Iowa Medicaid Fee-for-Service: Claims and Billing and Provider

Provider Outreach Education (POE)

Fee-for-Service (FFS) Guidance

IOWA Health and Human Services

Topics

Provider Claims and Billing

- Electronic Billing Standards
- Timely Filing, Provider Inquiry Guidance, Get in Touch
- Remittance Advice
- Top 10 Claim Denials
- Resources

Fee-for-Service Claims and Billing

Electronic Billing Standards

Provider Inquiry Guidance

Top 10 Claim Denials

IOWA Health and Human Services

Fee-for-Service (FFS) Electronic Billing Standards

Fee-for-Service Electronic Billing Standards

All claim submissions must comply with the Mandatory Electronic Billing Requirements Informational Letter IL 2022-MC-FFS:

Ability PC-ACE Pro (Billing Software via EDISS)

- Free billing software provided by Iowa Medicaid
- Accessible through EDISS
- No cost for submitting FFS member claims

Provider's Own Billing Software/Third-Party Vendors/Clearinghouse

- Providers may use their own billing systems, third-party vendors or clearinghouse
- Strongly encouraged to register with Iowa Medicaid Portal Access (IMPA)
- IMPA registration ensure access to accurate remittance and claim data

Fee-for-Service Electronic Billing Standards (cont.)

Utilize EDI Support Services

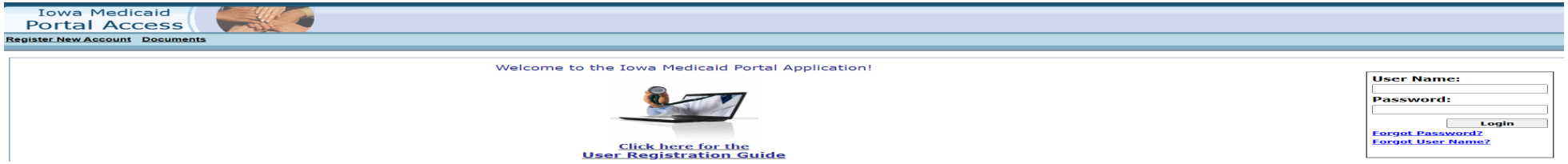
- **Contact your EDI Help Desk for**:
  - Technical assistance
  - EDI Enrollment issues
  - Electronic claim rejections
- They also provide training materials, newsletters, and updates on EDI requirements.

- **Track and Reconcile Claims**
  - Use Electronic Remittance Advice (ERA) to match payments with submitted claims.
  - Address denials or discrepancies promptly using EDI tools.

- **Toolbox**
  - Contact EDI Support Services
  - Software/Connectivity - medicaid – edissweb, and
  - EDISS Quick Reference for the PC-ACE User Guide

Fee-for-Service Electronic Billing Standards (cont.)

Key Point: Use IMPA to review remits and interpret Medicaid guidelines



- How to **read a remittance Advice**: Billing Iowa Medicaid manual. Section “O” IV. BILLING IOWA MEDICAID
- **Diagnose common errors**: Recognize issues like billing incarceration, secondary billing, or missing or incorrect modifiers.
- **Correct billing processes**: Learn appropriate remediation steps for each denial type to minimize future errors.

Fee-for-Service Electronic Billing Standards (cont.)

- Use this link to stay up to date on Iowa Medicaid Electronic Billing Requirements: Claims & Billing | Health & Human Services
- Use this link to find trainings related to you: Medicaid Provider Trainings | Health & Human Services
- IMPA Registration Guide: https://secureapp.dhs.state.ia.us/impa/Assets/IMPAUserRegistration.pdf

Fee-for-Service Electronic Billing Standards (cont.)

Use the Iowa Medicaid Portal Access (**IMPA system**) for submitting FFS Claim supporting documents.

- Providers only need to submit supporting documents within 7 business days of submitting the medical claim, when such documents are necessary to process a claim.
- Providers are not required to resubmit documentation that has previously been uploaded when submitting additional materials.

Fee-for-Service Electronic Billing Standards (cont.)

How to submit claim documentation into IMPA

1. Go to File>Upload File, select Electronic Billing Attachments (do NOT select “Documents to IME”)
2. Choose “Claim Attachment” in the Document Type dropdown.
3. Enter a 16-digit Attachment Control Number (ACN) using the member ID + date of service (DOS) (ie – 1234567A08012019).
4. If you get a duplicate file name error, add_2, _3, etc. to the end of the ACN. Do not use form 470-5403 with electronic billing uploads.

Remittance Advice (RA)

Remittance Advice (RA)

The *Remittance Advice* is separated into categories indicating the status of those claims:

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.).

All Providers Chapter IV. Billing Iowa Medicaid

Remittance Advice (RA)

What is an Electronic Remittance Advice (ERA)?

- 835 Transaction
- Electronic version of the Standard Paper Remit (SPR)
- A notice of payments and adjustments sent to providers, billers, and suppliers
- Explains the reimbursement decisions of the payer, including:
  - Reasons for payments
  - Adjustments

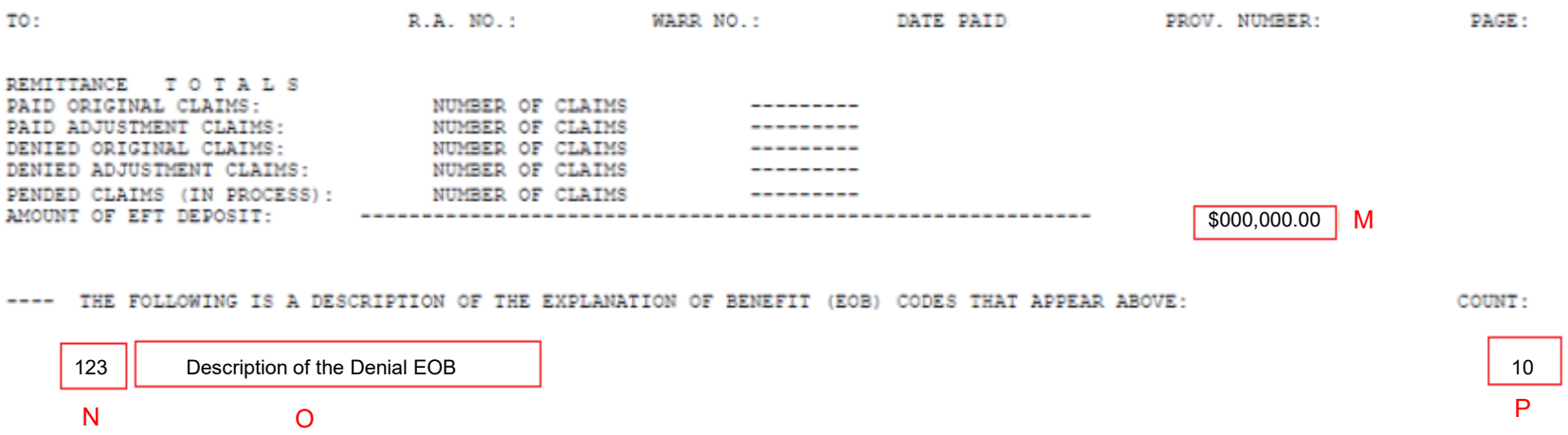
How to receive Electronic Remittance Advice (ERA)?

- Add the 835 transaction to your profile in EDISS Connect
- Remits can be sent to a Billing Service/Clearinghouse or directly back to your facility

Note: If choosing the direction, connectivity will need to be established with a Network Service Vendor.

All Providers Chapter IV. Billing Iowa Medicaid

UB-04 (Inpatient)Remittance Advice



TO: R.A. NO.: WARR NO.: DATE PAID PROV. NUMBER: PAGE:

REMITTANCE T O T A L S

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	---------
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	---------
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	---------
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	---------
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	---------
AMOUNT OF EFT DEPOSIT:	----------	$000,000.00 M

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

123	Description of the Denial EOB	10
N	O	P

M. Amount of Deposit Total check amount for claims paid on this Remittance Advice

N. EOB Code Explanation of Benefits (EOB) code or denial code

O. Description of the denial EOB

P. Number of claims that denied for the EOB code described

CMS 1500 - Remittance Advice

IAMC8000-R001 (CP-0-12)
AS OF XX/XX/XX

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM
REMITTANCE ADVICE

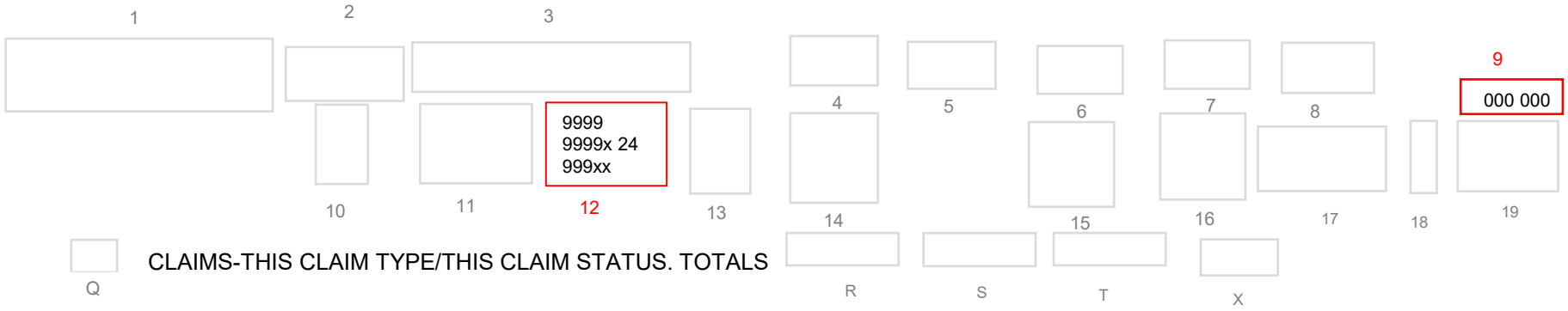
RUN DATE

TO: RA NO. WARR NO. DATE PAID PROVIDER NUMBER: PAGE:

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

***CLAIM TYPE: HCFA 1600

***CLAIM STATUS: PAID



9. EOB denial reason code if entire claim denied.
(Full description of denial can be found on the last page of the Remittance Advice statement.)

12. CPT or HCPCS code and modifier billed

CMS 1500 - Remittance Advice

IAMC8000-R001 (CP-0-12)
AS OF XX/XX/XX

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM
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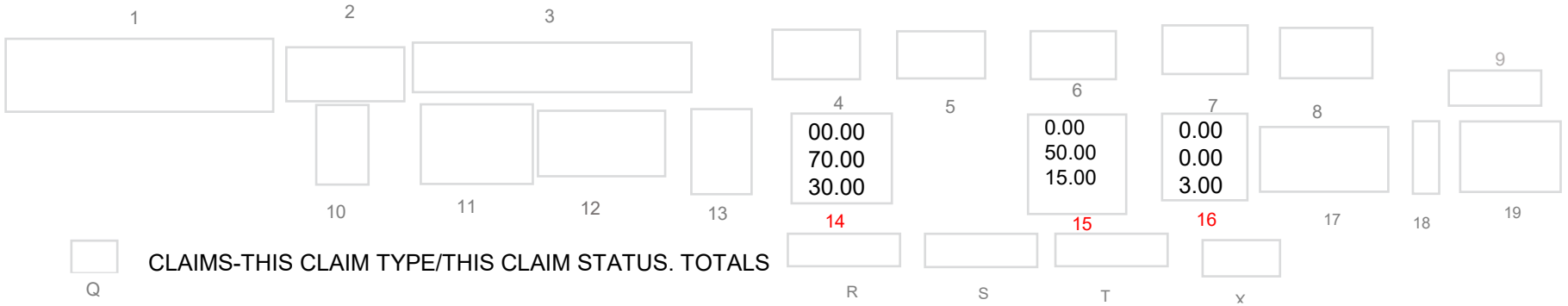

14. Billed amount on this line

15. Amount paid by Medicaid on this line

16. Copayment amount on this line

CMS 1500 - Remittance Advice

IAMC8000-R001 (CP-0-12)
AS OF XX/XX/XX

IOWA DEPARTMENT OF HUMAN SERVICES
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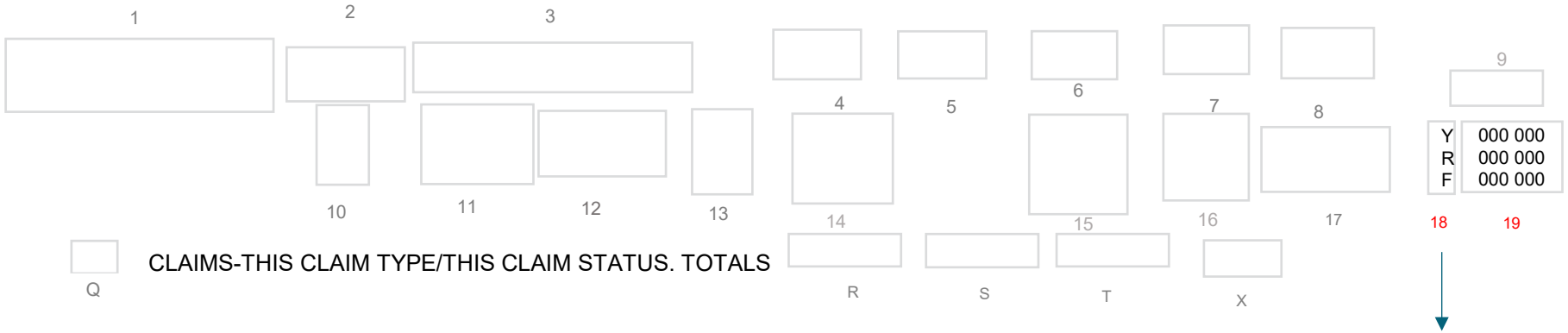
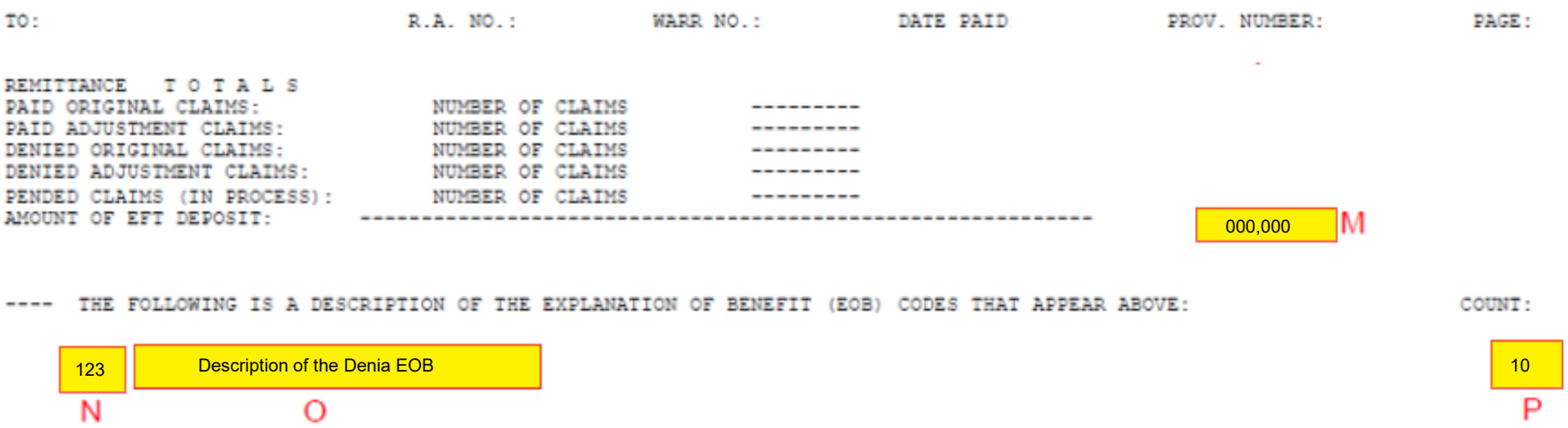


18. “S” Source of payment.
    Examples within the All Providers Chapter 4 Billing Manual:

Source Code	Description
A	Anesthesia
B	Billed charge
C	Percentage of charges
D	Inpatient per diem rate
E	EAC priced plus dispense fee
F	Fee schedule

19. EOB denial reason code

CMS 1500 - Remittance Advice



M. Total check amount for claims paid on this Remittance Advice
N. EOB code or denial code
O. Description of the denial EOB
P. Number of claims that denied for the EOB code described

Adjustment Request

An ***adjustment*** is an electronic request for Medicaid to make a change to a previously paid claim.

- Work with EDI or your 3rd party vendor to request an adjustment request.

A ***recoupment*** is a request for Medicaid to take back the entire, original claim payment.

- You would use the *Recoupment Request*, to notify Iowa Medicaid to take an action against a paid claim when money needs to be credited back.
- Denied claims must be resubmitted in the normal claim submission process. Denied claims cannot be adjusted or recouped.

Remittance Advice (RA)

Top Denials to Watch

- Incarceration
- Missing Modifier (e.g., mental health claims per IL 1613)
- Billing Secondary Insurance
- Timely Filing
- Prior Authorization mismatch

TIP: For smoother and faster provider services questions regarding your RA, have your TCN ready or claim information which includes, NPI, Member ID, DOS, and billed amount.

Remittance Advice (RA)

Be Aware:

- **Medicare Crossover Billing:** Use correct SBR09 codes: MA, MB, 16, CI. Include EOB, AMT, CAS segments for processing accuracy.
- **Timely Filing Process:** Claims outside the time window must follow the ETP process. Proof of timely submission is required.
- **Waiver Claims:** If Prior Authorization is missing/incorrect, work with the member's case manager.
- **IL 2372 Eligibility Recovery Claim Guidance:** Resubmissions must include full documentation: claim form, provider inquiry, MCO letter, eligibility proof, and service documentation.

Top 10 Claim Denials

Top 10 Claim Denials

Identify trending denials: **Below are top 10 utilized edits across denied claims:**

- (EOB 001) Exact Duplicate Claim
- (EOB 094) Billing Provider NPI/Taxonomy/Zip combination invalid
- (EOB 081) Recipient is Medicare eligible, and claim was not sent as a Crossover Claim
- (EOB 090) Member's third-party insurance payment or denial was not indicated on claim
- (EOB 157) No provider rate found
- (EOB 177) Procedure not allowed for date of service – refer to fee schedule
- (EOB 178) Member has an MCO for date of service
- (EOB 480) Member is medically needy and has a spenddown
- (EOB 097) Service not covered for recipient; limited or no Medicaid benefits for date of service
- (EOB 097) Service not covered for recipient; limited or no Medicaid benefits for date of service

Top 10 Claim Denials, (cont.)

Exact Duplicate Claim (EOB 001)

Issue: Claim submitted more than once for the same service/date.

Common Issues:

- **Paid** at $0, When reviewing the remittance advice, the claim may pay out at $0. This represents a “paid” claim, this is NOT a denial.
- **Do not resubmit**!

Fix: Avoid resubmitting identical claims. Use modifiers if services were repeated legitimately.

Track and Respond to Denials Promptly

- Review remittance advice for denial codes and reasons**.**
- Use denial edit guides to understand and correct issues (e.g., duplicate claims, missing COB).
- Resubmit **corrected** claims.

Resources:

IL 966 - Duplicate Claim Submission

Top 10 Claim Denials, (cont.)

Invalid Billing Provider NPI/Taxonomy/ZIP (EOB 094)

Issue: Provider's NPI, taxonomy, and ZIP code combo doesn't match Medicaid records.

Fix:

- The provider must use the correct combination of **NPI**, **taxonomy**, and **ZIP code** that matches their enrollment with **Iowa Medicaid**.

- If you are unsure, please double-check all provider enrollment data to ensure accuracy.

Top 10 Claim Denials, (cont.)

Medicare Eligible, Not a Crossover Claim (EOB 081)
Issue: Member is a dual eligible and Medicare eligible services must be submitted as secondary to Medicaid.

Step	Action	Details/Codes
Step 1	Identify Claim Type	Professional (837P) or Institutional (837I)
Step 2	Determine Insurance Type	Use correct indicator: MA – Medicare Part A, MB – Medicare Part B, 16 – Medicare HMO (Replacement/Supplement), CI – Commercial Insurance (Third Party Liability)
Step 3	Enter Medicare Payment Information	Loop 2320 AMT – Medicare paid amounts
Step 4	Enter Cost Sharing Details	Loop 2430 CAS – Deductibles, Coininsurance, Copays

IL 2157 “Lesser than logic” information affects how Medicaid calculates payment after Medicare. Refer to IL 2157 Medicare Part A and Part B Crossover Claims for Dually Eligible Medicare and Medicaid Members

Top 10 Claim Denials, (cont.)

Missing Third Party Insurance Info (EOB 090)

Issue: Member has other insurance, but **no payment or denial info** was submitted on the claim.

Fix: Ensure third party payments and denials are reflected on the claim accurately.

- For Fee-for-Service claims, use the Eligibility Verification System (ELVS) to confirm Third Party Liability (TPL) before submission.
- If the member's file needs to be updated use this form to update member's TPL: Fee-for-Service Members Insurance Update or the member can call member service to update.
- For clarification regarding Fee-for-Service claims after processing, refer to Informational Letter (IL) 1668 - IL 1668 Submitting Claims to the IME after Third Party Liability (TPL) Adjudication

Top 10 Claim Denials, (cont.)

No Provider Rate Found (EOB 157)

Issue: No Medicaid rate exists for the billed procedure.

Fix:

- Check the fee schedule.
- Ensure procedure code is valid for provider type.
- Billing with correct modifiers.

Use Correct Coding and Fee Schedules:

- Reference the **Iowa Medicaid Fee Schedule** and **National Correct Coding Initiative (NCCI)** edits.
- Avoid billing for non-covered services or using outdated codes.
- Apply modifiers like **NU** for new DME items when required.

Top 10 Claim Denials, (cont.)

Procedure Not Allowed for Date of Service (EOB 177)

Issue: Procedure code isn't valid for the billed date.

Fix:

- Refer to the Iowa Medicaid fee schedule.
- Verify that the procedure code is active and able to bill.

Top 10 Claim Denials, (cont.)

Member Has MCO Coverage (EOB 178)

Issue: Member was enrolled in a Managed Care Organization (MCO).

Fix:

- Verify eligibility for date of service.
- Submit claim to the appropriate MCO, not Fee-for-Service Medicaid.

Top 10 Claim Denials, (cont.)

Medically Needy with Spenddown (EOB 480)

Issue: Member must meet spenddown before Medicaid pays.

Fix:

- Include qualifying medical expenses to meet spenddown threshold.
- Ensure that you are reviewing the member's eligibility for spenddown.

Top 10 Claim Denials, (cont.)

Member Had Limited or No Medicaid Coverage on Date of Service (EOB 097)

Issue: Member had limited or no Medicaid coverage on the date of service.

Fix:

- Check coverage **before** providing service, every time!
- Eligibility Verification System (ELVS) is Iowa Medicaid's source of truth and is accurate in real time.

Top 10 Claim Denials, (cont.)

Service Not Covered for Recipient – Incarcerated Individual (EOB 097)

Issue: Member had limited or no Medicaid coverage on date of service. As a reminder an incarcerated individual are only eligible for in-patient hospital services.

Fix: Confirm eligibility for the date before billing. Avoid billing non-covered services.

Incarcerated Eligibility Services: Iowa Code 441-75.12

Top Claim Denial Remedies

Patient Eligibility Verification

Why It Matters

Eligibility issues are a top cause of claim denials. Avoid delays by verifying coverage before appointments.

Best Practices

Use the **Eligibility Verification Information System (ELVS)**

Establish a robust verification process

Check for:

- Lapsed coverage
- Incorrect patient details

Pro Tip - Proactive checks = fewer denials + faster reimbursement

Need Help with ELVS

👉 Access the **ELVS Portal Training**: Eligibility Verification Information System (ELVS)

Top Claim Denial Remedies

Coordination of Benefits (COB)

Why It's Important

For patients with multiple insurance plans, COB ensures claims are processed correctly and denials are avoided.

Key Concepts

- **Third Party Liability (TPL):** Does the member have Medicare or other insurance?
- **Verify Coverage:** Confirm primary and secondary plans before submitting claims.
- **Billing Sequence Matters:** Bill Medicaid only after billing the primary insurance.

Reminder:

Medicaid is the payor of last resort. Submitting claims in the wrong order can lead to COB-related denials.

Top Claim Denial Remedies

Coding Accuracy

Why It Matters

Medicaid plans require specific codes and modifiers. Accurate coding is essential for claim approval and reimbursement.

Key Actions

- **Know Your Codes:** Train staff on Medicaid-specific coding rules and modifiers
- **Medical Necessity:** Medicaid reimburses only medically necessary care
- **Definitions** may vary by plan
- **Timely Documentation:** Submit supporting documentation within 7 days of claim submission
- **Supports claim** validity and speeds up reimbursement

Common Pitfall: Incorrect or missing codes = **denied claims** Late documentation = **delayed payments**

Claims and Billing Wrap Up

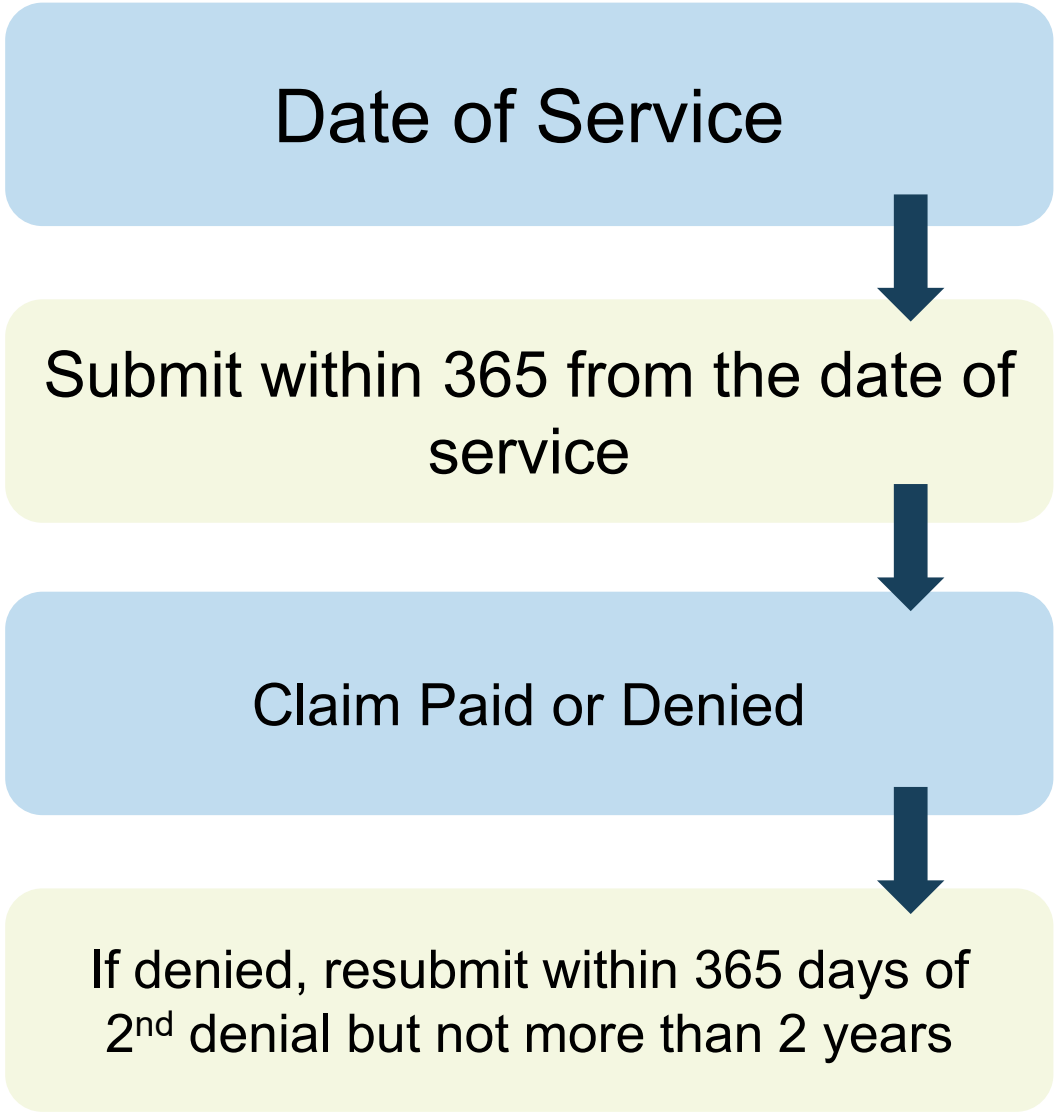
Timely Filing Guidelines

Initial Claims: Must be submitted within **365 days** from the **date of service**.

Important Notes:

- Claims **not paid or denied** (e.g., rejected by a clearinghouse or returned for errors) are **not considered filed** for timely submission.

- IL 1899 – Timely filing guidelines: Timely Filing Reminder



Provider Inquiry Guidance

Provider Inquiry Form - Provider Inquiry Form

Iowa Medicaid providers use Provider Inquiry forms to formally request:

- **Information**: Claim specific issues
- Requesting Medical Services/policy review of Healthcare Common Procedure Coding System (HCPCS) and review of fee schedule for HCPCS code

- **Disputing denial** of a previously reviewed claim
  - Submit via US Mail only using Form 470-3744.
  - Do **not** use this form to submit documentation or resubmit claims.
  - Once reviewed, a response letter will be mailed. If disputed, a new inquiry can be submitted.

Informational Letters (IL)

What Are Informational Letters?

- Official communications from Iowa Medicaid
- Share updates on:
  - Policy changes
  - Billing procedures
  - System enhancements
  - Provider guidance
- Issued regularly to keep providers informed and compliant

Why They Matter:

- Help providers maintain compliance
- Clarify operational processes
- Announce upcoming system or policy changes
- Ensure timely action and preparation
- For more details, visit: Information Letters

Best Practices

Top 4 Provider Claims Best Practices – Iowa Medicaid

1. **Submit Claims Electronically** - Iowa Medicaid requires electronic submission for Fee-for-Service.
    - Ensure all claim submissions follow IL 2022-MC-FFS
    - Submit FFS claims through your clearinghouse, Ability PC-ACE Pro or Electronic Data Interchange (EDI) Clearinghouse.
2. **Patient Eligibility Verification** – ELVS: Eligibility & Verification Information System | Health & Human Services
    - Eligibility issues are a frequent cause of claim denials.
    - Conducting insurance coverage checks before appointments can identify potential issues, such as lapsed coverage or incorrect patient information.

Best Practices, (cont.)

Top 4 Provider Claims Best Practices – Iowa Medicaid

3. **Coordination of Benefits** (COB)

   - For patients with multiple insurance plans, coordination of benefits is essential.
   - Providers should verify patients' secondary insurance plans and determine the primary and secondary plans before submitting claims. Billing Medicaid only after billing the primary insurance can prevent COB-related claim denials.

Best Practices, (cont.)

Top 5 Provider Claims Best Practices – Iowa Medicaid

4. **Coding Accuracy and Documentation requirements**

   - Providers must make sure that to submit claims with the correct NPI, Tax ID, and address.
   - Ensure that the claim is submitted with the correct documentation required.
   - Ensure that the procedure codes are correct for the services provided.

5. **Reminder:** As a condition of participation in the Medicaid program, providers must agree to accept the payment made by the Medicaid program as payment in full and make no additional charges to the member or others.

Resources

Supporting Providers. Strengthening Care. Serving Iowans.

IOWA Health and Human Services

Get in Touch

Provider Service Inbox – IMEProviderServices@hhs.iowa.gov

How to best utilize this communication tool:

- MCO Liaison referrals
- Escalated issues that cannot be resolved through the call center
- Request for addition of codes to fee schedules
- Policy questions - Informational Letter clarifications

Provider Services Resources

- **Contact Provider Services Monday to Friday from 8 a.m. to 5 p.m. CST**
- **Toll Free Phone:** 1-800-338-7909
- **Des Moines Area Phone:** 515-256-4609
- **RELAY IOWA TTY:** 1-800-735-2942
- **Website Link:** Medicaid Provider Services | Health & Human Services
- **FAQ:** Claims and Billing Frequently Asked Questions and Answers
- **Email:** imeproviderservices@hhs.iowa.gov

Provider Enrollment Resources

- **Contact Provider Enrollment** Monday to Friday from 8 a.m. to 5 p.m. CST
- **Toll Free Phone:** 1-800-338-7909
- **Des Moines Area Phone:** 515-256-4609 opt. 2
- **Submit Forms by Fax:** 515-725-1155
- **Link** to enrollment process: Iowa Medicaid Provider Enrollment Flow Chart
- **FAQ:** Provider Enrollment FAQ
- **RELAY IOWA TTY:** 1-800-735-2942
- **Website Link:** Provider Enrollment
- **Email:** imeproviderenrollment@hhs.iowa.gov

Provider Services

- **Provider Training:** Medicaid Provider Trainings | Health & Human Services
- **Provider Policy Manuals:** Provider Policy Manuals | Health & Human Services
- **Informational Letters and Policy Clarifications:** Information Letters and Policy Clarifications
- **Provider Town Halls:** Third Thursday of the month - Medicaid Town Halls | Health & Human Services
- **Mandatory Electronic Billing Requirements:** IL 2022-MC-FFS

Provider Services

- **Electronic Data Interchange (EDI) Clearinghouse -** Contact EDISS - Medicaid - EDISS
- **ABILITY PC-ACE Pro** (Billing software): PC-ACE - Medicaid - EDISS
- **FFS claims:** IMPA system
- **How to read a remittance advice:**
  Billing Iowa Medicaid manual. Section “O” Chapter IV BILLING IOWA MEDICAID
- **ELVS Portal Training:** Eligibility Verification Information System (ELVS) - 2-24-25.pptx

Provider Services

- **Timely filing guidelines:** IL 1899 IL 1899-FFS Timely Filing Reminder
- **Provider Inquiries (PIs):** Microsoft Word - 470-3744.doc
- **Eligibility Recovery Claim Submission Guidance - IL 2372 guidelines:** 2372-MC-FFS_Eligibility_Recovery_Claim_Submission_Guidance (1).pdf
- **Claim Submission Guidance:** IL 2022-MC-FFS
- **Duplicate Claim Submissions**: IL 966 - Duplicate Claim Submissions

Resources - Forms

- **Ambulance Enrollment Form -** Ambulance Verification of Compliance
- **Iowa Medicaid Universal Provider Enrollment Application**: 470-0254, Iowa Medicaid Universal Enrollment Application
- **HHS website provider enrollment**: Provider Enrollment | Health & Human Services
- **Provider Forms:** Provider Forms | Health & Human Services (iowa.gov)
- **Designated Contact Person (DCP) Form**: https://hhs.iowa.gov/media/12377/download?inBox
- **Provider Request to Terminate Enrollment**: https://hhs.iowa.gov/media/6036/download?inBox
- **EFT Authorization Form**: https://hhs.iowa.gov/media/5442/download?inBox

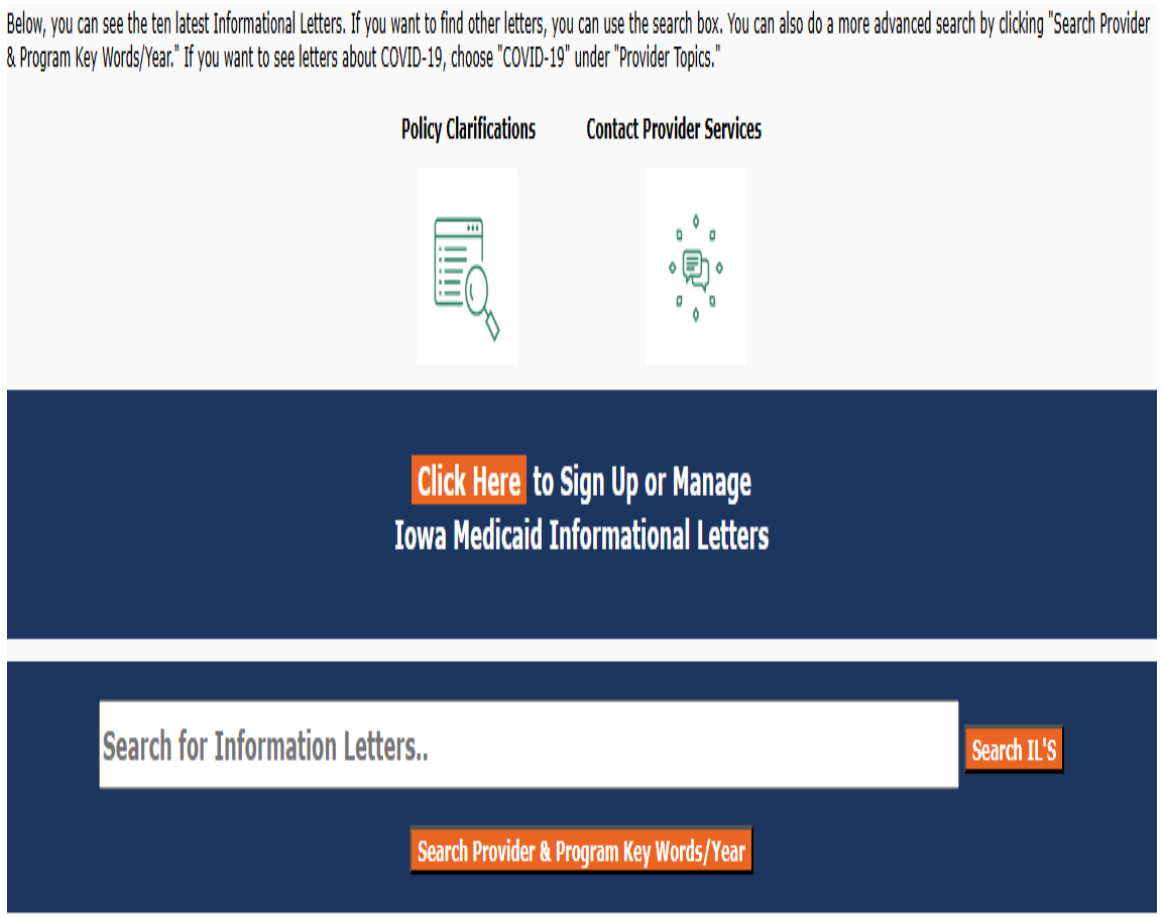
Informational Letters

How to Enroll:

1. Access the Informational Letters page on the HHS website: Informational Letters or https://secureapp.dhs.state.ia.us/IMPA/Information/Bulletins.aspx

2. Subscribe to the email distribution list to receive letters directly.

3. You can research policy clarifications on this page as well.



Iowa Medicaid
Provider Outreach Education

Provider Services: IMEProviderServices@HHS.Iowa.Gov

Provider Enrollment: IMEProviderEnrollment@HHS.Iowa.Gov

Toll Free Phone: 1-800-338-7909

IOWA™ | Health and Human Services

Fee-for-Service (FFS) Guidance