



Iowa Department of Human Services

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For Human Services use only:

General Letter No. 8-AP-379

Employees' Manual, Title 8
Medicaid Appendix

May 16, 2014

ALL PROVIDERS MANUAL TRANSMITTAL NO. 14-2

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **ALL PROVIDERS MANUAL**, Chapter IV, *Billing Iowa Medicaid*, Contents (page 1), revised; pages 2, 10, 18, 35 through 62, 69, 78, 84, 87, 88, 89, 96, 103, 110, 117, 123, 128, 133, 140, 146, 153, and 159, revised; and the following form:

CMS-1500 *Health Insurance Claim Form*, revised

Summary

ALL PROVIDERS MANUAL, Chapter IV. *Billing Iowa Medicaid*, is revised to:

- ◆ Update the inpatient codes for the UB-04, *Claim Form* (CMS-1450).
- ◆ Update CMS-1500, *Health Insurance Claim Form*, and the instructions.
- ◆ Remove personal health information from the *Remittance Advice* samples.

Date Effective

Upon receipt.

Material Superseded

This material replaces the following pages in the **ALL PROVIDERS MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter IV	
Contents (page 1)	October 1, 2013
2, 10, 18, 35, 36	October 1, 2013
CMS-1500	8/05
37-62, 69, 78, 84, 87-89, 96, 103, 110, 117, 123, 128, 133, 140, 146, 153, 159	October 1, 2013

Additional Information

The updated provider manual containing the revised pages can be found at:
http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



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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

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](#).



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
73	Untitled	OPTIONAL	No entry required.
74	Principal Procedure Code and Date	<i>SITUATIONAL</i>	REQUIRED for the principal surgical procedure. Enter the ICD-9 procedure code and surgery date, when applicable.
74 a-e	Other Procedure Codes and Dates	<i>SITUATIONAL</i>	REQUIRED for additional surgical procedures. Enter the ICD-9 procedure codes and surgery dates.
75	Untitled	OPTIONAL	No entry required.
<i>Attending Provider Name and Identifiers</i>			
76 *	NPI	REQUIRED	Enter the NPI of the attending physician. REQUIRED 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 blank . Entering information in this field will cause the claim to be returned.
	Last	REQUIRED	Enter the last name of the referring physician.
	First	REQUIRED	Enter the first name of the referring physician.



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Provider and Chapter

All Providers

Chapter IV. Billing Iowa Medicaid

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Date

May 1, 2014

Code	Defined	Subcategories
99X Member Convenience Items	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.



C. 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.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY					STATE					8. RESERVED FOR NUCC USE					CITY					STATE																																							
ZIP CODE					TELEPHONE (Include Area Code) ()					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										b. OTHER CLAIM ID (Designated by NUCC)																																							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____										15. OTHER DATE MM DD YY QUAL. _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
17b. NPI _____										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										23. PRIOR AUTHORIZATION NUMBER _____																																							
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																							
1																				NPI _____																																							
2																				NPI _____																																							
3																				NPI _____																																							
4																				NPI _____																																							
5																				NPI _____																																							
6																				NPI _____																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ _____										29. AMOUNT PAID \$ _____										30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____																																							

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Field No.	Field Name/Description	Requirements	Instructions
1	Check One	REQUIRED	Check the applicable program.
1a	Insured's ID Number	REQUIRED	<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	REQUIRED	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>	REQUIRED if the Medicaid member is covered under other additional insurance, enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "Yes," this field must be completed.
9a	Other Insured's Name, etc.	<i>SITUATIONAL</i>	REQUIRED if the Medicaid member is covered under other additional insurance, enter the name of the policyholder of that insurance. NOTE: 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>	REQUIRED if the Medicaid member is covered under other additional insurance. Enter the name of the plan or program. NOTE: If 11d is "Yes," this field must be completed.
10	<i>Is Member's Condition Related to:</i>		
10a	Employment?	<i>SITUATIONAL</i>	REQUIRED 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?	REQUIRED	<p>REQUIRED 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>NOTE: 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. REQUIRED 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>	REQUIRED for chiropractors. Chiropractors must 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 blank .
17b	NPI	<i>SITUATIONAL</i>	REQUIRED 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 Required 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	REQUIRED	<p>Indicate the applicable ICD-9-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 member is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648; 670 through 677; V22; V23.</p> <p>Do not enter descriptions.</p> <p>Indicate a 9 for the ICD Ind. When submitting ICD-9-CM diagnosis codes.</p>
22	Resubmission Code	OPTIONAL	No entry required.
23	Prior Authorization Number	<i>SITUATIONAL</i>	REQUIRED 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>REQUIRED 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	REQUIRED	<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	REQUIRED	<p>Using the chart below, enter the number corresponding to the place service was provide. Do not use alphabetic characters.</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/ intellectually disabled 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility



Field No.	Field Name/Description	Requirements	Instructions
24C	EMG	OPTIONAL	No entry required.
24D	Procedures, Services, or Supplies	REQUIRED	Enter the codes for each of the dates of service. Do not list services for which no fees were charged. Do not enter the description. 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.
24E	Diagnosis Pointer	REQUIRED	Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., C. Do not enter the actual diagnosis code in this field. Doing so will cause the claim to deny. NOTE: There is a maximum of four diagnosis codes per claim.
24F	\$ Charges	REQUIRED	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	REQUIRED	Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the <u>total minutes</u> of general anesthesia.



Field No.	Field Name/Description	Requirements	Instructions
24H	EPSDT/Family Planning	<i>SITUATIONAL</i>	REQUIRED 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 blank .
24J Top shaded portion	Rendering Provider ID #	LEAVE BLANK	This field must be left blank .
24J Bottom portion	NPI	REQUIRED	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	REQUIRED	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>	REQUIRED 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 blank .
31	Signature of Physician or Supplier	REQUIRED	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 blank .
33	Billing Provider Info and Phone #	REQUIRED	Enter the name and complete address of the billing provider. NOTE: The address must contain the zip code associated with the billing provider's NPI.
33a	NPI	REQUIRED	Enter the NPI of the billing provider.
33b	Untitled	REQUIRED	Enter the taxonomy code associated with the billing provider's NPI . A " ZZ " qualifier must precede the taxonomy code.



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D. 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, 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	REQUIRED	Check "Statement of Actual Services" if the statement is for actual services. Check "EPSDT/Title XIX" if the services are a result of a referral from an EPSDT Care for Kids screening examination. NOTE: Requests for predetermination/preauthorization should be completed using the prior authorization form.
2	Predetermination/Pre-authorization Number	<i>SITUATIONAL</i>	REQUIRED 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	REQUIRED	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. NOTE: Medicaid should be billed only after the other insurance plans have been billed. 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.
5	Name of Policyholder	<i>SITUATIONAL</i>	REQUIRED 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>	REQUIRED 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>	REQUIRED if the member has other insurance. Check the appropriate box for the primary subscriber's gender.
8	Policyholder	<i>SITUATIONAL</i>	REQUIRED 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>	REQUIRED 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>	REQUIRED 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>	REQUIRED 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	REQUIRED	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	REQUIRED	Enter the date of birth if the member. Entry should be made in MM/DD/YYYY format.
14	Gender	REQUIRED	Check the appropriate box for the member's gender.
15	Policyholder/ Subscriber ID	REQUIRED	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	REQUIRED	Enter the date of service. Entry should be made in MM/DD/YYYY format. NOTE: 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"> • The procedure identified in field 29 requires the identification of a tooth or a range of teeth. • The procedure identified in field 29 incorporates a specific area of the oral cavity (for example: D5110 complete denture – maxillary). • 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). <p>NOTE: <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"> 00 Whole of the oral cavity 01 Maxillary area 02 Mandibular area 10 Upper right quadrant 20 Upper left quadrant 30 Lower left quadrant 40 Lower right quadrant



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>NOTE: <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.	REQUIRED	Enter the number of units provided.
30	Description	REQUIRED	Enter a description of the procedure.
31	Fee	REQUIRED	Enter the usual and customary charge for each line item billed. NOTE: 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. NOTE: The total must include both dollars and cents.
32	Total Fee	REQUIRED	Enter the sum of the charges listed in field 31 (Fee). This field should be completed on the last page of the claim only. NOTE: 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. NOTE: 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>	<p>REQUIRED if a diagnosis code is entered in field 29a. Indicate whether the claim reflects ICD-9 diagnosis codes.</p> <p>Currently only ICD-9 diagnosis codes are allowed by Iowa Medicaid, therefore "B" should be entered.</p>
34a	Diagnosis Code(s)	<i>SITUATIONAL</i>	<p>Only REQUIRED 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.</p> <p>If the member is pregnant, enter diagnosis code "V22.2." This will indicate that the member is pregnant and exempt from the copay requirement.</p> <p>If the member is disabled, enter diagnosis code "V49.89." This will allow for reimbursement of preventive services otherwise limited.</p> <p>Do not enter descriptions.</p>
35	Remarks	<i>SITUATIONAL</i>	<p>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.</p> <p>NOTE: This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth.</p> <p>It can also be used to convey additional information believed necessary to process the claim.</p> <p>Remarks should be concise and pertinent to the claim submission.</p> <p>Pregnancy is now indicated in field 34a.</p>



Field No.	Field Name/ Description	Requirements	Instructions
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>	REQUIRED 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>	REQUIRED 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>	REQUIRED 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>	REQUIRED 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>	REQUIRED 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	REQUIRED	Enter the name and complete address of the billing dentist or the dental entity (corporation, group, etc.). NOTE: 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	REQUIRED	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 blank . The claim will be returned if information is submitted in this field.
53	Treating Dentist Signature	REQUIRED	Enter the name of the treating dentist and the date the form is signed.
54	NPI	REQUIRED	Enter the NPI of the treating dentist.
55	License Number	REQUIRED	Enter the license number of the treating dentist.
56	Address, City, State, Zip Code	REQUIRED	Enter the complete address of the treating dentist. NOTE: 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	REQUIRED	Enter the taxonomy code associated with the billing entity's NPI. NOTE: 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 blank . 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.



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Page 60 is reserved for future use.



E. 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 www.edissweb.com. Click [here](#) for more information on how to obtain PC-ACE software or to view help resources.

F. 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



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.

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



I. 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
<i>Member Information</i>			
1	Medicaid ID Number	REQUIRED	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>).

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K. 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.



- ◆ **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.

L. 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



M. 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.*



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IAMC8000-R001 (CP-O-12)
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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: [] [] [] [] [] [] [] [] [] []

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

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

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



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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

TO: PROVIDER NAME R.A. NO.: MAPD NO.: DATE PAID: PROV. NUMBER: PAGE:
 **** PATIENT NAME **** RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY
 LAST FIRST MI LINE SVC-DATE PROC/NOBS UNITS AMT. SOURCES MEDID MED RCD NUM / MED RCD NUM /
 * * * CLAIM TYPE: HCFM 1500 * * * CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9
ERRST	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						
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		19						

01 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS.:
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MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE

TO: DENTAL PROVIDER NAME R.A. NO.: A WARR NO.: B DATE PAID: G PROV. NUMBER: 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/MODS UNITS AMT. SOURCES MCALID PAID MCALID AMT. 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="200000"/>	<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="200000"/>	<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="21 940"/>
<input type="text" value="18"/>	<input type="text" value="19"/>	<input type="text" value="F"/>	<input type="text" value="000 000"/>	<input type="text" value="000 000"/>				

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

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RUN DATE: MM/DD/YY
F

TO: PROVIDER NAME C R.A. NO.: A MAOR NO.: B DATE PAID: G PROV. 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 WCAID EOB EOB
 * * * CLAIM TYPE: LONG TERM CASE * * * CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1 2 3 4 5 6 7 8 9 10 11 12
 00000000 0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 31 0 0 0 0000.00 0.00 0.00 1
 PREVIOUS-DATE-PAID: MM/DD/YY 13 CONFLICTING-ICN: 14

ADJUSTMENT CLAIMS:

0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 29 0 0 0 0000.00- 0000.00- 0000.00- 15
 0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 29 0 0 0 0000.00 00.00 0000.00 16
 ADD-R: 94 ICN-TO-CREDIT: 19 NET 0000.00
 4 CLAIMS = THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS... 00000.00 R 00000.00 S 00000.00 T



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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 = 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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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- MEDICAL
 LAST FI MI IDENT NUM TRANS-CONTROL-NUMBER FIRST LAST PAID AMT ISLE 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

3-00000-00-000-0000-01 XX/XX/XX XX/XX/XX 2000.00 250.00 25.00 275.00 XXXXXXXXXXXX

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



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May 1, 2014

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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. \$ RCB RCB

*** CLAIM TYPE: MEDICAID PART B CROSSOVER *** CLAIM STATUS: PAID

ORIGINAL CLAIMS:	1	2	3	4	5	6	7	8	9	10	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="X"/>	<input type="text"/>
	<input type="text" value="11"/>	<input type="text" value="12"/>	<input type="text" value="13"/>	<input type="text" value="14"/>	<input type="text" value="15"/>	<input type="text" value="16"/>	<input type="text" value="17"/>	<input type="text" value="18"/>	<input type="text" value="19"/>	<input type="text" value="20"/>	<input type="text"/>	<input type="text"/>

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



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IRANCS000-R001 (CE-0-12)
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IOWA DEPARTMENT OF HUMAN SERVICES
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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**



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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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 AS OF XX/XX/XX MEDICAID MANAGEMENT INFORMATION SYSTEM
 R E N I T A N C E R 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. SOURCE Medicaid AMT. MED PCD NON / S BOB BOB
 ***** CLAIM TYPE: CAPITATION ***** CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9
DOE	JOSN		2.00	0.00	2.00	0.00		000 000
	01	XX/XX/XX	2.00		2.00	0.00		000 000
DOE	JANE	4-000000-00-000-0000-02	2.00	0.00	2.00	0.00		000 000
	01	XX/XX/XX	2.00		2.00	0.00		000 000
2 CLAIMS - THIS TREATING PROVIDER. TOTALS...			4.00	0.00	4.00	0.00		