



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

For Human Services use only:

General Letter No. 8-AP-407
Employees' Manual, Title 8
Medicaid Appendix

January 9, 2015

ALL PROVIDERS MANUAL TRANSMITTAL NO. 15-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **ALL PROVIDERS MANUAL**, Chapter IV, *Billing Iowa Medicaid*, Contents (pages 1, 2, and 3), revised; and pages 1 through 61, 77, 78, 83, 84, 88, 89, and 91, revised.

Summary

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

- ◆ Provide a general introduction to the manual (Section A).
- ◆ Disclose specific information for Indian Health Services providers.
- ◆ Re-paginate the manual based on Section A additions.

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Material Superseded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) | May 1, 2014 |
| Contents (pages 2 and 3) | October 1, 2013 |
| 1 | October 1, 2013 |
| 2 | May 1, 2014 |
| 3-9 | October 1, 2013 |
| 10 | May 1, 2014 |
| 11-17 | October 1, 2013 |
| 18 | May 1, 2014 |
| 19-34 | October 1, 2013 |
| 35-61 | May 1, 2014 |
| 77 | October 1, 2013 |
| 78 | May 1, 2014 |
| 83 | October 1, 2013 |
| 84, 88, 89 | May 1, 2014 |
| 91 | October 1, 2013 |

Additional Information

The updated provider manual containing the revised pages can be found at:
<http://dhs.iowa.gov/sites/default/files/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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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.

1. Claim Forms

The IME uses the following claim forms:

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

Each claim form is used by specific provider types for billing purposes.

2. Information Regarding Indian Health Services Providers

Iowa Medicaid covers services provided by Indian Health Services (IHS) clinics if they are an enrolled provider (by provider type) in the Iowa Medicaid Program. Covered services may include both outpatient and inpatient services such as physician services, nurse practitioner services, hospitalization, and other medically necessary services. All services provided as part of the IHS encounter must be provided within the scope of practice of the health professional rendering the service.

Except for other ambulatory services, services must be within the Medicaid coverage limits as defined in each of the Chapter III provider-specific manuals, based on services provided. Coverage includes any other ambulatory services offered by the center that are otherwise covered by the IME and are provided within the limits on coverage for that service.

Claim completion and submission should follow the instructions provided in this manual based upon your professional designation and not by the federal definition of Indian Health Services.

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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

| | | |
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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](#).

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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](#).

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. 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

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, 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 | REQUIRED | Enter the name, address, and phone number of the billing facility or service supplier. NOTE: 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> | REQUIRED 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 | REQUIRED | <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>NOTE: 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) | REQUIRED | <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. NOTE: Covered and non-covered days are reported using value codes in fields 39a-41d. |
| Patient Name | | | |
| 8a | Last Name | REQUIRED | Enter the last name of the member. |
| 8a | First Name | REQUIRED | Enter the first name and middle initial of the member. |
| Patient Address | | | |
| 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 | REQUIRED | Enter the member's sex: "M" for male or "F" for female. |
| 12 | Admission Date | REQUIRED | 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>REQUIRED FOR INPATIENT/PMIC/SNF</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 | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | Admission Type/Visit | <i>SITUATIONAL</i> | <p>REQUIRED FOR INPATIENT/PMIC/SNF</p> <p>Enter the code corresponding to the priority level of this inpatient admission:</p> <ul style="list-style-type: none"> 1 Emergency 2 Urgent 3 Elective 4 Newborn 9 Information unavailable | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



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



| 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>REQUIRED 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 | REQUIRED | <p>Enter the value code, followed by the NUMBER of covered or non-covered days that are included in the billing period. (NOTE: There should not be a dollar amount in this field.)</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 | REQUIRED | <p>Enter the revenue code that corresponds to each item or service billed.</p> <p><i>A list of valid revenue codes can be found at the end of these UB-04 claim form instructions.</i></p> <p>NOTE: Not all listed revenue codes are payable by Medicaid.</p> |
| 43 | Revenue Description | <i>SITUATIONAL</i> | <p>REQUIRED 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. No other entries should be made in this field.</p> |
| 43 Line 23 | Page ___ of ___ | <i>SITUATIONAL</i> | <p>REQUIRED if claim is more than one page. Enter the page number and the total number of pages for the claim.</p> <p>NOTE: 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>REQUIRED 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>Do not 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>REQUIRED for outpatient claims.</p> <p>Outpatient: Enter the service date for outpatient service referenced in field 42 or field 44. Note that one entry is required for each date in which the service was performed.</p> |
| 46 | Service Units | <i>SITUATIONAL</i> | <p>REQUIRED 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 | REQUIRED | Enter the total charges for each line billed. The total must include both dollars and cents. |
| 47 Line 23 | Totals | REQUIRED | 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 | REQUIRED | Enter the non-covered charges for each applicable line. <i>*** The total must include both dollars and cents.</i> |
| 48 Line 23 | Totals | REQUIRED | 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 | REQUIRED | 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 blank . 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 | REQUIRED 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) | REQUIRED | Enter the NPI of the billing entity. |
| 57A * | Untitled | LEAVE BLANK | This field must be left blank . Entering information in this field will cause the claim to be returned. |
| 57B * | Other | LEAVE BLANK | This field must be left blank . Entering information in this field will cause the claim to be returned. |
| 57C * | Provider ID | LEAVE BLANK | This field must be left blank . Entering information in this field will cause the claim to be returned. |
| 58 | Insured's Name | REQUIRED | 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 field 50 . |



| Field No. | Field Name/Description | Requirements | Instructions |
|-----------|--|--------------------|--|
| 59 | Patient's Relationship to Insured | OPTIONAL | No entry required. |
| 60 A-C | Insured's Unique ID | REQUIRED | 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 field 50 . |
| 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. NOTE: <i>This field is no longer used to report the MediPASS referral. Refer to field 79 to enter the MediPASS referral.</i> NOTE: <i>Lock-in moved to field 78.</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) | OPTIONAL | No entry required. Medicaid only accepts ICD-9 codes. |



| Field No. | Field Name/Description | Requirements | Instructions |
|-----------|---------------------------------------|--------------------|---|
| 67 | Principal Diagnosis Code | REQUIRED | Enter the ICD-9-CM code for the principal diagnosis. |
| | Present on Admission (POA) | REQUIRED | <p>POA indicator is the eighth digit of field 67 A-Q. 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> | REQUIRED 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> | REQUIRED for inpatient hospital claims. Inpatient hospital: The admitting diagnosis is required. |
| 70 a-c | Member's Reason for Visit | <i>SITUATIONAL</i> | REQUIRED 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> | 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. |



| Field No. | Field Name/Description | Requirements | Instructions |
|---|------------------------|--------------------|--|
| <i>Operating Provider Name and Identifiers</i> | | | |
| 77 * | NPI | <i>SITUATIONAL</i> | REQUIRED 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 blank . 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. |
| <i>Other Provider Name and Identifiers</i> | | | |
| 78 * | NPI | <i>SITUATIONAL</i> | REQUIRED 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 blank . 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 |
|---|------------------------|--------------------|--|
| <i>Other Provider Name and Identifiers</i> | | | |
| 79 * | NPI | <i>SITUATIONAL</i> | REQUIRED 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 blank . 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> | REQUIRED if a diagnosis other than the principal is made. When applicable enter one of the following: <ul style="list-style-type: none"> • "Not a Medicare benefit." • "Resubmit" (and list the original filing date). • Member is "Retro-Eligible and NOD is attached." (Notice of Decision) |
| 81* | Code-Code Fields | REQUIRED | Enter taxonomy code associated with the NPI of the billing entity (field 56). Precede taxonomy code with qualifier "B3" (healthcare provider taxonomy code). NOTE: The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. |



| Revenue Codes Field 42 | | |
|--|--|--|
| Code | Defined | Subcategories |
| 11X Room & Board Private (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 |
| 12X Room & Board Semi-Private Two Bed (medical or general) | Charges for accommodations with two beds. | 0 General classifications 4 Sterile environment 7 Self care 9 Other |
| 13X Room & Board Semi-Private Three and Four Beds (medical or general) | Charges for accommodations with three and four beds. | 0 General classifications 4 Sterile environment 7 Self care 9 Other |
| 14X Private (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 |
| 15X Room & Board Ward (medical or general) | Charges for accommodations with five or more beds. | 0 General classifications 4 Sterile environment 7 Self care 9 Other |
| 16X Other Room & Board | 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 |



| Code | Defined | Subcategories |
|--|--|---|
| 17X Nursery | Charges for nursing care for newborn and premature infants in nurseries. | 0 General classification 1 Newborn 2 Premature 5 Neonatal ICU 9 Other |
| 18X Leave of Absence | Charges for holding a room or bed for a member while they are temporarily away from the provider. | 5 Nursing home (for hospitalization) |
| 20X Intensive Care | 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 |
| 21X Coronary Care | 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 |
| 22X Special Charges | 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 |
| 23X Incremental Nursing Charge Rate | | 0 General classification 1 Nursery 2 OB 3 ICU 4 CCU 9 Other |



| Code | Defined | Subcategories |
|--|---|--|
| 24X All Inclusive Ancillary | A flat rate charge incurred on either a daily or total stay basis for ancillary services only. | 0 General classification 9 Other inclusive ancillary |
| 25X Pharmacy | 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 |
| 26X IV Therapy | 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 |
| 27X Medical/Surgical Supplies and Devices (also see 62X , 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 |
| 28X Oncology | Charges for the treatment of tumors and related diseases. | 0 General classification 9 Other oncology |



| Code | Defined | Subcategories |
|--|---|---|
| 29X Durable Medical Equipment (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 |
| 30X Laboratory | 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 |
| 31X Laboratory Pathological | 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 |
| 32X Radiology Diagnostic | 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 |
| 33X Radiology Therapeutic | 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>34X Nuclear Medicine</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>35X CT Scan</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>36X Operating Room Services</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>37X Anesthesia</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>38X Blood</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 |
|---|--|--|
| <p>39X Blood Storage and Processing</p> | <p>Charges for the storage and processing of whole blood.</p> | <p>0 General classification 1 Blood administration 9 Other blood storage and processing</p> |
| <p>40X Other Imaging Services</p> | | <p>0 General classification 1 Diagnostic mammography 2 Ultrasound 3 Screening mammography 4 Positron emission tomography 9 Other imaging services</p> |
| <p>41X Respiratory Services</p> | <p>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.</p> | <p>0 General classification 1 Inhalation services 3 Hyperbaric oxygen therapy 9 Other respiratory services</p> |
| <p>42X Physical Therapy</p> | <p>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.</p> | <p>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</p> |



| Code | Defined | Subcategories |
|--|--|--|
| 43X Occupational Therapy | 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 |
| 44X Speech Language Pathology | 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 |
| 45X Emergency Room | Charges for emergency treatment to ill and injured requiring immediate unscheduled medical or surgical care. | 0 General classification 9 Other emergency room |
| 46X Pulmonary Function | 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 |
| 47X Audiology | 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 |



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



| Code | Defined | Subcategories |
|--|---|---|
| <p>54X Ambulance</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>55X Skilled Nursing (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>56X Medical Social Services (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>57X Home Health Aide (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>61X MRI</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>62X Medical/Surgical Supplies (extension of 27X)</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>63X Drugs Requiring Specific Identification</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>64X Home IV Therapy Services</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>65X Hospice Services (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>70X Cast Room</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>71X Recovery Room</p> | | <p>0 General classification 9 Other recovery room</p> |
| <p>72X Labor Room/Delivery</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>73X EKG/ECG (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>74X EEG (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>75X Gastro-Intestinal Services</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>76X Treatment or Observation Room</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>79X Lithotripsy</p> | <p>Charges for the use of lithotripsy in the treatment of kidney stones.</p> | <p>0 General classification 9 Other lithotripsy</p> |
| <p>80X Inpatient Renal Dialysis</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>81X Organ Acquisition (see 89X)</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>82X Hemodialysis (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>83X Peritoneal Dialysis (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>84X Continuous Ambulatory Peritoneal Dialysis (CCPD) (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>85X Continuous Cycling Peritoneal Dialysis (CCPD) (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>88X Miscellaneous Dialysis</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>89X Other Donor Bank (extension of 81X)</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>92X Other Diagnostic Services</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>94X Other Therapeutic Services</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> |



| 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.



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 | 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 | <p>Enter the codes for each of the dates of service.</p> <p>Do not list services for which no fees were charged.</p> <p>Do not 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 | REQUIRED | <p>Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., C.</p> <p>Do not enter the actual diagnosis code in this field. Doing so will cause the claim to deny.</p> <p>NOTE: There is a maximum of four diagnosis codes per claim.</p> |
| 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 | <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> | 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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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, 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 | <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>NOTE: Requests for predetermination/preauthorization should be completed using the prior authorization form.</p> |
| 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 | <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>NOTE: 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> | 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.



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 www.edissweb.com. 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.



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 |
|----------------------------------|------------------------|-----------------|---|
| <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>). |



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).



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.

| | | |
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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.*



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.).