: [G] 07/12/10 FROM: [H] PAGE: [I] 1

PATIENT NAME = [C] RECIPIENT TRANS-CONTROL-NUMBER FIRST LAST PAID AMT IBLE AMT. PAID AMT MEDICAL RECORD NO. E08 E08  
LAST FI MI IDENT NUM \* \* \* CLAIM TYPE: INPATIENT CROSSOVER \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS: [1] [2] [X-XXXXX-XX-XXX-XIXX-XX] [3] [06/09/10 06/11/10] [4] [4265.43] [5] [1100.00] [6] [0.00] [7] [1100.00] [8] [ ] [9] [000] [10]

[Q] CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS... [R] 4265.43 [S] 1100.00 [T] 0.00 [X] 1100.00



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of Human  
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Date

October 1, 2013

TO: **C** PROVIDER NAME **A** R.A. NO.: 000000000 **B** MARR NO.: 00000000 **J** DATE PAID: MM/DD/YY **G** PROV. NUMBER: 00000000000 **H** PAGE: **I** 2

REMITTANCE T O T A L S

	NUMBER OF CLAIMS	AMOUNT
PAID ORIGINAL CLAIMS:	0	0,000.00
PAID ADJUSTMENT CLAIMS:	0	0.00
DENIED ORIGINAL CLAIMS:	0	0.00
DENIED ADJUSTMENT CLAIMS:	0	0.00
PENDED CLAIMS (IN PROCESS):	0	0.00
AMOUNT OF EFT DEPOSIT:	0	0,000.00

**M**

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

COUNT:

**N** 000 **O** EXPLANATION (EOB) OF DENIAL CODE **P** 1



## 7. Medicare Crossover (Outpatient) Remittance Advice Guide

This section covers the following material:

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Medicare Crossover \(Outpatient\) Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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



Field	Field Name	Field Description
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	Medicare Paid Amt	Total dollar amount of Medicare payment
S	Deductible	Total deductible paid amount within same claim type or status
T	Coins. Amt.	Total coinsurance paid amount within same claim type or status
X	Mcaid Paid Amt	Total amount Medicaid paid within same claim type or status

1	Member Name	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dates of Service (first and last)	First and last date of service
5	Medicare Paid Amt	Total paid by Medicare on claim
6	Deductible	Total Medicare deductible on claim
7	Coins. Amt.	Total Medicare coinsurance on claim
8	Mcaid Paid Amt	Total amount paid by Medicaid on claim
9	Medical Record No.	Medical record number or member account number
10	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.)



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b. Medicare Crossover (Outpatient) Remittance Advice Sample

R.A. NO. : 00000000

A

TRAPRANT NUMBER: 0000000

B

PROVIDER NAME  
PROVIDER ADDRESS  
PO BOX XXX  
ANYTOWN IA 00000-0000

C

D

----- NEWSLETTER UPDATE -----

E

\*\*\*\*\*IMPORTANT IWE INFORMATION\*\*\*\*\*  
IMPORTANT INFORMATION AND REMINDERS FROM IWE WILL BE POSTED IN THIS SECTION OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-256-4609. E-MAIL: IWEPROVIDERSERVICES@DHS.STATE.IA.US



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Date

May 1, 2014

IAW0000-R001 (CP-0-12) IOWA DEPARTMENT OF HUMAN SERVICES  
 AS OF XX/XX/XX MEDICAID MANAGEMENT INFORMATION SYSTEM  
 R E T A N C E A D V I C E

NO: PROVIDER NAME C R.A. NO.: A MADE NO.: B DATE PAID: XX/XX/XX G PROV. NUMBER: H PAGE: I

\* PATIENT NAME \* RECIPIENT \* DATES OF SERVICE MEDICARE DEDUCT- \* COINS. \* MONTH \* MEDICAL  
 LAST FI MI IDENT NUM TRANS-CONTROL-NUMBER FIRST LAST PAID AMT ISLE TISE AMT. PAID AMT RECORD NO. EOB EOB

\* \* \* CLAIM TYPE: OUTPATIENT CROSSOVER \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS: 2 3 4 5 6 7 8 9 10  
 9-00000-00-000-0000-01 XX/XX/XX XX/XX/XX 2000.00 250.00 25.00 275.00 XXXXXXXXXXXXX

Q 2 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS... R 3000.00 S 250.00 T 75.00 X 325.00





## 8. Medicare Part B Crossover Remittance Advice Guide

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Allowed Charge Source Codes](#)
- ◆ [Medicare Part B Crossover Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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



Field	Field Name	Field Description
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
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	Member	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member 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 member account number



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Field	Field Name	Field Description
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
21	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
22	EOB	Explanation of Benefits denial reason code (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



**b. Allowed Charge Source Codes**

Source Code	Description
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 fee
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

Source Code	Description
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



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Date

October 1, 2013

c. Medicare Part B Crossover Remittance Advice Sample

R.A. NO. : 00000000

A

WARRANT NUMBER: 00000000

B

PROVIDER NAME  
PROVIDER ADDRESS  
PO BOX XXX  
ANYTOWN IA 00000-0000

C

D

----- NEWSLETTER UPDATE -----

\*\*\*\*\*IMPORTANT IVE INFORMATION\*\*\*\*\*

IMPORTANT INFORMATION AND REMINDERS FROM IVE WILL BE POSTED IN THIS SECTION OF THE REMITTANCE ADVICE.

E

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-256-4609. E-MAIL: IMPROVIDERSERVICES@DHS.STATE.IA.US



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Date

May 1, 2014

IAMC8000-R001 (CP-O-12)  
AS OF XX/XX/XX

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE  **F**

TO: PROVIDER NAME  R.A. NO.:  **A** MAR. NO.:  **B** DATE PAID:  **G** PROV. NUMBER:  PAGE:  **I**

\* PATIENT \* RECIPIENT TRANS-CONTROL-NUMBER / NAME MCARE DEDUCT- COINS. MCALD MED RCD NUM /  
LAST IDENT NUM LINE SVC-DATE PROC MODS UNITS PAID AMT APRRD ISBE AMT. COPAY PAID AMT PERP-PROV. \$ EOB EOB

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
<input type="text" value="01"/>	<input type="text" value="XX/XX/XX"/>	<input type="text" value="99999"/>	<input type="text" value="1"/>	<input type="text" value="4.00"/>	<input type="text" value="30.00"/>	<input type="text" value="15.00"/>	<input type="text" value="0.00"/>	<input type="text" value="1.00"/>	<input type="text" value="15.00"/>	<input type="text" value="15.00"/>	<input type="text" value="X"/>										

**Q** CLAIMS - THIS CLAIM TYPE / CLAIM STATUS. TOTAL  **R**  **S**  **T**  **U**  **V**  **X**



Iowa  
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of Human  
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Date

October 1, 2013

TO: PROVIDER NAME **C** R.A. NO.: **A** 00000000 MARK NO.: **B** 00000000 DATE PAID: **G** MM/DD/YY PROV. NUMBER: **H** 0000000000 PAGE: **I** 2

REMITTANCE T O T A L S  
 PAID ORIGINAL CLAIMS: NUMBER OF CLAIMS 0  
 PAID ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0  
 DENIED ORIGINAL CLAIMS: NUMBER OF CLAIMS 0  
 DENIED ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0  
 PENDING CLAIMS (IN PROCESS): NUMBER OF CLAIMS 0  
 AMOUNT OF EFT DEPOSIT: 0.00

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

COUNT:

**N** 000 EXPLANATION (EOB) OF DENIAL CODE **O** **P** 1



## 9. Pharmacy Remittance Advice Guide

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Allowed Charge Source Codes](#)
- ◆ [Pharmacy Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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	Total number of claims within same claim type or status



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

1	Member Name	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dispense Date	Date of service
5	National Drug Code	11-digit NDC number
6	Sub Units	Number of units billed
7	Rx No.	Prescription number
8	Billed Amt.	Total amount billed to Medicaid
9	Other Sources	Third party insurance payment or spenddown amount applied
10	Paid by Mcaid	Total amount paid by Medicaid
11	Copay Amt.	Member's copay amount (applied per date of service, when applicable)
12	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
13	EOB	Explanation of Benefits (EOB) code, if denied. A description of the code can be found on the summary page of the <i>Remittance Advice</i> (field O).
14	Practitioner	Name of prescribing provider
15	Drug Name	Name and dosage of drug dispensed
16	Adj-R	Reason code indicating the reason for the adjustment
17	TCN-to-Credit	17-digit TCN number of the claim being credited



**b. Allowed Charge Source Codes**

Source Code	Description
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 fee
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

Source Code	Description
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



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Date

October 1, 2013

### c. Pharmacy Remittance Advice Sample

R.A. NO. : 00000000

A

WARRANT NUMBER: 00000000

B

PROVIDER NAME	D
PROVIDER ADDRESS	
PO BOX XXX	
ANYTOWN IA 00000-0000	

C

----- NEWSLETTER UPDATE -----

\*\*\*\*\* IMPORTANT IHE INFORMATION \*\*\*\*\*

IMPORTANT INFORMATION AND REMINDERS FROM IHE WILL BE POSTED IN THIS SECTION OF THE REMITTANCE ADVICE.

E

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-256-4609. E-MAIL: IHEPROVIDERSERVICES@DHS.STATE.IA.US



Iowa  
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Date

May 1, 2014

IRANCS000-R001 (CE-0-12)  
HS OF XX/XX/XX

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
R E M I T T A N C E A D V I C E

RUN DATE XX/XX/XX

TO: PHARMACY NAME **C** R.A. NO.: **A** MARF. NO.: **B** INTR. PAID: **G** PRCV. NUMBER: **H** PAGE: **I**

PATIENT NAME RECEIPT TRANS-CONTROL-NUMBER DISENSE NATIONAL SUB BILLED OTHER PAID BY COPY  
LAST FI MI IDENT NUM DATE DRUG CODE UNITS RX NO. AMT. SOURCES MCALD AMT. S EOS EOS  
\* \* \* CLAIM TYPE: PHARMACY \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

**1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** **12** **13**  
PROFESSOR: PROVIDER NAME DO DRUG NAME: ISONIAZIDE 000 UNITS/ML VIAL

ADJUSTMENT CLAIMS: **14**

LAST F 1-000000-00-100-0001-00 NY/ED/YY **45** 2013671 10.00 0.00 5.00- 0.00 B 000 000  
PROFESSOR: PROVIDER NAME DO DRUG NAME: ISONIAZIDE 000 MG TABLET

ADV-R: **16** TOB TO CREDIT: **17**

**P** **1** CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS, TOTALS... **Q** **50.00** **R** **0.00** **S** **25.00** **T** **1.00**



Iowa  
Department  
of Human  
Services

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**All Providers**

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Date

October 1, 2013

TO: PHARMACY NAME **C** R.A. NO.: **A** 000000000 WARR NO.: **B** 00000000 DATE PAID: **G** MM/DD/YY PROV. NUMBER: **H** 0000000000 PAGE: **I** 2

REMITTANCE T O T A L S  
 PAID ORIGINAL CLAIMS: NUMBER OF CLAIMS **J** 0  
 PAID ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0  
 DENIED ORIGINAL CLAIMS: NUMBER OF CLAIMS 0  
 DENIED ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0  
 PENDING CLAIMS (IN PROCESS): NUMBER OF CLAIMS 0  
 AMOUNT OF EFT DEPOSIT: 0.00

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

COUNT:

**N** 000 **O** EXPLANATION (EOB) OF DENIAL CODE **P** 1



## 10. Waiver Provider Remittance Advice Guide

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Allowed Charge Source Codes](#)
- ◆ [Waiver Provider Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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 for the mailing of <i>Remittance Advice</i> and paper checks
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> was mailed and check was 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



Field	Field Name	Field Description
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	Billed Amt.	Total billed amount within same claim type or status
S	Other Sources	Total other sources (for example: TPL) within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
U	TIN	Tax identification number
V	Copay Amt.	Total copayment amount within same claim type or status

1	Member Name	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member 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	Other sources on claim (for example: TPL)
6	Paid by Mcaid	Dollar amount paid by Medicaid on claim
7	Copay Amt.	Copayment amount on claim
8	Med Rcd Num	Medical record number assigned by provider
9	EOB	Explanation of benefit code, denial reason for claim
10	Line	Line numbers of claim
11	Svc-Date	Date of service as listed on claim
12	Proc/Mods	CPT or HCPCS code billed and any modifiers



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Field	Field Name	Field Description
13	Units	Number of units for each line item billed on claim
14	Billed Amt.	Billed amount for each line item on claim
15	Paid by Mcaid	Amount paid by Medicaid for each line
16	Copay Amt.	Copayment amount for each line item
17	Perf. Prov.	Performing provider number
18	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
19	EOB	Explanation of benefit code, denial reason code



**b. Allowed Charge Source Codes**

Source Code	Description
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 fee
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

Source Code	Description
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



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### c. Waiver Provider Remittance Advice Sample

R.A. NO. :

00000000

A

WRAPANT NUMBER :

00000000

B

PROVIDER NAME	
PROVIDER ADDRESS	
PO BOX XXX	
ANYTOWN	IA 00000-0000

C

D

----- NEWSLETTER UPDATE -----

\*\*\*\*\*IMPORTANT IWE INFORMATION\*\*\*\*\*

IMPORTANT INFORMATION AND REMINDERS FROM IWE WILL BE POSTED IN THIS SECTION OF THE REMITTANCE ADVICE.

E

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-256-4609. E-MAIL: IWEPROVIDERSERVICES@DHS.STATE.IA.US



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Date

May 1, 2014

IAMC3000-8001 (CP-0-12)  
AS OF 07/12/10

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 07/09/10

TO: PROVIDER NAME C R.A. NO.: A TIN: U MAR NO: B DATE PD: 07/12/10 PROV: H PAGE: I

\*\*\*\* PATIENT NAME \*\*\*\* RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /  
LAST FIRST MI LINE SVC-DATE PROC/MOOS UNITS AMT. SOURCES NCAID PERF. PROV. S EOS EOS

\*\*\* CLAIM TYPE: WAIVER \*\*\* CLAIM STATUS: PAID

ORIGINAL CLAIMS:	1	2	3	4	5	6	7	8	9
	01	05/01/10	W1267	60	585.00	585.00	0.00	X000123456	1
	02	06/01/10	W1267	60	585.00	585.00	0.00	X000123456	1
	10								009 009
									009 009

1 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS... 1170.00 0.00 585.00 0.00



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Date

October 1, 2013

TO: PROVIDER NAME **C** R.A. NO.: **A** 00000000 WARR NO.: **B** 00000000 DATE PAID: **G** MM/DD/YY PROV. NUMBER: **H** 0000000000 PAGE: **I** 2

REMITTANCE T O T A L S  
 PAID ORIGINAL CLAIMS: NUMBER OF CLAIMS **J** 0  
 PAID ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0  
 DENIED ORIGINAL CLAIMS: NUMBER OF CLAIMS 0  
 DENIED ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0  
 PENDING CLAIMS (IN PROCESS): NUMBER OF CLAIMS 0  
 AMOUNT OF EFT DEPOSIT: 0.00

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

<b>N</b>	<b>O</b>	<b>P</b>
000	EXPLANATION (EOB) OF DENIAL CODE	1



## 11. Capitation and Administrative Fee Remittance Advice Guide

- ◆ [Remittance Advice Field Descriptions](#)
- ◆ [Allowed Charge Source Codes](#)
- ◆ [Capitation and Administrative Remittance Advice Sample](#)

### a. Remittance Advice Field Descriptions

Field	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	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	Member Name	Last, first name or initial of the member as shown on the Medicaid identification 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 copayment on claim
8	Med Rcd Num	Account number assigned by the provider
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 line
15	Paid by Mcaid	Amount paid by Medicaid on line
16	Copay Amt.	Copayment amount on line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number
18	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
19	EOB	Explanation of Benefits denial reason code



**b. Allowed Charge Source Codes**

Source Code	Description
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 fee
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

Source Code	Description
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



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Date

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**c. Capitation and Administrative Fee Remittance Advice Sample**

R.A. NO. : 00000000 **A**

WARRANT NUMBER: 00000000 **B**

**C** PROVIDER NAME **D**  
PROVIDER ADDRESS  
PO BOX XXX  
ANTHONY IA 00000-0000

----- NEWSLETTER UPDATE -----

**E**  
\*\*\*\*\*IMPORTANT IME INFORMATION\*\*\*\*\*  
IMPORTANT INFORMATION AND REMINDERS FROM IME WILL BE POSTED IN THIS SECTION  
OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES  
MOINES AREA AT 515-256-4609. E-MAIL: IMEPROVIDERSERVICES@DHS.STATE.IA.US



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Date

May 1, 2014

IAWC0000-R001 (CP-0-12) IOWA DEPARTMENT OF HUMAN SERVICES  
 AS OF XX/XX/XX MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE XX/XX/XX  
 R E M I T T A N C E A D V I C E  
 TO: PROVIDER NAME [C] R.A. NO.: [A] MARK NO.: [B] DATE PAID: [G] PROV. NUMBER: [H] PAGE: [I]  
 \*\*\*\*\* PATIENT NAME \*\*\*\*\* RECEIPT ID / TRANS-CONTROL-NUMBER / SILLED OTHER SAID BY COPAY MED PCD NON /  
 LAST FIRST MI LINE SVC-DATE PROC/RODS UNITS AMT. SOURCES MOAID MOAID AMT. PERP. PROV. S BOB BOB  
 \* \* \* CLAIM TYPE: CAPITATION \* \* \* CLAIM STATUS: PAID  
 ORIGINAL CLAIMS:  
 DOE [1] JOEN [2] [3] [4] [5] [6] [7] [8] [9]  
 01 [10] [11] [12] [13] [14] [15] [16] [17] [18] [19]  
 189782D 4-00000-00-000-00000-02 2.00 0.00 2.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00  
 01 XX/XX/XX M4001 1 2.00 0.00 2.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00  
 [2] CLAIMS - THIS TREATING PROVIDER. TOTALS... [R] [S] [T] [X]  
 4.00 0.00 4.00 0.00



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Date

October 1, 2013

TO: PROVIDER NAME DDS **C** R.A. NO.: 00000000 **A** WARR NO.: 00000000 **B** DATE PAID: MM/DD/YY **G** PROV. NUMBER: 0000000000 **H** PAGE: **2**

REMITTANCE TOTALS

	NUMBER OF CLAIMS	AMOUNT	NUMBER OF CLAIMS	AMOUNT
PAID ORIGINAL CLAIMS:	2	40.00		
PAID ADJUSTMENT CLAIMS:	0	0.00		
DENIED ORIGINAL CLAIMS:	0	0.00		
DENIED ADJUSTMENT CLAIMS:	0	40.00		
PENDED CLAIMS (IN PROCESS):	0	0.00		
AMOUNT OF EFT DEPOSIT:		0.00		

-----

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

EOB CODE	EXPLANATION (EOB) OF DENIAL CODE	COUNT
<b>N</b>	000	1
<b>O</b>		
<b>P</b>		