

**ALL PROVIDERS**

**IV. BILLING IOWA MEDICAID**





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## Preamble

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

## CHAPTER IV. BILLING IOWA MEDICAID

### A. INTRODUCTION

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

The IME used the following claim forms:

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

### B. TIMELY FILING REQUIREMENTS

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

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



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 one year past the date of service 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 Third Party Liability (TPL) explanation of benefits and must be received at the IME within 365 days of the TPL process date.

Medicaid Claims  
PO Box 150001  
Des Moines, IA 50315

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

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

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

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

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

- ◆ When completing the claim form, enter the ETP 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 ETP letter states that additional attachments are required with the claim, these attachments must be faxed to (515) 725-1318. Additional attachments will be itemized in the ETP letter. The ETP letter is not considered an additional attachment and does not need to be faxed to the IME. Attachments that cannot be faxed will require that the claim be submitted on paper according to [Informational Letter 637](#).

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

## 2. Electronic Billing

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



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

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

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

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

The billing instructions linked below contain information that will aid in the completion of the UB-04 claim form. The table follows the form by field number and name, providing a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

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

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

Medicaid Claims  
PO Box 150001  
Des Moines, IA 50315

See [UB-04 Claim Instructions](#).

If you have any questions about this form or instructions, please contact IME Provider Services at (800) 338-7909.



## 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 linked 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, providing 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.

See [CMS-1500 Claim Form Instructions](#).

If you have any questions about this form or instructions, please contact IME Provider Services at (800) 338-7909.



## 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 linked 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, providing a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

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

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

Medicaid Claims  
PO Box 150001  
Des Moines, IA 50315

See the [ADA 2012 Claim Form Instructions](#).

If you have any questions about this form or instructions, please contact IME Provider Services at (800) 338-7909.

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

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



## G. INSTRUCTIONS FOR SUBMITTING MEDICARE CROSSOVER CLAIMS

For Medicare Part A or Part B claims that do not crossover electronically from Medicare, providers must submit Medicare Part A or Part B crossover claims electronically via the 837I (Institutional) or 837P (Professional) transaction.

The IME offers free electronic billing software; PC-ACE Pro 32, available through [www.edissweb.com](http://www.edissweb.com). Click [here](#) for more information on how to obtain PC-ACE software or to view help resources.

## 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 Crossover Claim 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 billing instructions linked below follow 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

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See the [Claim for Targeted Medical Care Instructions](#).

If you have any questions about this form or instructions, please contact IME Provider Services at (800) 338-7909.

## 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 up to the Medicaid fee schedule amount, 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 appropriate Medicaid billing form.

### Medicare with Other Insurance

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

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

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## L. PRIOR AUTHORIZATION

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

### 1. Procedure for Requesting Authorization

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

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

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

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

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

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

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

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

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



You can verify eligibility by checking the Eligibility Verification System (ELVS) hotline, which is available 24 hours a day, 7 days a week at phone (800) 338-7752, locally in Des Moines at (515) 323-9639, or by accessing the IME Provider Web Portal Services at:  
<https://ime-ediss5010.noridian.com/iowaxchange5010/LogonDisplay.do>

## 2. Instructions for Completing Request for Prior Authorization

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



- ◆ **Prior Authorization No.** Leave blank. The IME will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.
- ◆ **Reasons for Request.** Provide the required information for the type of approval being requested in this area along with the "Services to Be Authorized" area.

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

### Services to Be Authorized

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



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

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

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

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

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

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

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

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

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

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

### M. PROVIDER INQUIRY

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

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

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

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

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

Send these forms to:

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



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## 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.*

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

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

**b. For Medicare Crossover Claims**

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

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

**2. Paper Adjustment or Recoupment Requests**

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

**3. Requesting an Adjustment on Paper**

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



Send form 470-0040 and required attachments to:

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

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

#### 4. Requesting a Recoupment on Paper

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

Send form 470-4987 and required attachments to:

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

## O. REMITTANCE ADVICE INSTRUCTIONS

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.

- ◆ "PAID" indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ "DENIED" represents all processed claims for which no reimbursement is made.
- ◆ "SUSPENDED" reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).



Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

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

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

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

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



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

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

### a. Remittance Advice Field Descriptions

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



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

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



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

R.A. NO.: 00000000

A

WARRANT NUMBER: 00000000

B

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

C

D

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

\*\*\*\*\*IMPORTANT INFO INFORMATION\*\*\*\*\*

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

E

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





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Date

October 1, 2013

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

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

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

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



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

This section covers the following material:

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

### a. Remittance Advice Field Descriptions

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



Field	Field Name	Field Description
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
T	Total Non Cov Charges	Total non-covered charges within same claim type or status
U	Total Allowed Charge	Total dollar amount allowed by Medicaid within same claim type or status
X	Total Paid by Mcaid	Total dollar amount paid within same claim type or status

1	Member Name	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Non Cov Charges	Total non-covered charges on claim
7	Allowed Charge	Allowed charge for claim
8	Paid by Mcaid	Dollar amount paid by Medicaid for claim
9	Medical Rec. No.	Medical record number assigned by provider
10	EOB	Explanation of Benefits denial code for claim



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



**b. Allowed Charge Source Codes**

Source Code	Description
A	Anesthesia
B	Billed charge
C	Percentage of charges
D	Inpatient per diem rate
E	EAC priced plus dispense fee
F	Fee schedule
G	FMAC priced plus dispense fee
H	Encounter fee
I	Prior authorization rate
K	Denied
L	Maximum suspend ceiling
M	Manually priced
N	Provider charge rate
O	Professional component
P	Group therapy
Q	EPSDT total over 17
R	EPSDT total under 18
S	EPSDT partial over 17
SP	Not yet priced
T	EPSDT partial under 18
U	Gynecology fee
V	Obstetrics fee
W	Child fee
X	Medicare or coinsurance deductibles
Y	Immunization replacement
Z	Batch bill APG

Source Code	Description
0	APG
1	No payment APG
3	HMO/PHP rate
4	System parameter rate
5	Statewide per diem
6	DRG auth or new
7	Inlier/outlier adjust
8	DRG ADR inlier
9	DRG ADR



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Date

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

R.A. NO.: 00000000

A

WARRANT NUMBER: 00000000

B

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

C

D

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

E

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

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



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Date

May 1, 2014

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

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 07/09/10

TO: PROVIDER NAME [C] R.A. NO.: [A] TIN: [U] WAR NO: [B] DTE PD: [G] PROV: [H] PAGE: [I]

\*\*\*\*\* PATIENT NAME \*\*\*\*\* RECIPIENT NAME \*\*\*\*\* TRANS-CONTROL-NUMBER BILLED OTHER NON COV ALLOWED PAID BY MEDICAL  
LINE SVC-DATE PROC AFG/APC UNITS AMT. SOURCES CHARGES CHARGE MCAID REC. NO. S EOB EOB

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

ORIGINAL CLAIMS: [1] FROM 06/10/10 TO 06/10/10 MED EDUC ADD: [4] 4057.18 [5] 0.00 [6] 0.00 [7] 1277.30 [8] 1277.30 [9] 0.00 [10] 000.000

01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22				
06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	06/10/10	0.00	0.00	0.00	14.67	A	1	0	0.00000	F	000	0
80053	82055	84484	85025	85610	70450	71275	96374	86376	99284	12060	09967	93005	93005	99285	115.50	0.00	0.00	14.99	A	1	0	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	32.00	0.00	0.00	13.65	A	1	0	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	26.00	0.00	0.00	10.78	A	1	0	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	498.00	0.00	0.00	4.85	A	1	0	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1024.00	0.00	0.00	623.40	N	1	0	9.32400	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	216.00	0.00	0.00	0.00	N	1	0	0.55550	K	826	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	71.75	0.00	0.00	20.19	A	1	0	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	900.00	0.00	0.00	221.37	V	1	0	3.31090	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	85.40	0.00	0.00	0.00	N	1	1	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	85.00	0.00	0.00	0.00	N	1	1	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	185.00	0.00	0.00	26.34	S	1	0	0.39400	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	609.00	0.00	0.00	327.06	V	1	0	4.89170	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	35.50	0.00	0.00	0.00	B	1	0	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	4057.18	0.00	0.00	1277.30	A	1	0	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.00	0.00	0.00	1277.30	B	1	0	0.00000	F	000	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.00	0.00	0.00	1277.30	X	1	0	0.00000	F	000	0

[1] CLAIMS-THIS CLAIM TYPE/CLAIM STATUS. TOTALS.. [R] 4057.18 [S] 0.00 [T] 0.00 [V] 1277.30 [X] 1277.30



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Date

October 1, 2013

TO: **C** PROVIDER NAME: [REDACTED] R.A. NO.: **A** [REDACTED] WARR. NO.: **B** [REDACTED] DATE PAID: **G** [REDACTED] PROV. NUMBER: **H** [REDACTED] PAGE: **I** [REDACTED]

REMITTANCE TOTALS  
 PAID ORIGINAL CLAIMS: [REDACTED] NUMBER OF CLAIMS: **J** [REDACTED]  
 PAID ADJUSTMENT CLAIMS: [REDACTED] NUMBER OF CLAIMS: [REDACTED]  
 DENIED ORIGINAL CLAIMS: [REDACTED] NUMBER OF CLAIMS: [REDACTED]  
 DENIED ADJUSTMENT CLAIMS: [REDACTED] NUMBER OF CLAIMS: [REDACTED]  
 DENIED CLAIMS (IN PROCESS): [REDACTED] NUMBER OF CLAIMS: [REDACTED]  
 AMOUNT OF EFT DEPOSIT: [REDACTED] NUMBER OF CLAIMS: [REDACTED]

DATE PAID: [REDACTED] **K** [REDACTED] 0,000.00  
 0.00  
 0.00  
 0.00  
 0.00  
 0.00

PROV. NUMBER: [REDACTED] **L** [REDACTED] 0,000.00  
 0.00  
 0.00  
 0.00  
 0.00  
 0.00

**M** [REDACTED] 0,000.00

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

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



### 3. CMS-1500 Remittance Advice Guide

This section covers the following material:

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

#### a. Remittance Advice Field Descriptions

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



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

1	Member Name	Last, first name or initial of the member as shown on the Medicaid identification card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total copayment on claim
8	Med Rcd Num	Medical record number or member account number
9	EOB	Explanation of Benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



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Field	Field Name	Field Description
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on this line
15	Paid by Mcaid	Amount paid by Medicaid on this line
16	Copay Amt.	Copayment amount on this line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number
18	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
19	EOB	Explanation of Benefits denial reason code



**b. Allowed Charge Source Codes**

Source Code	Description
A	Anesthesia
B	Billed charge
C	Percentage of charges
D	Inpatient per diem rate
E	EAC priced plus dispense fee
F	Fee schedule
G	FMAC priced plus dispense fee
H	Encounter fee
I	Prior authorization rate
K	Denied
L	Maximum suspend ceiling
M	Manually priced
N	Provider charge rate
O	Professional component
P	Group therapy
Q	EPSDT total over 17
R	EPSDT total under 18
S	EPSDT partial over 17
SP	Not yet priced
T	EPSDT partial under 18
U	Gynecology fee
V	Obstetrics fee
W	Child fee
X	Medicare or coinsurance deductibles
Y	Immunization replacement
Z	Batch bill APG

Source Code	Description
0	APG
1	No payment APG
3	HMO/PHP rate
4	System parameter rate
5	Statewide per diem
6	DRG auth or new
7	Inlier/outlier adjust
8	DRG ADR inlier
9	DRG ADR



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Date

October 1, 2013

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

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

WARRANT NUMBER: 00000000 **B**

**C**

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

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

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

**E**

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

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



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Date

May 1, 2014

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

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

ORIGINAL CLAIMS:

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

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



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Date

October 1, 2013

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

REMITTANCE TOTALS

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

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

COUNT:

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



#### 4. Dental Remittance Advice Guide

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

##### a. Remittance Advice Field Descriptions

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



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

1	Member Name	Last, first name or initial of the member as shown on the Medicaid identification card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid
7	Copay Amt.	Total copayment on claim
8	Med Rcd Num	Member account number assigned by the provider
9	EOB	Explanation of Benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)
10	Line	Line number
11	Svc-Date	Date of service
12	Proc/Mods	ADA or CPT code and modifier billed



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



**b. Allowed Charge Source Codes**

Source Code	Description
A	Anesthesia
B	Billed charge
C	Percentage of charges
D	Inpatient per diem rate
E	EAC priced plus dispense fee
F	Fee schedule
G	FMAC priced plus dispense fee
H	Encounter fee
I	Prior authorization rate
K	Denied
L	Maximum suspend ceiling
M	Manually priced
N	Provider charge rate
O	Professional component
P	Group therapy
Q	EPSDT total over 17
R	EPSDT total under 18
S	EPSDT partial over 17
SP	Not yet priced
T	EPSDT partial under 18
U	Gynecology fee
V	Obstetrics fee
W	Child fee
X	Medicare or coinsurance deductibles
Y	Immunization replacement
Z	Batch bill APG

Source Code	Description
0	APG
1	No payment APG
3	HMO/PHP rate
4	System parameter rate
5	Statewide per diem
6	DRG auth or new
7	Inlier/outlier adjust
8	DRG ADR inlier
9	DRG ADR



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Date

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**c. Dental Claim Remittance Advice Sample**

R.A. NO. : 00000000

A

APPRAINT NUMBER: 00000000

B

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

C

D

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

\*\*\*\*\*IMPORTANT IME INFORMATION\*\*\*\*\*

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

E

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





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

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

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

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

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

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

**N**

**O**

**P**



## 5. Long-Term Care Remittance Advice Guide

This section covers the following material:

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

### a. Remittance Advice Field Descriptions

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



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

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



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



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Date

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

R.A. NO.: 00000000

A

WARRANT NUMBER: 00000000

B

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

C

D

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

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

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

E

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



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Date

May 1, 2014

RUN DATE: MM/DD/YY  
F

TO: PROVIDER NAME C R.A. NO.: A MAOR NO.: B DATE PAID: G ENOV. NUMBER: H PAGE: I  
 \*\*\* PATIENT NAME \*\*\* RECEIPT FIRST LAST COVID MOSP NCOV VISIT BILLED OTHER PAID BY  
 LAST FI MI IDENT NUM TRANS-CONTROL-NUMBER SVC DATE SVC DATE DAYS DAYS DAYS AMT. SOURCES WCALD EOB EOB  
 \* \* \* CLAIM TYPE: LONG TERM CASE \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

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

ADJUSTMENT CLAIMS:

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



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Date

October 1, 2013

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

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

NUMBER OF CLAIMS  
 NUMBER OF CLAIMS

0,000.00 **J**  
 0.00  
 0.00  
 0.00  
 0.00  
 0.00

0,000.00 **K**  
 0.00  
 0.00  
 0.00  
 0.00  
 0.00

0,000.00 **L**  
 0.00  
 0.00  
 0.00  
 0.00  
 0.00

0,000.00 **M**

----- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT: 1

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



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

This section covers the following material:

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

### a. Remittance Advice Field Descriptions

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



Field	Field Name	Field Description
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Medicare Paid Amt	Total dollar amount of Medicare payment
S	Deductible	Total deductible paid amount within same claim type or status
T	Coins. Amt.	Total coinsurance paid amount within same claim type or status
U	TIN	Total dollar amount allowed by Medicaid within same claim type or status
X	Mcaid Paid Amt	Total amount Medicaid paid within same claim type or status

1	Member Nme	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dates of Service (first and last)	First and last date of service
5	Medicare Paid Amt	Total paid by Medicare on claim
6	Deductible	Total Medicare deductible on claim
7	Coins. Amt.	Total Medicare coinsurance on claim
8	Mcaid Paid Amt	Total amount paid by Medicaid on claim
9	Medical Record No.	Medical record number or member account number
10	EOB	Explanation of Benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



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Date

October 1, 2013

**b. Medicare Crossover (Inpatient) Remittance Advice Sample**

R.A. NO. : 00000000

A

WARRANT NUMBER: 0000000

B

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

C

D

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

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

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

E

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



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Date

May 1, 2014

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

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 07/09/10

TO: PROVIDER NAME [C] R.A. NO.: [A] 00000006 TIN: [U] XXXXXXXXXX MAR NO: [B] 99999999 DTE PD: [G] 07/12/10 FROM: [H] PAGE: [I] 1

PATIENT NAME = LAST FI MI IDENT NUM \* \* \* CLAIM TYPE: INPATIENT CROSSOVER \* \* \* CLAIM STATUS: PAID DATES OF SERVICE MEDICARE DEDUCT- COINS. MCAID MEDICAL RECD NO. E08 E08 LAST PAID AMT IBLE AMT. PAID AMT

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

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



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Date

October 1, 2013

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

REMITTANCE T O T A L S

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

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

COUNT:

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



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

This section covers the following material:

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

### a. Remittance Advice Field Descriptions

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



Field	Field Name	Field Description
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Medicare Paid Amt	Total dollar amount of Medicare payment
S	Deductible	Total deductible paid amount within same claim type or status
T	Coins. Amt.	Total coinsurance paid amount within same claim type or status
X	Mcaid Paid Amt	Total amount Medicaid paid within same claim type or status

1	Member Name	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dates of Service (first and last)	First and last date of service
5	Medicare Paid Amt	Total paid by Medicare on claim
6	Deductible	Total Medicare deductible on claim
7	Coins. Amt.	Total Medicare coinsurance on claim
8	Mcaid Paid Amt	Total amount paid by Medicaid on claim
9	Medical Record No.	Medical record number or member account number
10	EOB	Explanation of Benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



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Date

October 1, 2013

b. Medicare Crossover (Outpatient) Remittance Advice Sample

R.A. NO. : 00000000

A

TRAPRANT NUMBER: 00000000

B

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

C

D

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

E

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

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



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Date

May 1, 2014

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

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

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

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

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

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

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



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Date

October 1, 2013

TO: **C** PROVIDER NAME **A** R.A. NO.: 000000000 **B** MARR NO.: 00000000 **J** DATE PAID: MM/DD/YY **G** PROV. NUMBER: 000000000000 **H** PAGE: **I**

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

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

COUNT:

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



## 8. Medicare Part B Crossover Remittance Advice Guide

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

### a. Remittance Advice Field Descriptions

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



Field	Field Name	Field Description
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Mcare Paid Amt	Total Medicare payment within same claim type or status
S	Mcare Apprd	Total Medicare approved within same claim type or status
T	Deductible	Total deductible amount within same claim type or status
U	Coins. Amt.	Total coinsurance amount within same claim type or status
V	Copay	Total copayment amount within same claim type or status
X	Mcaid Paid Amt	Total Medicaid payment within same claim type or status

1	Member	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Mcare Paid Amt	Total paid by Medicare on claim
5	Mcare Apprd	Total amount Medicare approved
6	Deductible	Total Medicare deductible on claim
7	Coins. Amt.	Total Medicare coinsurance on claim
8	Copay	Total Iowa Medicaid copayment on claim
9	Mcaid Paid Amt	Total amount paid by Medicaid on claim
10	Med Rcd Num	Medical record number OR member account number



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Date

October 1, 2013

Field	Field Name	Field Description
11	Line	Line number
12	Svc-Date	Date of service on line
13	Proc Mods	CPT or HCPCS code and modifier billed
14	Units	Number of units billed
15	Mcare Paid Amt	Medicare paid amount on line item
16	Mcare Apprd	Medicare approved amount on line item
17	Deductible	Medicare deductible amount on line item
18	Coins. Amt.	Medicare coinsurance amount on line item
19	Copay	Iowa Medicaid copayment on line item
20	Mcaid Paid Amt	Total amount paid by Medicaid on line
21	S	Source of payment. See <a href="#">Allowed Charge Source Codes</a> .
22	EOB	Explanation of Benefits denial reason code (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)



**b. Allowed Charge Source Codes**

Source Code	Description
A	Anesthesia
B	Billed charge
C	Percentage of charges
D	Inpatient per diem rate
E	EAC priced plus dispense fee
F	Fee schedule
G	FMAC priced plus dispense fee
H	Encounter fee
I	Prior authorization rate
K	Denied
L	Maximum suspend ceiling
M	Manually priced
N	Provider charge rate
O	Professional component
P	Group therapy
Q	EPSDT total over 17
R	EPSDT total under 18
S	EPSDT partial over 17
SP	Not yet priced
T	EPSDT partial under 18
U	Gynecology fee
V	Obstetrics fee
W	Child fee
X	Medicare or coinsurance deductibles
Y	Immunization replacement
Z	Batch bill APG

Source Code	Description
0	APG
1	No payment APG
3	HMO/PHP rate
4	System parameter rate
5	Statewide per diem
6	DRG auth or new
7	Inlier/outlier adjust
8	DRG ADR inlier
9	DRG ADR



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of Human  
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Date

October 1, 2013

**c. Medicare Part B Crossover Remittance Advice Sample**

R.A. NO. : 00000000

A

WARRANT NUMBER : 00000000

B

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

C

D

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

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

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

E

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





Iowa  
Department  
of Human  
Services

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Date

October 1, 2013

TO: PROVIDER NAME **C** R.A. NO.: 00000000 **A** WARR NO.: 00000000 **B** DATE PAID: 10/01/13 **G** PROV. NUMBER: 0000000000 **H** PAGE: 2 **I**

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

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

COUNT:

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



## 9. Pharmacy Remittance Advice Guide

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

### a. Remittance Advice Field Descriptions

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



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

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



**b. Allowed Charge Source Codes**

Source Code	Description
A	Anesthesia
B	Billed charge
C	Percentage of charges
D	Inpatient per diem rate
E	EAC priced plus dispense fee
F	Fee schedule
G	FMAC priced plus dispense fee
H	Encounter fee
I	Prior authorization rate
K	Denied
L	Maximum suspend ceiling
M	Manually priced
N	Provider charge rate
O	Professional component
P	Group therapy
Q	EPSDT total over 17
R	EPSDT total under 18
S	EPSDT partial over 17
SP	Not yet priced
T	EPSDT partial under 18
U	Gynecology fee
V	Obstetrics fee
W	Child fee
X	Medicare or coinsurance deductibles
Y	Immunization replacement
Z	Batch bill APG

Source Code	Description
0	APG
1	No payment APG
3	HMO/PHP rate
4	System parameter rate
5	Statewide per diem
6	DRG auth or new
7	Inlier/outlier adjust
8	DRG ADR inlier
9	DRG ADR



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Date

October 1, 2013

c. Pharmacy Remittance Advice Sample

R.A. NO. : 00000000

A

WARRANT NUMBER: 00000000

B

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

C

D

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

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

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

E

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



Iowa  
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Date

May 1, 2014

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

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

RUN DATE XX/XX/XX

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

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

ORIGINAL CLAIMS:

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

ADJUSTMENT CLAIMS: **14**

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

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

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



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Date

October 1, 2013

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

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

0,000.00 **K**  
 0.00  
 0.00  
 0.00  
 0.00  
 0.00

0,000.00 **L**  
 0.00  
 0.00  
 0.00  
 0.00  
 0.00

0,000.00 **M**

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

COUNT:

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



## 10. Waiver Provider Remittance Advice Guide

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

### a. Remittance Advice Field Descriptions

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



Field	Field Name	Field Description
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Billed Amt.	Total billed amount within same claim type or status
S	Other Sources	Total other sources (for example: TPL) within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
U	TIN	Tax identification number
V	Copay Amt.	Total copayment amount within same claim type or status

1	Member Name	Name of the member as shown on the Medicaid identification card (last name and first initial)
2	Member ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Other sources on claim (for example: TPL)
6	Paid by Mcaid	Dollar amount paid by Medicaid on claim
7	Copay Amt.	Copayment amount on claim
8	Med Rcd Num	Medical record number assigned by provider
9	EOB	Explanation of benefit code, denial reason for claim
10	Line	Line numbers of claim
11	Svc-Date	Date of service as listed on claim
12	Proc/Mods	CPT or HCPCS code billed and any modifiers



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Date

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



**b. Allowed Charge Source Codes**

Source Code	Description
A	Anesthesia
B	Billed charge
C	Percentage of charges
D	Inpatient per diem rate
E	EAC priced plus dispense fee
F	Fee schedule
G	FMAC priced plus dispense fee
H	Encounter fee
I	Prior authorization rate
K	Denied
L	Maximum suspend ceiling
M	Manually priced
N	Provider charge rate
O	Professional component
P	Group therapy
Q	EPSDT total over 17
R	EPSDT total under 18
S	EPSDT partial over 17
SP	Not yet priced
T	EPSDT partial under 18
U	Gynecology fee
V	Obstetrics fee
W	Child fee
X	Medicare or coinsurance deductibles
Y	Immunization replacement
Z	Batch bill APG

Source Code	Description
0	APG
1	No payment APG
3	HMO/PHP rate
4	System parameter rate
5	Statewide per diem
6	DRG auth or new
7	Inlier/outlier adjust
8	DRG ADR inlier
9	DRG ADR



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Date

October 1, 2013

**c. Waiver Provider Remittance Advice Sample**

R.A. NO. : 0000000

A

WRAPANT NUMBER : 0000000

B

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

C

D

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

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

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

E

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



Iowa  
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of Human  
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Date

May 1, 2014

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

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 07/09/10

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

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

ORIGINAL CLAIMS:

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

1 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS... 1170.00 0.00 585.00 0.00  
R S T V



Iowa  
Department  
of Human  
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Date

October 1, 2013

TO: PROVIDER NAME

R.A. NO.: 00000000

WARR NO.: 00000000

DATE PAID: MM/DD/YY

PROV. NUMBER: 0000000000

PAGE: 2

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

NUMBER OF CLAIMS  
NUMBER OF CLAIMS

0  
0  
0  
0  
0  
0

0,000.00  
0.00  
0.00  
0.00  
0.00  
0.00

0,000.00  
0.00  
0.00  
0.00  
0.00  
0.00

0,000.00

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

COUNT:

000 EXPLANATION (EOB) OF DENIAL CODE

N

O

1

P



## 11. Capitation and Administrative Fee Remittance Advice Guide

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

### a. Remittance Advice Field Descriptions

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



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

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



**b. Allowed Charge Source Codes**

Source Code	Description
A	Anesthesia
B	Billed charge
C	Percentage of charges
D	Inpatient per diem rate
E	EAC priced plus dispense fee
F	Fee schedule
G	FMAC priced plus dispense fee
H	Encounter fee
I	Prior authorization rate
K	Denied
L	Maximum suspend ceiling
M	Manually priced
N	Provider charge rate
O	Professional component
P	Group therapy
Q	EPSDT total over 17
R	EPSDT total under 18
S	EPSDT partial over 17
SP	Not yet priced
T	EPSDT partial under 18
U	Gynecology fee
V	Obstetrics fee
W	Child fee
X	Medicare or coinsurance deductibles
Y	Immunization replacement
Z	Batch bill APG

Source Code	Description
0	APG
1	No payment APG
3	HMO/PHP rate
4	System parameter rate
5	Statewide per diem
6	DRG auth or new
7	Inlier/outlier adjust
8	DRG ADR inlier
9	DRG ADR



Iowa  
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of Human  
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Date

October 1, 2013

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

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

WARRANT NUMBER: 00000000 **B**

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

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

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

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



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of Human  
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Date

May 1, 2014

IAWC0000-R001 (CP-0-12) IOWA DEPARTMENT OF HUMAN SERVICES  
 AS OF XX/XX/XX MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE XX/XX/XX  
 R E M I T T A N C E A D V I C E  
 TO: PROVIDER NAME [C] R.A. NO.: [A] MARK NO.: [B] DATE PAID: [G] PROV. NUMBER: [H] PAGE: [I]  
 \*\*\*\*\* PATIENT NAME \*\*\*\*\* RECEIPT ID / TRANS-CONTROL-NUMBER / SILLED OTHER SAID BY COPAY MED PCD NON /  
 LAST FIRST MI LINE SVC-DATE PROC/RODS UNITS AMT. SOURCES MOAID MOAID AMT. PERP. PROV. S BOB BOB  
 \* \* \* CLAIM TYPE: CAPITATION \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9
DOE [1] JOSEPH [2]	[01]	XX/XX/XX [4001]	[2.00]	[0.00]	[2.00]	[0.00]	[ ]	[000 000]
DOE [1] JANE [2]	[10]	4-000000-00-000-00000-02 [11]	[2.00]	[0.00]	[2.00]	[0.00]	[ ]	[000 000]
	[01]	XX/XX/XX M4001 [12]	[2.00]	[0.00]	[2.00]	[0.00]	[ ]	[000 000]
			[14]		[15]	[16]	[17]	[18]
			[13]					[19]
			[1]					
			[4.00]	[0.00]	[4.00]	[0.00]		

[2] CLAIMS - THIS TREATING PROVIDER. TOTALS... [R] [S] [T] [X]



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Date

October 1, 2013

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

REMITTANCE TOTALS

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

-----

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

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