



Medicaid Enterprise

Iowa Department of Human Services

Home Health Services Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CONDITIONS OF PARTICIPATION

Home health agencies are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Medicare-certified agencies are eligible to provide the following Medicaid services:

- ◆ Home health agency intermittent services. Services are for members of all ages, but are limited by the intermittent policy. See [HOME HEALTH AGENCY INTERMITTENT SERVICES](#).
- ◆ Private-duty nursing and personal care services under the early and periodic screening, diagnosis, and treatment authority. These services are only for members aged 20 and under and are covered when they are medically necessary, appropriate, and exceed intermittent policy. See [PRIVATE-DUTY NURSING AND PERSONAL CARE SERVICES](#).

While an agency may provide both groups of services, the Medicaid guidelines for each group differ, for example, in the number of available hours, billing mechanism, prior authorization. Each group is defined in a separate section of the manual. Be sure that you are following the guidelines for the service you are providing.

B. TREATMENT PLAN

Service must be authorized by a physician, as evidenced by the physician's signature and date on a plan of treatment. For a home health service to be payable, a plan of treatment must be completed before the start of care and reviewed at a minimum of every 62 days thereafter.

The home health agency is responsible for coordination of care provided to a member. As a result, the plan of care shall reflect **all** services provided for the Medicaid member, regardless of whether the services are personally provided by the home health agency.



For example, all home health agency skilled services, home health aide services, in-home health-related care program services, and waiver services shall be reflected in **one** treatment plan. To assist in the review process, the plan shall note what is being proposed for each payer.

We encourage you to use Medicare HCFA 485, 486, or 487 forms to present the plan of care. If you use other forms, they must contain the information noted in this section.

The following sections describe:

- ◆ General requirements for all home health agency treatment plans.
- ◆ Additional requirements for plans that include rehabilitation services, home health aide services, or teaching, training or counseling services.

1. General Requirements

The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- ◆ The member's medical condition, as reflected by the following information, if applicable:
 - Dates of prior hospitalization.
 - Dates of prior surgery.
 - Date last seen by a physician.
 - Diagnoses for which treatment is being rendered.
 - Dates of onset of these diagnoses.
 - Prognosis.
 - Functional limitations.
 - Vital signs reading.
 - Date of last episode of instability.
 - Date of last episode of acute recurrence of illness or symptoms.
 - Medications.
- ◆ Type of service required.
- ◆ Type of service to be rendered.
- ◆ Place of service.



- ◆ Discipline of the person providing the service.
- ◆ Treatment modalities being used.
- ◆ Frequency of the services.
- ◆ Assistance devices to be used.
- ◆ Medical supplies to be furnished.
- ◆ Certification period (no more than 62 days).
- ◆ Date home health services initiated.
- ◆ The date of onset of the teaching, training, or counseling provided by the home health agency.
- ◆ Progress of the member in response to treatment.
- ◆ Estimated date of discharge from the hospital or home health agency services, if applicable.
- ◆ Physician's signature and date. The date of signature shall be before the submission of the claim for reimbursement.

2. Rehabilitation Services

For physical, speech, or occupational therapy, the treatment plan shall additionally be completed every 30 days, indicate the type of service required and include:

- ◆ Measurable goals.
- ◆ Modalities of treatment.
- ◆ Date of onset of conditions being treated.
- ◆ Restorative potential.
- ◆ Progress notes reflecting progress toward measurable goals.

3. Home Health Aide Services

For home health aide services, the treatment plan shall additionally include:

- ◆ Frequency of visits.
- ◆ Number of hours per visit.
- ◆ Living arrangement for member (lives alone, with family, status of caregiver, etc.).
- ◆ Services rendered.



4. Teaching, Training, and Counseling

For teaching, training, or counseling, the treatment plan shall also include:

- ◆ To whom services were provided (member, family member, etc.).
- ◆ Prior teaching, training, or counseling provided.
- ◆ Medical necessity for the rendered service.
- ◆ Specific services and goals.
- ◆ Date of onset of teaching, training, or counseling.
- ◆ Frequency of services.
- ◆ Progress of member in response to treatment.
- ◆ Estimated length of time these services will be needed.

C. HOME HEALTH AGENCY INTERMITTENT SERVICES

Home health agency intermittent services are an appropriate alternative to unnecessary institutionalization. The services are provided in the member's home by a registered nurse, a licensed practical nurse, a home health aide, a speech therapist, a physical therapist, an occupational therapist, or a social worker employed by the agency.

These services are available for members of all ages, but are limited to those visits that meet the definition of "intermittent." Generally, "intermittent service" means services for a member who has a medically predictable recurring need that does not exceed two to three visits per week for two to three hours at a time.

The number of hours of intermittent services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Home health agency intermittent services are covered only when provided in the member's residence.

Components of intermittent services are specifically addressed in the component sections. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability. Submit documentation with each claim to support the need for the services being provided.

Unlike the Medicare program, Medicaid members need not first require "skilled" care before they are entitled to home health aide services. For example, a member who requires only home health aide services is entitled to these services under the Medicaid program without respect to the need for skilled services.



The member need not be homebound to be eligible for home health agency intermittent services. However, home health agency services are covered only when provided in the member's residence.

As in the Medicare program, payment will be made both for restorative service and for maintenance services. Essentially, "maintenance service" means service to a member whose condition is stabilized and who requires observation by a nurse of conditions defined by the physician as indicating a possible deterioration of health status. This includes members with long-term illnesses whose condition is stable rather than post-hospital.

Payment may be made for teaching, training, and counseling in the provision of health care services.

When the need for services exceeds the intermittent guidelines, a request for an exception to policy may be submitted in writing, by fax (515-281-4597) or by mailing to the:

Appeals Section
Department of Human Services
1305 E Walnut, 5th Floor
Des Moines, IA 50319-0114

The request should include:

- ◆ A cover letter.
- ◆ A current plan of care.
- ◆ At least four weeks notes for each service requested.
- ◆ A breakdown of the direct costs of providing services.
- ◆ A copy of the agency's mileage reimbursement policy (when mileage reimbursement is included in the cost breakdown).

The cost breakdown must include:

- ◆ The salaries or the range or average salary for each type of care requested.
- ◆ Fringe benefits paid for each category of caregiver identifying each benefit paid.
- ◆ The actual amount paid for each benefit or the percent of salary for each benefit.
- ◆ The number of miles driven to provide care.



All home health services provided during each month for which an exception to policy is approved must be included in and billed under the exception to policy. (See [Basis of Payment for Intermittent Services](#) for instructions on how to bill services under an exception to policy.)

1. Skilled Nursing Care

Home health agency “skilled nursing” services must be performed by a licensed registered nurse or licensed practical nurse. Services that can safely be performed by the member or by an unskilled person who has received the proper training or instruction and services provided when there is no one else to perform the services are not considered “skilled nursing services.”

Skilled nursing services are available only on an intermittent basis. For skilled nursing, “intermittent services” are defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end.

Daily visits (six or seven days per week) that are reasonable and necessary and show an **attempt** to have a predictable end are covered for up to three weeks.

Coverage of additional daily visits beyond that initial period may be appropriate for a short period, based on the medical necessity of service. Submit medical documentation justifying the need for continued visits, including the physician’s estimate of the length of time that the services will be necessary.

Daily skilled nursing visits or multiple daily skilled nursing visits for wound care or insulin injections are covered when ordered by a physician and included in the plan of care.

When daily skilled nursing visits are ordered for other than wound care or insulin injections for an **indefinite** period of time (daily without a stated end date) and designated as daily skilled nursing care, the visits do not meet the “intermittent” definition and will be denied.



At the time of recertification, evaluate the care rendered to the member as to whether it is reasonable and necessary. Training and teaching can rarely be justified after the first certification.

Skilled nursing services are evaluated based on the complexity of the service and condition of the member. Refer to **Medicare Intermediary Manual**, Section 3118.1, and the Iowa Nurse Practice Act to determine what is considered to be a skilled nursing service.

NOTE: Private-duty nursing is not a covered service for members aged 21 or older.

2. Home Health Aide Services

“Home health aide services” are unskilled services that are covered if the following conditions are met:

- ◆ The service, the frequency, and the duration are stated in a written plan of treatment established by a physician. You are encouraged to collaborate with the member or, in the case of a child, with the member’s caregiver in the development and implementation of the plan of treatment.
- ◆ The member requires personal care services as determined by a registered nurse or other appropriate therapist.
- ◆ The services are given under the supervision of a registered nurse or a physical, speech, or occupational therapist who assigns the aide who will provide the care and makes supervisory visits. See [Supervisory Visits](#).
- ◆ Services are provided on an intermittent basis. “Intermittent basis” is defined as services that are **usually** two to three times a week for two to three hours at a time.

Service provided four to seven days per week, not to exceed 28 hours per week, are allowed as intermittent services when ordered by a physician and included in a plan of care. Increased services may also be allowed as intermittent services on a short-term basis of two to three weeks when medically necessary and provided due to unusual circumstances. Document the need for the excessive time required.



Home health aide daily care may be provided for members who are employed or attending school and whose disabling conditions (e.g., quadriplegia) require them to be assisted with morning and evening activities of daily living in order to support their independent living.

“Personal care services” include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

When the primary need of the member for home health aide services is for personal care, the aide may perform certain household services to prevent or postpone the member’s institutionalization. Examples of household services are:

- ◆ Changing the member’s bed.
- ◆ Light meal preparation.
- ◆ Light cleaning.
- ◆ Laundering essential to the member’s comfort and cleanliness.
- ◆ Rearrangements to ensure that the member has and can safely reach necessary supplies or medications.

If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service.

Domestic or housekeeping services that are not related to member care are not a covered service if personal care is not rendered during the visit.

3. High-Risk Maternity or Child Health Care

The intent of home health services to maternity patients and children is to provide services when the members are unable to receive the care outside their home and require home health care due to a high risk factor.

Routine prenatal, postpartum, or child health care for Medicaid members is a covered service in a physician’s office or clinic. Therefore, Medicaid does **not** cover routine care when provided by a home health agency.



Payment is approved for care of high-risk patients when identified as such in the comment section of the billing form. In these cases, the treatment plan must indicate:

- ◆ The potential risk factors.
- ◆ The medical factor or symptom that verifies that the member is at risk.
- ◆ The reason the member is unable to obtain care outside the home.
- ◆ The medically related tasks of the home health agency.

The following list of potential high risk factors **may** indicate a need for home health services to maternity patients or children. A single risk factor is not sufficient information to allow reimbursement for home health agency services. Documentation must demonstrate:

- ◆ Evidence of the diagnosis.
- ◆ The specific services and goals.
- ◆ The medical necessity for the services to be rendered.

a. Prenatal Patients

Potential high risk factors for pregnant women include:

- ◆ Age 16 or under.
- ◆ First pregnancy for a woman aged 35 or over.
- ◆ Previous history of prenatal complications (fetal death, eclampsia, Cesarean section delivery, psychosis, diabetes).
- ◆ Current prenatal problems, such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol misuse.
- ◆ Sociocultural or ethnic problems, such as language barriers, lack of family support, insufficient dietary practices, history of victimization (child abuse or neglect), or single mothers.
- ◆ Pre-existing handicaps, such as sensory deficits or mental or physical handicaps.
- ◆ History of infant problems, such as premature birth, congenital anomalies, or sudden infant death.
- ◆ Second pregnancy in 12 months.
- ◆ Death of a close family member or significant other within the previous year.



b. Postpartum Maternity Patients

Potential high risk factors for postpartum women include:

- ◆ Age 16 or under.
- ◆ First pregnancy for a woman aged 35 or over.
- ◆ Major postpartum complications, such as severe hemorrhage, eclampsia, or Cesarean section delivery.
- ◆ Pre-existing mental or physical disabilities, such as deafness, blindness, hemiplegia, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.
- ◆ Drug or alcohol abuse.
- ◆ Symptoms of postpartum psychosis.
- ◆ Special sociocultural or ethnic problems, such as lack of job, family problems, single mother, lack of support system, history of child abuse or neglect.
- ◆ Demonstrated disturbance in maternal and infant bonding.
- ◆ Discharge or release from hospital against medical advice before 30 hours postpartum.
- ◆ Insufficient antepartum care by history.
- ◆ Multiple births.
- ◆ Nonhospital delivery.

c. Newborns

Potential high risk factors for newborns include:

- ◆ Birth weight 5 pounds or under or over 10 pounds.
- ◆ History of severe respiratory distress.
- ◆ Major congenital anomalies as neonatal complications that necessitate planning for long-term follow-up, such as post-surgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- ◆ Disabling birth injuries.



- ◆ Extended hospitalization and separation from other family members.
- ◆ Genetic disorders such as Down's syndrome and phenylketonuria, or other metabolic conditions that may lead to mental retardation.
- ◆ Noted parental rejection or indifference toward the baby, such as never visiting or calling about the baby's condition during the baby's extended stay.
- ◆ Family sociocultural or ethnic problems, such as low education level or lack of knowledge of child care.
- ◆ Discharge or release against medical advice before 36 hours of age.
- ◆ Nutrition or feeding problems.

d. Preschool or School-Aged Children

Potential high risk factors for preschool or school-aged children include:

- ◆ Child or sibling victim of child abuse or neglect (services are necessary to assist the child to remain in or return to the family home, if possible).
- ◆ Mental retardation or physical disabilities necessitating long-term follow-up or major readjustments in family life style.
- ◆ Failure to complete basic series of immunizations by 18 months, or boosters by 6 years.
- ◆ Chronic illness, such as asthma, cardiac, respiratory or renal diseases, diabetes, cystic fibrosis, or muscular dystrophy.
- ◆ Malignancies, such as leukemia or carcinoma.
- ◆ Severe injuries necessitating treatment or rehabilitation.
- ◆ Disruption in family or peer relationships.
- ◆ Suspected developmental delay.
- ◆ Nutritional deficiencies.

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4. Immunizations

Use current CPT codes for immunizations. The immunization procedure includes the supply of related materials.

You must provide Medicaid immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are found at http://www.idph.state.ia.us/adper/vaccines_for_children.asp or at 1-800-831-6293.

When a child receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.

Bill code 90471, 90472, or 90473 for vaccine administration in addition to the CPT code. For VFC vaccine, the charges in field 47 should be "0."

5. Medical Social Services

Payment will be made for medical social work services when:

- ◆ Services are provided in the member's home;
- ◆ The problems are not responding to medical treatment;
- ◆ There does not appear to be a medical reason for the lack of response; and
- ◆ The services meet all of the following conditions:
 - They are reasonable and necessary to the treatment of the member's illness or injury.
 - They contribute meaningfully to the treatment of the member's condition.
 - They are under the direction of a physician.
 - They address social problems impeding the member's recovery.
 - They are given by or under the supervision of a qualified medical or psychiatric social worker.



Any medical social services directed toward minimizing the problems that an illness may create for the member and family (such as encouraging them to air their concerns and providing them with reassurance) **are not** considered reasonable and necessary to the treatment of a member's illness or injury.

6. Medical Supplies and Equipment

Supplies should be incidental to the member's care, such as syringes for Prolixin injections. Home health agencies are limited to supplies and equipment of no more than \$15 per month. When random postpayment review identifies supplies billed in excess of \$15 per month, the overpayment will be recouped.

Dressings, durable medical equipment, and other supplies shall be obtained from a medical equipment dealer or pharmacy. (Special consideration may be given to unusual circumstances, such as when a pharmacy or medical equipment dealer is not available in the member's community.)

If you choose to provide durable medical supplies and equipment in excess of the \$15 per month limit, you must enroll in the Medicaid program as medical equipment dealer and bill for these supplies under your medical equipment dealer number on a CMS-1500 claim form.

7. Occupational Therapy

The following sections explain general requirements and covered services for occupational therapy.

a. General Requirements

The coverage decision for occupational therapy services is based on the need for the skills of a therapist and not only on the diagnosis. To be covered under home health rehabilitation services, occupational therapy services must:

- ◆ Be provided in the member's home.
- ◆ Improve or restore functions that have been impaired by illness or injury or enhance the member's ability to perform those tasks required for independent functioning.



- ◆ Be reasonable and necessary for the treatment of the member's illness or injury.
- ◆ Be performed by a qualified occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified, licensed occupational therapist, as allowed by Iowa licensure.
- ◆ Follow an active written treatment plan established by the physician that is reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month. The plan of treatment must include:
 - The member's functional limitations.
 - Date of onset of conditions being treated.
 - Restorative potential.
 - Modalities of treatment.
 - Goals.
 - Progress notes.
 - Documentation of progress toward the goals.
- ◆ Meet the guidelines defined for restorative, maintenance, or trial therapy. See [Limits on Rehabilitation Services](#).

b. Covered Services

Restorative therapy is a covered occupational therapy service when an expectation exists that the therapy will result in a significant practical improvement in the member's condition.

Where there is a valid expectation of improvement at the time the occupational therapy program is instituted, but the expectation (goal) is not realized, services are covered only up to the time one can reasonably conclude the member will not improve.

The teaching of activities of daily living and energy conservation to improve the level of independence of a member is covered when it requires the skill of a licensed therapist and meets the definition of restorative therapy. Refer to [Limits on Rehabilitation Services: Restorative Therapy](#) for further information.



Maintenance therapy, or any activity or exercise program required to maintain a function at the present level, is **not** a covered service. However, **design** of a maintenance program and infrequent but periodic evaluation of its effectiveness by the therapist is covered.

Planning and implementing therapeutic tasks are covered, such as:

- ◆ Activities to restore sensory-integrative functions.
- ◆ Selection and teaching of tasks designed to restore physical function.
- ◆ Providing motor and tactile activities to increase input and improve responses for a stroke patient.

For coverage of design and monitoring of an occupational therapy maintenance program, see [Limits on Rehabilitation Services: Maintenance Therapy](#).

The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the member's condition and required occupational therapy. A maximum of 13 visits is reimbursable.

For coverage of a trial occupational therapy, see [Limits on Rehabilitation Services: Diagnostic or Trial Therapy](#).

Vocational and prevocational assessment and training are not payable by Medicaid. These include services that are related **solely** to specific employment opportunities, work skills, or work settings.

Occupational therapy frequently necessitates the use of various supplies, e.g., ceramic tiles, leather, etc. The cost of such supplies may be included in the occupational therapy cost center.

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8. Physical Therapy

The coverage decision for physical therapy services is based on the need for the skills of a therapist and not only on the diagnosis. The following sections explain general requirements and covered services for physical therapy.

a. General Requirements

To be covered under home health rehabilitation services, physical therapy services must:

- ◆ Be reasonable and necessary to the treatment of the member's illness, injury, or disabling conditions.
- ◆ Be specific and effective treatment for the member's medical or disabling conditions.
- ◆ Be provided in the member's home.
- ◆ Relate directly and specifically to an active written treatment plan established by the physician after any needed consultation with the qualified physical therapist. The plan must be reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month. The plan must include:
 - The member's functional limitations.
 - Date of onset of conditions being treated.
 - Restorative potential.
 - Modalities of treatment.
 - Goals.
 - Progress notes.
 - Documentation of progress toward the goals.
- ◆ Be of such a level of complexity and sophistication, or the condition of the member must be such, that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

The initial physical therapy evaluation must be provided by a licensed physical therapist. This evaluation may have been performed by other than the home health agency staff.



A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of a therapist as allowed by Iowa licensure.

The provider must demonstrate that there is a need to establish a safe and effective maintenance program related to a specific illness, injury, or disabling condition. The selection and teaching of tasks to restore physical functions are covered.

- ◆ Meet the guidelines defined for restorative, maintenance, or trial therapy. (See [Limits on Rehabilitation Services](#).)

There must be an expectation that there will be a significant, practical improvement in the member's condition in a reasonable amount of time, based on the member's restorative potential assessed by the physician. The amount, frequency, and duration of the services must be reasonable.

b. Covered Services

When a member is under a restorative physical therapy program, the physical therapist regularly reevaluates the member's condition and adjusts the program. It is expected then, that the physical therapist has designed a maintenance program before discharge.

Consequently, maintenance programs that are not established until after the restorative program has been completed are not considered reasonable and necessary to the treatment of the member's condition and are excluded from coverage. Refer to [Limits on Rehabilitation Services: Restorative Therapy](#) for further information.

For coverage of design and monitoring of a physical therapy maintenance program, see [Limits on Rehabilitation Services: Maintenance Therapy](#).

For coverage of a physical therapy trial therapy, refer to [Limits on Rehabilitation Services: Diagnostic or Trial Therapy](#).



Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require skills of a qualified physical therapist. These are covered when the condition is complicated by other conditions, such as circulatory deficiency or open wounds, or if the service is an integral part of a skilled physical therapy procedure.

Gait training and gait evaluation and training constitute a covered service if the member's ability to walk has been impaired by a neurological, muscular, or skeletal condition or illness. The gait training must be expected to significantly improve the member's ability to walk.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, or nursing personnel. Therefore, it is not a covered physical therapy service.

Ultrasound, short wave, and microwave diathermy treatments are considered covered services.

Use of isokinetic or isotonic equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament, or tendon injury or postsurgical trauma. Billing can be made only for the time the therapist actually spends instructing the member and assessing the member's progress.

Therapeutic exercises may constitute a physical therapy service due either to the type of exercise employed or the condition of the member.

Range-of-motion tests must be performed by a qualified physical therapist. Range-of-motion exercises require the skills of a qualified physical therapist **only** when they are part of the active treatment of a specific disease or disabling condition that has resulted in a loss or restriction of mobility. Documentation must reflect:

- ◆ The degree of motion lost.
- ◆ The normal range of motion.
- ◆ The degree to be restored.



Range-of-motion to unaffected joints only does not constitute a covered physical therapy service.

Reconditioning programs after surgery or prolonged hospitalization are **not** covered as physical therapy (work-hardening programs, for example). However, initial instruction for such programs is a covered service.

9. Speech Therapy

For speech therapy services, the treatment plan shall additionally reflect the goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

a. General Requirements

To be covered by Medicaid as home health rehabilitative services, speech therapy services must:

- ◆ Be provided in the member's home;
- ◆ Be related directly to an active written treatment plan that is reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month, include the functional limitations and document progress toward the goals;
- ◆ Follow a treatment plan established by a licensed skilled therapist after consultation with a physician;
- ◆ Be reasonable and necessary to the treatment of the member's illness or injury;
- ◆ Relate to a specific medical diagnosis or disabling condition which will significantly improve a member's practical functional level in a reasonable and predictable period of time;
- ◆ Require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable; and
- ◆ Meet the guidelines defined for restorative, maintenance, diagnostic, or trial therapy. (See [Limits on Rehabilitation Services](#).)

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b. Covered Services

Speech therapy activities that are considered covered services include restorative therapy services to:

- ◆ Restore functions affected by illness, injury, or disabling condition resulting in a communication impairment, or
- ◆ Develop functions where deficiencies currently exist.

“Communication impairments” fall into the general categories of disorders of:

- ◆ Voice
- ◆ Fluency
- ◆ Articulation
- ◆ Language
- ◆ Swallowing disorders resulting from any condition other than mental impairment

Treatment of these conditions is payable if restorative criteria are met. Refer to [Limits on Rehabilitation Services: Restorative Therapy](#).

Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to members who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the member's illness, or disabling condition. Group speech therapy is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

Teaching a member to use sign language or to use an augmentative communication device is reimbursable. The member must show significant progress outside the therapy sessions for these services to be reimbursable. (See [Limits on Rehabilitation Services: Diagnostic or Trial Therapy](#).)



Where a maintenance program is appropriate, the initial evaluation, the instruction of the member and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

However, designing a maintenance program, in accordance with the requirements of maintenance therapy, and monitoring the progress are covered. For coverage of design and monitoring of a maintenance program, see [Limits on Rehabilitation Services: Maintenance Therapy](#).

10. Supervisory Visits

Payment will be made for supervisory visits two times a month when a registered nurse, acting in a supervisory capacity, provides supervisory visits of services provided by a home health aide under a Medicare-certified home health agency plan of treatment.

EXCEPTIONS:

- ◆ When these visits are provided simultaneously with another Medicaid funded service, they are allowable for administrative costs only.

NOTE: No supervisory visit would be made when a registered nurse performs the home health agency service. The submitted care plan must indicate the services that the registered nurse will be providing in addition to supervising the aide or in-home provider.

- ◆ Supervisory visits are required only once every 60 days when the **only** service provided by the home health agency is home health aide services (no physician-directed nursing assessment has been ordered).

If the nurse provides assessment services pursuant to a physician's order, the home health aide service is not the only service provided. As a result, twice a month supervisory visits are required.

- ◆ When services are provided under the Department's in-home health-related care program (as set forth in 441 Iowa Administrative Code 177), supervisory visits shall be conducted every 60 days (or more often based on medical need).



11. Limits on Rehabilitation Services

Rehabilitation services include the following components:

- ◆ Physical therapy
- ◆ Occupational therapy
- ◆ Speech therapy

Each of these components must meet one of the following criteria:

- ◆ [Restorative therapy](#),
- ◆ [Maintenance therapy](#), or
- ◆ [Diagnostic or trial therapy](#)

a. Restorative Therapy

Restorative therapy must be reasonable and necessary to the treatment of the member's illness, injury, or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment.

There must be an expectation that the member's medical or disabling condition will show functional improvement within a reasonable period. "Functional improvement" means that demonstrable measurable increases have occurred in the member's level of independence outside the therapeutic environment.

If at any point of an illness or disabling condition, it is determined that this expectation will not be realized, the services are no longer considered reasonable and necessary.

Examples of covered service include:

- ◆ Construction of a device that enables a member to hold a utensil and eat or drink independently.
- ◆ Construction of a hand splint for a member with rheumatoid arthritis to maintain the hand in a functional position.
- ◆ Retraining communications skills of a laryngectomized person.



- ◆ Stimulating and retraining a stroke patient who has lost speech or language skills to communicate orally or through augmentative means.
- ◆ Stimulating and training a language-delayed or speech-delayed child's communication skills to more closely approximate age level.
- ◆ Teaching a member who has lost the use of an arm how to pare potatoes and chop vegetables with one hand.
- ◆ Teaching a stroke patient new techniques to enable the patient to perform feeding, dressing, and other activities of daily living as independently as possible.
- ◆ Training an abnormally dysfluent child or adult to speak more fluently.
- ◆ Training new patterns of voice production for a child or adult exhibiting vocally abusive behaviors.
- ◆ Training oral or augmentative communication skills of a mentally or physically handicapped person where a significant discrepancy occurs between the person's cognitive abilities and current level of communication function.

The following examples illustrate situations where restorative therapy is determined reasonable and necessary.

- ◆ A physician has ordered gait evaluation and training for a member whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the member's gait, to establish a gait-training program, and to provide the skilled services necessary to implement the program are covered.
- ◆ A member who has had a total hip replacement is ambulatory, but demonstrates weakness and is unable to climb stairs safely. Physical therapy is reasonable and necessary to teach the member to safely climb and descend stairs.
- ◆ A physician orders occupational therapy for a member who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting, and bathing.



The occupational therapist establishes goals for the member's rehabilitation (to be approved by the physician), and will undertake the teaching of the techniques necessary for the member to reach the goals. Occupational therapy services are covered at a duration and intensity appropriate to the severity of the member's impairment and the response to treatment.

- ◆ A member with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of her condition. She is now wheelchair-bound and, for the first time, without any expectation of achieving ambulation again.

The physician has ordered physical therapy to select the proper wheelchair for her long-term use and to teach safe use of the wheelchair and safe transfer techniques to the member and family.

Physical therapy is reasonable and necessary to evaluate the member's overall needs, to make the selection of the proper wheelchair, and to teach the member and family safe use of the wheelchair and proper transfer techniques.

b. Maintenance Therapy

Generally, maintenance therapy means services to a member whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes members with long-term illnesses or disabling condition whose status is stable rather than post-hospital.

Maintenance therapy is also appropriate for members whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels. Generally, the repetitive exercises to maintain function do not require services of a qualified physical therapist.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the member, family members, home health aides, or other caregiver to carry out the program are considered a covered service. Payment will be made for a maximum of three visits to establish a maintenance program and instruct the caregivers.



Payment for supervisory visits to monitor the program is limited to two per month for a maximum of 12 months. The plan of treatment must specify the anticipated monitoring of any supervisor. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a re-evaluation is a covered service, if medically necessary. A re-evaluation is considered medically necessary only if:

- ◆ There is a significant change in residential or employment situation, or
- ◆ The member exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition that previously contraindicated restorative therapy.

A statement by a developmentally disabled member's interdisciplinary team recommending a re-evaluation and stating the basis for medical necessity is considered as supporting the necessity of a re-evaluation and may expedite approval.

Examples of situations where maintenance therapy could be covered include:

- ◆ A member with Parkinson's disease who has not been under a restorative physical therapy program may require a maintenance program established by a qualified physical therapist.
- ◆ A member who has received gait training has reached maximum restoration potential. The physical therapist is teaching the member and family how to safely perform the activities that are a part of the maintenance program being established.

Although the activities by themselves do not require the skills of a therapist, the visits by the physical therapist to demonstrate and teach the activities are covered, since they are needed to establish the program.



- ◆ A stroke patient (or mentally retarded adult) exhibits deficits in communication function relative to the patient's cognitive abilities, but requires a therapy plan that slowly progresses in complexity and involves repetitious exercises or activities.

A program may be established to help the member advance through the levels. However, since it is of a less complex design, it does not require the constant contact with a skilled therapist and is payable as a maintenance program only.

- ◆ A mentally retarded adult has reached a plateau in progress in a restorative speech-language therapy program. Potential for further progress seems minimal, though a discrepancy exists between the member's cognitive skills and communication abilities. A maintenance program may be established to ensure that present level of functioning continues.

c. Diagnostic or Trial Therapy

Payment is made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a member's rehabilitation potential and appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic therapy or trial therapy.

Diagnostic or trial therapy may be appropriate when:

- ◆ The member does not meet restorative or maintenance therapy criteria.
- ◆ The member's initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed.
- ◆ The member needs evaluation in multiple environments to determine their rehabilitative potential adequately.
- ◆ There is a need to assess the member's response to treatment in the member's environment.



Trial therapy will not be granted more than once per year for the same issue. If the member has a previous history of rehabilitative services, trial therapy for the same type of services generally is payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue require documentation reflecting a significant change.

Further diagnostic or trial therapy for the same issue is not considered appropriate when progress was not achieved, unless the reasons that blocked change previously are listed and the reasons the diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required. The documentation will be reviewed to determine the medical necessity of the number of hours of service provided.

When a member has been sufficiently evaluated during diagnostic or trial therapy to determine potential for restorative or maintenance therapy (or lack of therapy potential), diagnostic or trial therapy ends.

At the end of diagnostic or trial therapy, recommend either continuance of services under restorative therapy, continuance of services under maintenance therapy, or discontinuance of services.

When result of diagnostic or trial therapy is that restorative or maintenance therapy is appropriate, submit claims noting restorative or maintenance therapy (instead of diagnostic or trial therapy). Continuance of services under restorative or maintenance therapy is reviewed based on the criteria in place for restorative or maintenance therapy.



Diagnostic or trial therapy must additionally meet the following criteria:

- ◆ There must be face-to-face interaction with a licensed therapist. (An aide's services are not payable.)
- ◆ Services must be provided on an individual basis. (Group diagnostic or trial therapy is not payable.)
- ◆ Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the member's response.
- ◆ For members who received previous rehabilitation treatment, consideration of trial therapy generally should occur only if the member has incorporated any regimen recommended during prior treatment into daily life to the extent of the member's abilities.

This criterion does not apply for speech therapy if the only goal of prior rehabilitative treatment was to learn the prerequisite speech components.

- ◆ If the member has a previous history of rehabilitative services, trial therapy for the same type of services generally is payable only when a significant change has occurred since the last therapy. A "significant change" is considered as having occurred when any of the following exist:
 - New onset.
 - New problem.
 - New need.
 - New growth issue.
 - Surgical intervention that may have caused new rehabilitative potentials.
 - A change in vocational or residential setting that requires a re-valuation of potential.
- ◆ Documentation should include any previous attempt to resolve problems using non-therapy personnel (e.g., residential group home staff, or family members) and whether follow-up programs from previous therapy have been carried out.



- ◆ For referrals from residential, vocational, or other rehabilitation personnel that do not meet present evaluation, restorative, or maintenance criteria, submit with the claim documentation of:
 - The proposed service.
 - The medical necessity.
 - The current medical condition, including any secondary rehabilitative diagnosis.
- ◆ Claims for diagnostic or trial therapy must reflect the progress being made toward the initial diagnostic or trial therapy plan.

12. Nonpayable Intermittent Services

The following services are not a payable benefit:

- ◆ Homemaker services.
- ◆ Services provided in the home health agency office.
- ◆ Transportation and escort services.
- ◆ Well-child medical care and supervision.

Medicaid members under the MediPASS program **must** have the MediPASS provider's approval for the service to be payable.

When a member is in a Medicaid health maintenance organization (HMO), the HMO covers home health agency services.

The Iowa Plan for Behavioral Health covers psychiatric nursing services for a member under age 65 who has a primary diagnosis of ICD-9 code 290 through 301.99 or 306 through 309.99 or 311 through 314.99.

Medical equipment rental is not reimbursable to a home health agency. Obtain and bill for dressings, durable medical equipment, and other supplies through a medical equipment dealer or pharmacy. (Special consideration may be given to unusual circumstances, such as when a pharmacy or medical equipment dealer is not available in the member's community.)

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13. Basis of Payment for Intermittent Services

Payment shall be made on an encounter basis. An “encounter” is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment of home health agency intermittent services is based on the **service** provided rather than the classification of the home health agency employee providing the service. Other insurance is primary and **must** be billed first. A current plan of care must be submitted with each claim.

Members under the MediPASS program **must** have the MediPASS provider’s approval for the service to be payable.

a. Supplies and Equipment

Payment for supplies will be approved when the supplies are incidental to the member’s care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy.

Payment of supplies may be made to home health agencies when a medical equipment dealer or pharmacy is not available in the member’s community. A home health agency must enroll as a medical equipment provider in order to be paid for equipment supplies over \$15.

b. Service Provided Under an Exception to Policy

When billing services provided under an exception to policy, follow the instructions in the decision letter. A current plan of care and a copy of the exception to policy decision letter must accompany each claim. The claim must include:

- ◆ The correct primary diagnosis.
- ◆ The revenue or procedure code.
- ◆ The number of hours of each service provided.
- ◆ The reimbursement rate identified in the decision letter for each service provided.

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14. Intermittent Procedure Codes and Nomenclature

Home health agency intermittent services are billed using revenue codes. Enter the three-digit code that identifies a specific accommodation or ancillary services.

550	Skilled nursing care
420	Physical therapy
440	Speech therapy
430	Occupational therapy
570	Home health aide
270	Medical supplies
560	Medical social worker

Show revenue code 001 as the last line on the claim form, indicating total charges for the entire bill.

A unit of service is one visit. Prepare one claim that includes all home health services provided during a calendar month.

Claims submitted without a revenue code and an ICD-9-CM diagnosis code will be denied.

D. PRIVATE-DUTY NURSING AND PERSONAL CARE SERVICES

Private-duty nursing and personal care services for children with special needs are covered for Medicaid members aged 20 or under when:

- ◆ The services are medically necessary.
- ◆ The services exceed the intermittent criteria.
- ◆ The service planning process has taken place.
- ◆ Prior authorization is approved.

These services are intended to:

- ◆ Promote alternatives to prolonged hospitalizations or institutionalization by providing for medically necessary and effective home care.
- ◆ Provide ongoing nursing support to a technology-dependent child or a child with multiple medical needs related to an acute or chronic medical condition in the home environment.



The objectives of services to children with special needs are:

- ◆ To provide direct patient care, supervision of family caregivers, and teaching of the necessary skills to care for a medically compromised child at home,
- ◆ To promote quality care and a safe home environment for the child,
- ◆ To provide for comprehensive and coordinated care in a cost-effective manner, and
- ◆ To reduce the number of hours funded and provided by the program to the minimum level necessary to meet the medical needs of the child safely while ensuring that quality care is maintained in the child's home environment.

Payment for private-duty nursing or personal care services for members aged 20 or under will be approved if determined to be medically necessary. "Medical necessity" means:

- ◆ The service is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, **and**
- ◆ No other equally effective course of treatment is available or suitable for the member requesting the service.

The role of the parents is central to the management of home care and must permeate all planning. Use family-centered concepts when working with the family to develop a treatment plan. Also involve the child in the planning of treatment services, based on the child's age and understanding of the condition.

The services are considered supportive to the care provided to the child by family, foster parents, or delegated caregivers. Whenever possible, teach the nursing regimen to the child, the family, or the foster parents, or delegate the regimen to an unlicensed caregiver to achieve the goals and objectives.

Maintenance of the nursing regimen plan of care is the responsibility of the child, family, foster parents, or delegated caregivers, with a registered nurse providing any necessary supervision and follow-up. Decrease care as the family, foster parents, or caregivers become able to meet the client's needs.

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Home health services are directed to support the extra burdens on the parents due to the child's medical needs. They are not available to meet a family's normal needs for child care and supervision, such as while a parent works.

1. Personal Care Services

"Personal care services" are services provided by a home health aide that are delegated and supervised by a registered nurse under the direction of the child's physician. Services may be provided to a child in the child's place of residence or outside the child's residence when normal life activities take the child outside the place of residence. Some of the care must be provided in the child's home.

Personal care services do **not** include:

- ◆ Respite care (a temporary intermission or period of rest for the caregiver to relieve the caregiver of the duties of providing continuous support and care to the child).
- ◆ Services provided to other members of the child's household.
- ◆ Services requiring prior authorization that are provided without regard to the prior authorization process.
- ◆ Assessment and monitoring.
- ◆ Cueing for behavior management.
- ◆ Other services listed in [Nonpayable Services](#).

2. Private-Duty Nursing

"Private-duty nursing services" are services provided to a child by a registered nurse or a licensed practical nurse under the direction of the child's physician. Services may be provided in the child's place of residence or outside the child's residence, when normal life activities take the child outside the place of residence. Some of the care must be provided in the child's home.



Private-duty nursing services do **not** include:

- ◆ Respite care (a temporary intermission or period of rest for the caregiver to relieve the caregiver of the duties of providing continuous support and care to the child).
- ◆ Nurse supervision services, such as chart review, case discussion, or scheduling by a registered nurse.
- ◆ Services provided to other members of the child's household.
- ◆ Services requiring prior authorization that are provided without regard to the prior authorization process.
- ◆ Other services listed in [Nonpayable Services](#).

3. Service Planning for Special-Needs Children

The child's assigned case manager or service worker is responsible for completing the service planning process. If there is not an assigned service worker or case manager, a Child Health Specialty Clinic nurse will be assigned to this role.

This planning process must be completed for each child before requesting a prior authorization for private-duty nursing or personal care services. (A time-limited authorization may be approved for children who need services before the planning process can be completed. See [Special Circumstances](#).)

The planning process must be repeated for each prior authorization request. Eight weeks before the expiration date of an existing prior authorization, IME Medical Services staff will notify the provider and the service worker, case manager or Child Health Specialty Clinic staff, by phone. Planning needs to occur within the next three weeks, unless it has already been initiated or completed.

This planning will result in a new prior authorization request and supporting documentation being prepared and submitted at least four weeks before the expiration of the current prior authorization. The planning process is needed to ensure that funding for services is not jeopardized by the failure to complete and timely submit a prior authorization.

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If the child will turn 21 within the next two months, IME staff will send an email to the child's case manager to advise of the need to begin planning for services when the child is no longer eligible for prior-authorized services.

a. Planning Process

The service worker, case manager or Child Health Specialty Clinic staff will involve in the planning:

- ◆ The family.
- ◆ Providers.
- ◆ Area education agency staff (for children in school).

Others who may be involved when applicable include:

- ◆ Child Health Specialty Clinic staff.
- ◆ Insurance case managers.
- ◆ HMO representatives.
- ◆ Iowa Plan contractor staff.
- ◆ Special program resources.
- ◆ County central point of coordination for children aged 16 through 20.
- ◆ Department of Human Services income maintenance staff.
- ◆ Physicians.
- ◆ Family support people and advocates.
- ◆ Department of Human Services service help desk staff.
- ◆ ISU home- and community-based services specialists.
- ◆ Medicaid policy staff.

At a minimum, the planning should address:

- ◆ What was covered by any prior authorization that will be expiring.
- ◆ Any changes which have occurred.
- ◆ If there were services that could not be covered when the current prior authorization was approved.
- ◆ Definitions of terms, including intermittent, private-duty nursing, personal care, medical necessity, scope of practice, waiver services, in-home health-related care.



- ◆ Hierarchy for the use of insurance, intermittent services, prior authorized services, waiver services, medical transportation, state funded services, and other funding such as county, school and civic organization funding.
- ◆ How different plans for the child interact, such as schedules, uses of services, level of detail, and how families, providers, and others involved in the planning are notified of service approvals.
- ◆ How waiver-funded nursing and home health services can be used.
- ◆ Use of waiver services such as supported community living, homemaker, consumer-directed attendant care, respite, and the requirements for use of gatekeeper services.
- ◆ Enrolled and available waiver providers in the area.
- ◆ Documentation requirements for home health agencies.
- ◆ When and how multiple provider agencies are used.
- ◆ Planning for nonschool days.
- ◆ Exception to policy processes, including who initiates the exception request, who needs to be involved, what needs to be submitted, and the steps to the process.
- ◆ Process for conference calls to be used if problems occur in finalizing the plan.

If services will meet the intermittent guidelines, a prior authorization will not be needed. The service worker, case manager or Child Health Specialty Clinic staff will notify IME of the resolution.

If it becomes evident during the planning that not all the issues can be resolved, or one or more of the core members of the team does not agree with the plan, a conference call must be scheduled. (See [Conference Call](#).)

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b. Service Authorization

When the planning results in the need for submission of a new prior authorization request, the service worker, case manager, or Child Health Specialty Clinic staff will request the home health agency to provide a copy of the prior authorization request. (See [Prior Authorization](#) for instructions on preparing form 470-0829, *Prior Authorization Request*.) This will be sent to the IME Medical Services Unit.

The Medical Services Unit will notify the service worker, case manager or Child Health Specialty Clinic staff if it has not received the new *Prior Authorization Request* four weeks before the expiration of the current authorization.

The service worker, case manager or Child Health Specialty Clinic staff will advise the family that:

- ◆ The home health agency has not submitted the new prior authorization request, and
- ◆ Funding for services may be jeopardized or consideration may need to be given to securing a different provider.

If the prior authorization can be approved as submitted, the Medical Services Unit will notify the service worker, case manager, or Child Health Specialty Clinic staff, who will confirm that the family's need for service has not changed. If the needs remain the same, the Medical Services Unit will approve the prior authorization as requested and return it to the provider.

Other activities needed to implement the decision may include revision of plans, submission of waiver forms, and completion of notices of decision by case managers and service workers.

If the prior authorization cannot be approved as submitted, the Medical Services Unit will notify the service worker, case manager, or Child Health Specialty Clinic staff, who will determine if other services discussed during the planning can be used to meet the need or if a conference call is needed.

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c. Conference Call

If the issues cannot be resolved through the planning process, the service worker, case manager, or Child Health Specialty Clinic staff will:

- ◆ Schedule a conference call by contacting the scheduler at IME.
- ◆ Provide the names and telephone numbers of those who will participate.

At a minimum, those participating in the call will include:

- ◆ The service worker or case manager.
- ◆ The family.
- ◆ Providers.
- ◆ IME medical review staff.
- ◆ Area education agency staff (for children in school).

Others participating when applicable include:

- ◆ Child Health Specialty Clinic staff.
- ◆ Insurance case managers.
- ◆ HMO representatives.
- ◆ Iowa Plan contractor staff.
- ◆ Special Program Resources.
- ◆ County central point of coordination for children aged 16 through 20.
- ◆ IM staff.
- ◆ Physicians.
- ◆ Family support people and advocates.
- ◆ Department of Human Services service help desk staff.
- ◆ ISU home- and community-based services specialists.
- ◆ Medicaid policy staff.

Calls will be scheduled at a mutually agreed upon time before the expiration date of the current prior authorization. They should be scheduled as soon as possible to allow adequate time for decisions to be made before the expiration of the prior authorization.



The IME Medical Services Unit will convene conference calls as scheduled. The service worker, case manager, or Child Health Specialty Clinic staff will either facilitate the call or ensure that a facilitator is designated. At the end of the conference call, the facilitator will provide a verbal summary of the outcome of the discussion.

The Medical Services Unit will complete a written summary of the conference call. The original will be kept in the member's file at IME and a copy will be sent to the member's service worker, case manager or Child Health Specialty Clinic staff. The information on the summary will include, at a minimum:

- ◆ The child's name and state ID number.
- ◆ The date the planning conference call was held.
- ◆ The participants in the planning conference call.
- ◆ A brief description of the outcome, including amount and type of services to be provided.

d. Special Circumstances

The service worker, case manager or Child Health Specialty Clinic staff will ensure that a planning discussion occurs in the following situations:

- ◆ A child is discharged from the hospital.
- ◆ A child is determined to be terminally ill.
- ◆ A child's service needs change.
- ◆ Changes in eligibility occur.
- ◆ Responsibility for services transfers from one agency to another.
- ◆ An initial prior authorization request with a proposed plan of care is submitted and no supporting documentation is available.
- ◆ A prior authorization request is submitted for a child aged 16 or older.
- ◆ A current prior authorization needs to be modified.

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A prior authorization request based on a proposed plan may be approved for a limited period of time, usually not more than four to eight weeks, to allow the regular planning process for services to occur.

When the IME Medical Services Unit receives a request to modify a current prior authorization, the service worker, case manager or Child Health Specialty Clinic staff will be notified. A mutual decision will be made to initiate planning, using some or all of the planning process, or approve a time-limited modification. Policy staff will be included in this discussion as needed.

e. Hospital Discharge Planning

For a child being discharged from a hospital, an initial prior authorization or modification of an existing prior authorization may be approved for a limited period. See [Special Circumstances](#).

Encourage the family to have support systems in place by working with the hospital discharge planner and community mental health support system. "Support systems" are services, resources, information, training, and emotional support that enable a family to assume responsibility and provide care for a technology-dependent child or a child with a chronic disability in addition to meeting the goals and accomplishing tasks of family life.

The discharging hospital has a responsibility to assist the family to identify potential providers of the home health agency services and to teach the necessary skills to the caregivers within the hospital setting. This teaching can be continued the first several weeks to reinforce skills with the caregivers.

Facility discharge planning includes extensive teaching of the main family caregivers within the facility setting, before discharge of the member. Teaching must include:

- ◆ An understanding of the child's diagnosis and prognosis.
- ◆ Ability to provide direct patient care.
- ◆ Demonstrated knowledge of the use and care of needed equipment.
- ◆ Emergency measures in the care of the member, including emergency preparedness for utility failure.



The family should be centrally involved in the selection process of the home care agency. Ideally, the family should select the home health agency at least two weeks before discharge and notify the agency of the referral.

The home health agency should be involved in the development of the home care plan before discharge. Coordination between the discharging hospital and the home health agency should be reflected on the plan of treatment. The care plan must address short-term goals as well as the long term nature of the care required.

Training family members in the care of the child should begin as early as possible in the hospital, but at least within the two weeks before discharge. The training of the family must include:

- ◆ Detailed documentation (written instruction) of the child's care needs.
- ◆ A systematic process for teaching the care of the child to parents and siblings (when appropriate).

Rooming in while the child is still an inpatient is recommended. Parents should be taught alternative ways of doing things, so they will become comfortable with problem solving regarding the care needs. Proper education of the caregivers regarding actions to take in the case of emergencies is essential before discharge home.

The discharging hospital should assist the family in locating a community-based pediatrician or other physician who is willing to accept primary care coordination for the member. The lines of communication must be open between the physician, the family caregivers, and the home health agency.

The parents are central to the management of home care. During all stages of adjusting to home care, it is very important to remember that the parents (or primary caregivers) remain the only "constant" factor in the home care experience over time. They have the accumulated knowledge and experience of their needs, as well as the needs of their child, which a health care provider may not have.



Coordination between the discharge planner or hospital social worker and the home health agency or the person responsible for ensuring psychosocial support must be initiated on an outpatient basis immediately at the time of discharge. Stressors imposed on the family due to the various factors involved in service delivery systems must be recognized.

The goal of all service providers should be to ensure alternative ways of decreasing stress and increasing the effectiveness of the services provided in the most cost-effective manner while enhancing family functioning.

Home care is a lot of work. Families will do better knowing the benefits and limitations up front, rather than getting discouraged because care for their child at home is not what they expected.

Giving the parents honest and factual information helps to better prepare them to the realities of home care. Parents need to know and understand that they have a responsibility in maintaining a business relationship with service providers.

Often, the depersonalization of home care is difficult for families to cope with but, nonetheless, reality. Presenting this reality before its occurrence helps to prepare the families for the idea that they need to rely on themselves to ensure that the service contracted for is, in fact, provided.

4. Prior Authorization

Private-duty nursing or personal care services require prior authorization. Medical personnel will individually review each prior authorization request. Prior authorization requests may be approved, modified, or denied.

The skill level approved for private-duty nursing or personal care services is based on the medical needs of the child and the Iowa Board of Nursing scope of practice guidelines, not the staffing preference of the provider or family.

Private-duty nursing or personal care services must be ordered in writing by a physician, as evidenced by the physician's signature on the plan of care.

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A prior authorization request can be reviewed without the physician's completed order, but any changes in the order must be communicated to the IME Medical Services Unit. (The plan of care must be signed within the certification period and attached to the claim for payment.)

The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. Request prior authorization based on the planning process outlined under [Service Planning for Special-Needs Children](#).

Submit initial requests and requests for renewal on form 470-0829, *Request for Prior Authorization*. (See [FORM 470-0829, REQUEST FOR PRIOR AUTHORIZATION](#), for further instructions and a facsimile of this form.)

Prior authorizations are member-specific, not provider-specific. Agencies that accept patients who have a current approved prior authorization from the patient's previous home health agency should notify the IME Medical Prior Authorization Unit by letter to receive a copy of the current prior authorization.

To request a transfer of the prior authorization to a new home health agency, notify the IME Medical Services Unit in writing. The written request must address the reasons for the agency change, the effective day of the change, and any changes in the services to be provided.

If you have questions related to prior authorization, you may telephone the IME Medical Prior Authorization Unit at 1-888-424-2070 or 515-256-4624.

5. Place of Service

Private-duty nursing and personal care services are provided to a member in the member's place of residence, or outside the member's residence when normal life activities take the member outside the place of residence. Some of the care must be provided in the member's home.

Additional hours of services will not be authorized outside the member's residence beyond what would normally be authorized in the residence. If a member wishes to receive nursing services to attend school or other activities outside the home, but does not need nursing services in the home, nursing services cannot be authorized.



The need for care to participate in activities outside the home is not a basis for authorizing additional hours of service.

Services provided in nursing facilities, skilled nursing facilities, intermediate care facilities for the mentally retarded, or hospitals are not payable.

Services that are provided in the home health agency office are not payable.

6. Nonpayable Services

The following services are not payable as private-duty nursing or personal care:

- ◆ Homemaker services.
- ◆ Homework assistance.
- ◆ Medical transportation.
- ◆ Nurse supervision services, such as chart review, case discussion, or scheduling by a registered nurse.
- ◆ Respite care (temporary intermission or period of rest for the caregiver that relieves the caregiver of the duties of providing continuous support and care to the member).
- ◆ Service requested for nonmedical reasons.
- ◆ Services provided to other members of the member's household.
- ◆ Services requiring prior authorization that are provided without regard to the prior authorization process.
- ◆ Services to members aged 21 and over.
- ◆ Two Medicaid services provided simultaneously.
- ◆ Well-child medical care and supervision.

Assessment and monitoring that require the skills of a licensed nurse are covered under private-duty nursing, but are not covered under personal care.

Medical equipment rental is not reimbursable to a home health agency.

Supplies incidental to a member's care may be billed monthly (i.e., syringes for Prolixin injections).

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Obtain and bill for dressings, durable medical equipment, and other supplies through a medical equipment dealer or pharmacy. (Special consideration may be given to unusual circumstances; e.g., a pharmacy or medical equipment dealer is not available in the member's community.)

Members under the MediPASS program **must** have the physician's approval for the service to be payable.

Home health agency services for a member in a Medicaid HMO are covered by the HMO.

The Iowa Department of Public Health may certify home health agencies to participate as child health centers and provide EPSDT screening services. Those agencies will be paid for health screening examinations for Medicaid-eligible members under 21 years of age. Those agencies should enroll as screening centers to provide EPSDT screening services.

7. Basis of Payment

Payment to a home health agency for private-duty nursing or personal care services is on an hourly fee-for-service basis. As a general rule, billing is per calendar month. Only the amount of care approved on the prior authorization can be billed.

Reimbursement is made for an hourly unit of service based on a fee schedule. Enhanced payment under the interim fee schedule will be made available for services to children who are technology-dependent (ventilator dependent or with a medical condition so unstable as to otherwise require intensive care in a hospital).

A person is considered ventilator dependent when the person:

- ◆ Is unable to initiate spontaneous breathing, and
- ◆ Needs a life sustaining medical device for respiration which meets the following definition: "A volume-cycled, mechanical device, including but not limited to adjustments for respiratory rates and tidal volume and oxygen concentration, that provides life sustaining respiration."

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8. Procedure Codes and Nomenclature

HCPCS codes have been established for billing. One unit equals one hour. Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied.

<u>Code</u>	<u>Description</u>
S9122	Home health aide or certified nurse assistant providing care in the home; per hour
S9123	Nursing care in the home by registered nurse; per hour
S9124	Nursing care in the home by licensed practical nurse; per hour

For nursing services provided at the enhanced rate, submit claims using the same code. The approved prior authorization form will reflect reimbursement at the enhanced rate.

E. FORM 470-0829, REQUEST FOR PRIOR AUTHORIZATION

For services requiring prior approval, form 470-0829, *Request for Prior Authorization*, must be completed and submitted to IME. To view a sample of this form on line, click [here](#). Do not use this form unless Medicaid requires prior approval for the service being provided.

- ◆ Mail requests to the IME Medical Prior Authorization Unit, Box 36478, Des Moines, IA 50315, or
- ◆ Fax them to 515-725-1356. (You must send the original, signed *Request for Prior Authorization* to IME to support a faxed prior authorization request.)

A request to modify a prior authorization may be made by telephone to **1-888-424-2070** or **515-256-4624**.

The request for prior authorization of home care services shall include:

- ◆ A nursing assessment.
- ◆ The plan of care.
- ◆ Supporting documentation showing the planning process.

Prior authorization for home care services will not be approved before:

- ◆ The regular service planning process or the planning process for special circumstances is completed.
- ◆ The designated review agent receives a telephone contact, fax, or a written request from the provider for prior authorization of the services.

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The Medical Prior Authorization 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. **Important:** Do not return the prior authorization form. You need to place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, the computer will then verify that the service has been approved for payment.

1. 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. Completing this area may expedite the processing of your *Request for Prior Authorization*. This area is optional.

Provider Fax. This area is optional. Completing it may expedite the processing of your *Request for Prior Authorization*.

Provider NPI. Enter your ten-digit national provider identifier.

Dates Covered by Request. Enter the applicable date span. Use two digits each for: month, day, year (MM, DD, YY). Be sure to include the date of service. If this request is approved, it will be valid only for this period.

Dispensing Provider Name. Complete the name of the provider who will provide services.

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Service Location Street Address. Enter the street address of the provider requesting prior authorization.

Service Location City, State, Zip. Enter the city, state, and zip of the provider requesting prior authorization.

Prior Authorization No. Leave blank. 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 in this area for the type of approval being requested. Refer to coverage sections of this chapter. Include all items identified in Section B as required treatment plan information. For enteral products, enter the number of cans or packets administered per day.

For private-duty nursing or personal care, also include:

- ◆ Any planned surgical interventions and projected date of the surgery.
- ◆ If the member is currently hospitalized, the projected date of discharge.
- ◆ Information regarding the caregiver's desire to:
 - Become involved in the child's care.
 - Adhere to program objectives.
 - Work toward treatment plan goals.
 - Work toward maximum independence.
- ◆ Identification of the types and service delivery levels of all other services to the child, whether or not the services are reimbursable by Medicaid.

For example, all members under 21 should be receiving well-child care from their physician, well child clinic, school-based clinic, and educational services from their area education agency or local education agency or local education agency. Some members may be involved with Child Health Specialty Clinics, or respite programs. Some may be eligible for private insurance services.

- ◆ If requesting extension of private-duty nursing or personal care, information regarding carry-over or follow-through of the work toward maximum independence by the child and the caregiver. Carry-over and follow-through compatible with the treatment goals must be documented.



- ♦ The expected number of private-duty nursing registered nurse hours, private-duty nursing licensed practical nurse hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. The total number of hours requested must exactly match the number of hours on the treatment plan.

NOTE: Prior authorization approvals will not be granted for treatment plans that exceed 16 hours of home health agency services per day.

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. 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. 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. IME will indicate "A" for approved or "D" for denied.

Requesting Provider. Enter the name of the provider requesting prior authorization, if other than the provider who will provide services.

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Prior Authorization Reviewer Use Only

Medicaid Services Are Hereby.... Do not complete. IME will complete this item after evaluating the request.

Comments or Reasons for Denial of Services. Do not complete. IME will complete this section should this request be denied.

Signature. Do not complete. The person making the final decision on this request will sign and date.

2. Electronic Prior Authorization Requests

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for Prior Authorization requests (278 transaction). However, there is no standard to use in submitting additional documentation electronically.

Therefore, if you want to submit a prior authorization request electronically, the additional documentation must be submitted on paper using the following procedure:

- ◆ Complete form 470-3970, *Prior Authorization Attachment Control*. To view a sample of this form on line, click [here](#).

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 number. If you do not know the attachment control number for the request, please contact the person in your facility responsible for electronic claims billing.

- ◆ **Staple** the additional information to the *Prior Authorization Attachment Control*.
- ◆ **Fax** the form with attachments to the Prior Authorization Unit at 800-574-2515 **or mail** the information to:

Iowa Medicaid Enterprise
 PO Box 36478
 Des Moines, IA 50315

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



F. INSTRUCTIONS AND CLAIM FORMS

1. Instructions for Completing the UB-04 Claim Form (CMS-1450)

Bill for services on claim form UB-04 *Uniform Bill* (CMS-1450). Use an original version of the UB-04 as found at an office supply store. To view a sample of this form on line, click [here](#). When more than one plan of care covers a calendar billing month, submit all pertinent care plans with the UB-04.

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

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

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	PROVIDER NAME, ADDRESS, & TELEPHONE NUMBER	REQUIRED. Enter the complete name, address, and phone number of the billing facility or service supplier. The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org .
2.	PAY-TO NAME, ADDRESS, & SECONDARY IDENTIFICATION	SITUATIONAL. Required if the "pay to" name and address information is different from the billing provider name in Item 1.
3a.	PATIENT CONTROL NUMBER	OPTIONAL. Enter the account number assigned to the member by the provider of service. This field is limited to 10 alpha/numeric characters.
3b.	MEDICAL RECORD NUMBER	OPTIONAL. Enter the number assigned to the patient's medical or health record by the provider. This field is limited to 20 alphanumeric characters. This number will be listed on the <i>Remittance Advice</i> only if field 3a is left blank.



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
4.	TYPE OF BILL	REQUIRED. Enter a three-digit number consisting of one digit from each of the following categories in this sequence: First digit Type of facility Second digit Bill classification Third digit Frequency <u>Type of Facility</u> 1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice <u>Bill Classification</u> 1 Inpatient hospital, inpatient SNF or hospice (nonhospital-based) 2 Hospice (hospital-based) 3 Outpatient hospital, outpatient SNF or hospice (hospital-based) 4 Hospital-referenced laboratory services, home health agency, rehabilitation agency <u>Frequency</u> 1 Admit through discharge claim 2 Interim, first claim 3 Interim, continuing claim 4 Interim, last claim
5.	FEDERAL TAX NUMBER	OPTIONAL. No entry required. NOTE: Changes to the provider's tax ID number must be reported through the IME Provider Services Unit at 1-800-338-7909 or 515-256-4609 in Des Moines.
6.	STATEMENT COVERS PERIOD	REQUIRED. Enter the month, day, and year (in MMDDYY format) under both the 'From' and 'To' categories for the period.
7.		OPTIONAL. No entry required. NOTE: Covered and noncovered days are reported using value codes in fields 39A-41d.



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS																																																								
8a.	PATIENT LAST NAME	REQUIRED. Enter the last name of the patient.																																																								
8a.	PATIENT FIRST NAME	REQUIRED. Enter the first name and middle initial of the patient.																																																								
9a-9d	PATIENT ADDRESS	OPTIONAL. Enter the full address of the patient.																																																								
9e	UNTITLED	OPTIONAL. No entry required.																																																								
10.	BIRTHDATE	OPTIONAL. Enter the patient's birth date as month, day, and year.																																																								
11.	SEX	REQUIRED. Enter the patient's sex.																																																								
12.	ADMISSION DATE	REQUIRED. Inpatient, PMIC, and SNF: Enter the date of admission for inpatient services. Outpatient: Enter the dates of service. Home health agency and hospice: Enter the date of admission for care. Rehabilitation agency: No entry required.																																																								
13.	ADMISSION HOUR	REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code from the following chart that corresponds to the hour when the patient was admitted for inpatient care. <table><tr><th><u>Code</u></th><th><u>Time - AM</u></th><th><u>Code</u></th><th><u>Time - PM</u></th></tr><tr><td>00</td><td>12:00 – 12:59 Midnight</td><td>12</td><td>12:00 – 12:59 Noon</td></tr><tr><td>01</td><td>1:00 – 1:59</td><td>13</td><td>1:00 – 1:59</td></tr><tr><td>02</td><td>2:00 – 2:59</td><td>14</td><td>2:00 – 2:59</td></tr><tr><td>03</td><td>3:00 – 3:59</td><td>15</td><td>3:00 – 3:59</td></tr><tr><td>04</td><td>4:00 – 4:59</td><td>16</td><td>4:00 – 4:59</td></tr><tr><td>05</td><td>5:00 – 5:59</td><td>17</td><td>5:00 – 5:59</td></tr><tr><td>06</td><td>6:00 – 6:59</td><td>18</td><td>6:00 – 6:59</td></tr><tr><td>07</td><td>7:00 – 7:59</td><td>19</td><td>7:00 – 7:59</td></tr><tr><td>08</td><td>8:00 – 8:59</td><td>20</td><td>8:00 – 8:59</td></tr><tr><td>09</td><td>9:00 – 9:59</td><td>21</td><td>9:00 – 9:59</td></tr><tr><td>10</td><td>10:00 – 10:59</td><td>22</td><td>10:00 – 10:59</td></tr><tr><td>11</td><td>11:00 – 11:59</td><td>23</td><td>11:00 – 11:59</td></tr><tr><td></td><td></td><td>99</td><td>Hour unknown</td></tr></table>	<u>Code</u>	<u>Time - AM</u>	<u>Code</u>	<u>Time - PM</u>	00	12:00 – 12:59 Midnight	12	12:00 – 12:59 Noon	01	1:00 – 1:59	13	1:00 – 1:59	02	2:00 – 2:59	14	2:00 – 2:59	03	3:00 – 3:59	15	3:00 – 3:59	04	4:00 – 4:59	16	4:00 – 4:59	05	5:00 – 5:59	17	5:00 – 5:59	06	6:00 – 6:59	18	6:00 – 6:59	07	7:00 – 7:59	19	7:00 – 7:59	08	8:00 – 8:59	20	8:00 – 8:59	09	9:00 – 9:59	21	9:00 – 9:59	10	10:00 – 10:59	22	10:00 – 10:59	11	11:00 – 11:59	23	11:00 – 11:59			99	Hour unknown
<u>Code</u>	<u>Time - AM</u>	<u>Code</u>	<u>Time - PM</u>																																																							
00	12:00 – 12:59 Midnight	12	12:00 – 12:59 Noon																																																							
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11	11:00 – 11:59	23	11:00 – 11:59																																																							
		99	Hour unknown																																																							



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
14.	TYPE OF ADMISSION/ VISIT	REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code corresponding to the priority level of this inpatient admission. 1 Emergency 2 Urgent 3 Elective 4 Newborn 9 Information unavailable
15.	SRC (SOURCE OF ADMISSION)	REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code that corresponds to the source of this admission. 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information unavailable
16.	DHR (DISCHARGE HOUR)	REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code that corresponds to the hour member was discharged from inpatient care, using the chart under Field 13, Admission Hour .
17.	STAT (PATIENT STATUS)	REQUIRED FOR INPATIENT/PMIC/SNF. Enter the code that corresponds to the status of the member at the end of service. 01 Discharged to home or self care (routine discharge) 02 Discharged or transferred to other short-term general hospital for inpatient care 03 Discharged or transferred to a skilled nursing facility (SNF) 04 Discharged or transferred to an intermediate care facility (ICF) 05 Discharged or transferred to another type of institution for inpatient care or outpatient services 06 Discharged or transferred to home with care of organized home health services



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		07 Left care against medical advice or otherwise discontinued own care 08 Discharged or transferred to home with care of home IV provider 10 Discharged or transferred to mental health care 11 Discharged or transferred to Medicaid-certified rehabilitation unit 12 Discharged or transferred to Medicaid-certified substance abuse unit 13 Discharged or transferred to Medicaid-certified psychiatric unit 20 Expired 30 Remains a patient or is expected to return for outpatient services (valid only for nonDRG claims) 40 Hospice patient died at home 41 Hospice patient died at medical facility 42 Hospice patient died unknown 43 Discharged or transferred to federal hospital 50 Hospice home 51 Hospice medical facility 61 Transferred to swing-bed unit 62 Transferred to rehabilitation facility 64 Transferred to nursing facility 65 Discharged or transferred to psychiatric hospital 71 Transferred for another outpatient facility 72 Transferred for outpatient service
18. – 28.	CONDITION CODES	SITUATIONAL. Enter corresponding codes to indicate whether treatment billed on this claim is related to any condition listed below. Up to seven codes may be used to describe the conditions surrounding a patient's treatment. <u>General</u> 01 Military service related 02 Condition is employment related 03 Patient covered by an insurance not reflected here 04 HMO enrollee 05 Lien has been filed



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		<u>Inpatient Only</u> 80 Neonatal level II or III unit 81 Physical rehabilitation unit 82 Substance abuse unit 83 Psychiatric unit X3 IME approved lower level of care, ICF X4 IME approved lower level of care, SNF 91 Respite care <u>Outpatient Only</u> 84 Cardiac rehabilitation program 85 Eating disorder program 86 Mental health program 87 Substance abuse program 88 Pain management program 89 Diabetic education program 90 Pulmonary rehabilitation program 98 Pregnancy indicator – outpatient or rehabilitation agency <u>Special Program Indicator</u> A1 EPSDT A2 Physically handicapped children's program A3 Special federal funding A4 Family planning A5 Disability A6 Vaccine/Medicare 100% payment A7 Induced abortion – danger to life A8 Induced abortion – victim rape/incest A9 Second opinion surgery <u>Home Health Agency</u> (Medicare not applicable) XA Condition stable XB Not homebound XC Maintenance care XD No skilled service
29.	ACCIDENT STATE	OPTIONAL. No entry required.
30.	UNTITLED	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
31. – 34.	OCCURRENCE CODES AND DATES	REQUIRED. If any of the occurrences listed below is applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence. <u>Accident-Related</u> 01 Auto accident 02 No fault insurance involved, including auto accident/other 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim <u>Insurance-Related</u> 17 Date outpatient occupational plan established or reviewed 24 Date insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan was established or last reviewed A3 Medicare benefits exhausted <u>Other</u> 11 Date of onset
35. - 36.	OCCURRENCE SPAN CODE AND DATES	OPTIONAL. No entry required.
37.	UNTITLED	OPTIONAL. No entry required.
38.	UNTITLED	OPTIONAL. No entry required.
39. – 41.	VALID CODES AND AMOUNTS	SITUATIONAL. Required if covered or noncovered days are included in the billing period. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. 80 Covered days 81 Noncovered days



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
42.	REVENUE CODE	REQUIRED. Enter the revenue code that corresponds for each item or service billed. Replace the "X" with a subcategory code, if applicable, to clarify the code. Note that not all of the revenue codes listed are payable by Medicaid. If you have questions concerning payment for a specific item or service, please call IME Provider Services at 1-800-338-7909 or 515-256-4609 (in Des Moines). 11X Room & board: private (medical or general) Charges for accommodations with a single bed. Subcategories: 0 General classifications 1 Medical/surgical/GYN 2 OB 3 Pediatric 4 Psychiatric 6 Detoxification 7 Oncology 8 Rehabilitation 9 Other 12X Room & board: semi-private two beds (medical or general) Charges for accommodations with two beds. Subcategories: 0 General classifications 4 Sterile environment 7 Self care 9 Other 13X Room & board: semi-private three or four beds (medical or general) Charges for accommodations with three or four beds. Subcategories: 0 General classifications 4 Sterile environment 7 Self care 9 Other



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		14X Private (deluxe) Charges for accommodations with amenities substantially in excess of those provided to other patients. Subcategories: 0 General classifications 4 Sterile environment 7 Self care 9 Other
		15X Room & board: ward (medical or general) Charges for accommodations with five or more beds. Subcategories: 0 General classifications 4 Sterile environment 7 Self care 9 Other
		16X Other room & board Charges for accommodations that cannot be included in the specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing. Subcategories: 0 General classifications 4 Sterile environment 7 Self care 9 Other
		17X Nursery Charges for nursing care to newborn and premature infants in nurseries. Subcategories: 0 General classification 1 Newborn 2 Premature 5 Neonatal ICU 9 Other
		18X Leave of absence Charges for holding a room or bed for a patient while the patient is temporarily away from the provider. Subcategory: 5 Nursing home (for hospitalization)



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		20X Intensive care Charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit. Subcategories: 0 General classification 1 Surgical 2 Medical 3 Pediatric 4 Psychiatric 6 Post ICU 7 Burn care 8 Trauma 9 Other intensive care
		21X Coronary care Charges for medical care provided to patients with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit. Subcategories: 0 General classification 1 Myocardial infarction 2 Pulmonary care 3 Heart transplant 4 Post CCU 9 Other coronary care
		22X Special charges Charges incurred during an inpatient stay or on a daily basis for certain services. Subcategories: 0 General classification 1 Admission charge 2 Technical support charge 3 U.R. service charge 4 Late discharge, medically necessary 9 Other special charges



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		23X Incremental nursing charge rate Subcategories: 0 General classification 1 Nursery 2 OB 3 ICU 4 CCU 9 Other
		24X All inclusive ancillary A flat rate charge incurred on either a daily or total-stay basis for ancillary services only. Subcategories: 0 General classification 9 Other inclusive ancillary
		25X Pharmacy Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies. Subcategories: 0 General classification 1 Generic drugs 2 Nongeneric drugs 3 Take-home drugs 4 Drugs incident to other diagnostic services 5 Drugs incident to radiology 6 Experimental drugs 7 Nonprescription 8 IV solutions 9 Other pharmacy
		26X IV therapy Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists. Subcategories: 0 General classification 1 Infusion pump 2 IV therapy/pharmacy services 3 IV therapy/drug/supply delivery 4 IV therapy/supplies 9 Other IV therapy



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		27X Medical/surgical supplies and devices (also see 62X, an extension of 27X) Charges for supply items required for patient care. Subcategories: 0 General classification 1 Nonsterile supply 2 Sterile supply 3 Take-home supplies 4 Prosthetic and orthotic devices 5 Pacemaker 6 Intraocular lens 7 Oxygen (take home) 8 Other implants 9 Other supplies and devices 28X Oncology Charges for the treatment of tumors and related diseases. Subcategories: 0 General classification 9 Other oncology 29X Durable medical equipment (other than renal) Charges for medical equipment that can withstand repeated use (excluding renal equipment). Subcategories: 0 General classification 1 Rental 2 Purchase of new equipment 3 Purchase of used equipment 4 Supplies or drugs for equipment effectiveness (home health agency only) 9 Other equipment



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		30X Laboratory Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, indicate the code for each laboratory charge in field 44. Subcategories: 0 General classification 1 Chemistry 2 Immunology 3 Renal patient (home) 4 Nonroutine dialysis 5 Hematology 6 Bacteriology and microbiology 9 Other laboratory 31X Laboratory, pathological Charges for diagnostic and routine laboratory tests on tissues and cultures. For outpatient services, indicate the CPT code for each laboratory charge in field 44. Subcategories: 0 General classification 1 Cytology 2 Histology 4 Biopsy 9 Other 32X Radiology, diagnostic Charges for diagnostic radiology services provided for the examination and care of members. Includes taking, processing, examining and interpreting radiographs and fluorographs. Subcategories: 0 General classification 1 Angiocardiology 2 Arthrography 3 Arteriography 4 Chest x-ray 9 Other



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		33X Radiology, therapeutic Charges for therapeutic radiology services and chemotherapy required for care and treatment of members. Includes therapy by injection or ingestion of radioactive substances. Subcategories: 0 General classification 1 Chemotherapy, injected 2 Chemotherapy, oral 3 Radiation therapy 5 Chemotherapy, IV 9 Other
		34X Nuclear medicine Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of members. Subcategories: 0 General classification 1 Diagnostic 2 Therapeutic 9 Other
		35X CT scan Charges for computed tomographic scans of the head and other parts of the body. Subcategories: 0 General classification 1 Head scan 2 Body scan 9 Other CT scans
		36X Operating room services Charges for services provided to patient by specifically trained nursing personnel who assisted physicians in surgical or related procedures during and immediately following surgery. Subcategories: 0 General classification 1 Minor surgery 2 Organ transplant other than kidney 7 Kidney transplant 9 Other operating room services



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		37X Anesthesia Charges for anesthesia services in the hospital. Subcategories: 0 General classification 1 Anesthesia incident to radiology 2 Anesthesia incident to other diagnostic services 4 Acupuncture 9 Other anesthesia 38X Blood Charges for blood must be separately identified for private payer purposes. Subcategories: 0 General classification 1 Packed red cells 2 Whole blood 3 Plasma 4 Platelets 5 Leukocytes 6 Other components 7 Other derivatives (cryoprecipitates) 9 Other blood 39X Blood storage and processing Charges for the storage and processing of whole blood. Subcategories: 0 General classification 1 Blood administration 9 Other blood storage and processing 40X Other imaging services Subcategories: 0 General classification 1 Diagnostic mammography 2 Ultrasound 3 Screening mammography 4 Positron emission tomography 9 Other imaging services



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		41X Respiratory services Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases. Subcategories: 0 General classification 1 Inhalation services 3 Hyperbaric oxygen therapy 9 Other respiratory services 42X Physical therapy Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of members who have neuromuscular, orthopedic, and other disabilities. Subcategories: 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other occupational therapy or trial occupational therapy by rehab agency 43X Occupational therapy Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients. Subcategories: 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other occupational therapy or trial occupational therapy by rehab agency



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		44X Speech language pathology Charges for services provided to those with impaired functional communication skills. Subcategories: 0 General classification 1 Visit charge 2 Hourly charge 3 Group rate 4 Evaluation or reevaluation 9 Other speech-language pathology or trial speech therapy by rehab agency
		45X Emergency room Charges for emergency treatment to those ill and injured persons requiring immediate unscheduled medical or surgical care. Subcategories: 0 General classification 9 Other emergency room
		46X Pulmonary function Charges for tests measuring inhaled and exhaled gases, the analysis of blood, and tests evaluating the patient's ability to exchange oxygen and other gases. Subcategories: 0 General classification 9 Other pulmonary function
		47X Audiology Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function. Subcategories: 0 General classification 1 Diagnosis 2 Treatment 9 Other audiology



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		48X Cardiology Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests. Subcategories: 0 General classification 1 Cardiac catheter lab 2 Stress test 9 Other cardiology
		49X Ambulatory surgical care Charges for ambulatory surgery not covered by other categories. Subcategories: 0 General classification 9 Other ambulatory surgical care
		50X Outpatient services Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service. Subcategories: 0 General classification 9 Other outpatient services
		51X Clinic Charges for providing diagnostic, preventive, curative, rehabilitative, and education services on a nonemergency, scheduled outpatient basis to ambulatory patients. Subcategories: 0 General classification 1 Chronic pain center 2 Dental clinic 3 Psychiatric clinic 4 OB-GYN clinic 5 Pediatric clinic 9 Other clinic
		52X Free-standing clinic Subcategories: 0 General classification 1 Rural health, at clinic 2 Rural health, at home 3 Family practice 9 Other free-standing clinic



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		53X Osteopathic services Charges for a structural evaluation of the cranium, entire cervical, dorsal, and lumbar spine by a doctor of osteopathy. Subcategories: 0 General classification 1 Osteopathic therapy 9 Other osteopathic services 54X Ambulance Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention. Subcategories: 0 General classification 1 Supplies 2 Medical transport 3 Heart mobile 4 Oxygen 5 Air ambulance 6 Neonatal ambulance services 7 Pharmacy 8 Telephone transmission EKG 9 Other ambulance Documentation of medical necessity must be provided for ambulance transport. The diagnosis and documentation must reflect that the patient was nonambulatory and the trip was to the nearest adequate facility. NOTE: Ambulance is payable on the UB-04 only in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form. 55X Skilled nursing (home health agency only) Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the patient and achieving the medically desired result. Subcategories: 0 General classification 1 Visit charge 2 Hourly charge 9 Other skilled nursing



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		56X Medical social services (home health agency only) Charges for services provided to patients on any basis, such as counseling, interviewing, and interpreting social situation problems. Subcategories: 0 General classification 1 Visit charge 2 Hourly charge 9 Other medical social services
		57X Home health aide (home health agency only) Charges made by a home health agency for personnel primarily responsible for the personal care of the patient. Subcategories: 0 General classification 1 Visit charge 2 Hourly charge 9 Other home health aide services
		61X MRI Charges for magnetic resonance imaging of the brain and other body parts. Subcategories: 0 General classification 1 Brain (including brainstem) 2 Spinal cord (including spine) 9 Other MRI
		62X Medical/surgical supplies (extension of 27X) Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcategories: 1 Supplies incident to radiology (for providers that cannot bill supplies used for radiology procedures under radiology) 2 Supplies incident to other diagnostic services (for providers that cannot bill supplies used for other diagnostic procedures)



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		63X Drugs requiring specific identification Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in field 44. Subcategories: 0 General classification 1 Single source drug 2 Multiple source drug 3 Restrictive prescription 4 Erythropoietin (EPO), less than 10,000 units 5 Erythropoietin (EPO), 10,000 or more units 6 Drugs requiring detailed coding
		64X Home IV therapy services Charges for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy. Subcategories: 0 General classification 1 Nonroutine nursing, central line 2 IV site care, central line 3 IV site/change, peripheral line 4 Nonroutine nursing, peripheral line 5 Training patient/caregiver, central line 6 Training, disabled patient, central line 7 Training, patient/caregiver, peripheral line 8 Training, disabled patient, peripheral line 9 Other IV therapy services
		65X Hospice services (hospice only) Charges for hospice care services for a terminally ill patient if he or she elects these services in lieu of other services for the terminal condition. Subcategories: 1 Routine home care 2 Continuous home care (hourly) 5 Inpatient respite care 6 General inpatient care 8 Care in an ICF or SNF



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		70X Cast room Charges for services related to the application, maintenance, and removal of casts. Subcategories: 0 General classification 9 Other cast room 71X Recovery room Subcategories: 0 General classification 9 Other recovery room 72X Labor room/delivery Charges for labor and delivery room services provided to patients by specially trained nursing personnel. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite. Subcategories: 0 General classification 1 Labor 2 Delivery 3 Circumcision 4 Birthing center 9 Other labor room/delivery 73X EKG/ECG (electro-cardiogram) Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments. Subcategories: <u>Subcategories</u> 0 General classification 1 Holter monitor 2 Telemetry 9 Other EKG/ECG



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		74X EEG (electro-encephalogram) Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders. Subcategories: 0 General classification 9 Other EEG 75X Gastro-intestinal services Procedure room charges for endoscopic procedures not performed in the operating room. Subcategories: 0 General classification 9 Other gastro-intestinal 76X Treatment or observation room Charges for the use of a treatment room or for the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes on outpatient claims (one unit per hour). Subcategories: 0 General classification 1 Treatment room 2 Observation room 9 Other treatment/observation room 79X Lithotripsy Charges for the use of lithotripsy in the treatment of kidney stones. Subcategories: 0 General classification 9 Other lithotripsy



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		80X Inpatient renal dialysis A waste removal process performed in an inpatient setting using an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue. Subcategories: 0 General classification 1 Inpatient hemodialysis 2 Inpatient peritoneal (nonCAPD) 3 Inpatient continuous ambulatory peritoneal dialysis 4 Inpatient continuous cycling peritoneal dialysis (CCPD) 9 Other inpatient dialysis 81X Organ acquisition (see 89X) The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.) Subcategories: 0 General classification 1 Living donor, kidney 2 Cadaver donor kidney 3 Unknown donor, kidney 4 Other kidney acquisition 5 Cadaver donor, heart 6 Other heart acquisition 7 Donor, liver 9 Other organ acquisition 82X Hemodialysis, outpatient or home A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Subcategories: 0 General classification 1 Hemodialysis/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient hemodialysis



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		83X Peritoneal dialysis, outpatient or home A waste removal process performed in an outpatient or home setting that is necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue. Subcategories: 0 General classification 1 Peritoneal/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient peritoneal dialysis
		84X Continuous ambulatory peritoneal dialysis (CCPD), outpatient or home A continuous dialysis process performed in an outpatient or home setting using the patient peritoneal membrane as a dialyzer. Subcategories: 0 General classification 1 CAPD/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient CAPD
		85X Continuous cycling peritoneal dialysis (CCPD), outpatient or home A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night. Subcategories: 0 General classification 1 CCPD/composite or other rate 2 Home supplies 3 Home equipment 4 Maintenance/100% 5 Support services 9 Other outpatient CCPD



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		88X Miscellaneous dialysis Charges for dialysis services not identified elsewhere. Subcategories: 0 General classification 1 Ultrafiltration 2 Home dialysis aid visit 9 Miscellaneous dialysis other
		89X Other donor bank (extension of 81X) Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts; see 81X). Subcategories: 0 General classification 1 Bone 2 Organ (other than kidney) 3 Skin 9 Other donor bank
		92X Other diagnostic services Subcategories: 0 General classification 1 Peripheral vascular lab 2 Electromyelogram 3 Pap smear 4 Allergy test 5 Pregnancy test 9 Other diagnostic services
		94X Other therapeutic services Charges for other therapeutic services not otherwise categorized. Subcategories: 0 General classification 1 Recreational therapy 2 Education/training 3 Cardiac rehabilitation 4 Drug rehabilitation 5 Alcohol rehabilitation 6 Complex medical equipment, routine 7 Complex medical equipment, ancillary 9 Other therapeutic services



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		99X Patient convenience items Charges for items generally considered by the third-party payers to be strictly convenience items, and, therefore, are not covered. Subcategories: 0 General classification 1 Cafeteria or guest tray 2 Private linen service 3 Telephone or telegraph 4 TV or radio 5 Nonpatient room rentals 6 Late discharge charge 7 Admission kits 8 Beauty shop or barber 9 Other patient convenience items
43.	DESCRIPTION	SITUATIONAL. Required if you enter a HCPCS "J" code for a drug that has been administered. Enter the National Drug Code (NDC) that corresponds to the J-code entered in Field 44 in NNNNN-NNNN-NN format, preceded by an "N4" qualifier. No other entries should be made in this field.
43.	PAGE ___ OF ___	REQUIRED if claim is more than one page. Enter the page number and the total number of pages for the claim.
44.	HCPCS/RATE/ HIPPS CODE	REQUIRED for outpatient hospital, inpatient SNF, and home health agencies. When applicable, add a procedure code modifier after the procedure code. Do not enter rates in this field. Outpatient hospital: Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APC. Inpatient SNF: Enter the HCPCS code W0511 for ventilator-dependent patients; otherwise leave blank. Home health agencies: Enter the appropriate HCPCS code from the prior authorization when billing for EPSDT-related services. All others: Leave blank.



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
45.	SERVICE DATES	SITUATIONAL. Required for outpatient claims. Enter the service date for outpatient service referenced in field 42 of field 44. Note that one entry is required for each date in which the service was performed.
46.	SERVICE UNITS	SITUATIONAL. Required for inpatient, outpatient, and home health agencies. Enter all units using whole numbers only (e.g., 1). Do not indicate partial units or anything after the decimal (e.g., 1.5 or 1.0). Inpatient: Enter the number of units of service for accommodation days. Outpatient: Enter the number of units of service provided per CPT or revenue code. (Batch-bill APCs require one unit for every 15 minutes of service time.) Home health agencies: Enter the number of units for each service billed. A unit of service equals a visit. For prior authorization private duty nursing or personal care, one unit equals an hour.
47.	TOTAL CHARGES	REQUIRED. Enter the total charges for each code billed. The total must include both dollars and cents.
47. LINE 23	TOTALS	REQUIRED. On the last page of the claim only, enter the sum of the total charges for all codes billed (all of field 47). The total must include both dollars and cents.
48.	NONCOVERED CHARGES	REQUIRED. Enter the noncovered charges for each applicable code.
48. LINE 23	TOTALS	REQUIRED. On the last page of the claim only, enter the sum of the total noncovered charges for all codes billed (all of field 48). The total must include both dollars and cents.
49.	UNTITLED	OPTIONAL. No entry required.
50. A–C	PAYER IDENTIFICATION	REQUIRED. Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill.



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
51. A–C	HEALTH PLAN ID	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
52. A–C	RELEASE OF INFORMATION CERTIFICATION INDICATOR	OPTIONAL. No entry required. By submitting the claim, you have agreed to all the information of the back of the claim form, including release of information.
53. A–C	ASSIGNMENT OF BENEFITS...	OPTIONAL. No entry required.
54. A–C	PRIOR PAYMENTS	REQUIRED if a payer other than Medicaid has made prior payments. If applicable, enter the amount paid by a payer other than Medicaid. Do not enter previous Medicaid payments. The total must include both dollars and cents.
55. A–C	ESTIMATED AMOUNT DUE	OPTIONAL. No entry required.
56.	NPI	REQUIRED. Enter the national provider ID of the billing entity.
57. A–C	OTHER PROVIDER ID	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
58. A–C	INSURED'S NAME	REQUIRED. Enter the last name, first name, and middle initial of the Medicaid member on the line (A, B, or C) that corresponds to Medicaid from Field 50.
59.	P REL	OPTIONAL. No entry required.
60. A–C	INSURED'S UNIQUE ID	REQUIRED. Enter the member's Medicaid identification number found on the line (A, B, or C) that corresponds to Medicaid from Field 50. Get the number from the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, e.g., 1234567A.
61. A–C	GROUP NAME	OPTIONAL. No entry required.
62. A–C	INSURANCE GROUP NUMBER	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
63.	TREATMENT AUTHORIZATION CODE	SITUATIONAL. Enter the prior authorization number, if applicable. NOTE: This field is no longer used to report a MediPASS referral. Refer to field 79 to enter the MediPASS referral. Lock-in is moved to field 78.
64.	DOCUMENT CONTROL NUMBER	OPTIONAL. No entry required.
65.	EMPLOYER NAME	OPTIONAL. No entry required.
66.	DX	OPTIONAL. No entry required.
67.	PRINCIPAL DIAGNOSIS CODE	REQUIRED. Enter the ICD-9-CM code for the principal diagnosis.
67. A-Q	OTHER DIAGNOSIS CODES	SITUATIONAL. Required if a diagnosis other than the principal is made. Enter the ICD-9-CM codes for additional diagnoses.
68.	UNTITLED	OPTIONAL. No entry required.
69.	ADMITTING DIAGNOSIS	SITUATIONAL. Required for inpatient hospital claims. For inpatient hospital, enter the admitting diagnosis
70. A-C	PATIENT REASON DX	SITUATIONAL. Required if visit is unscheduled. Enter the diagnosis code representing the patient's reason for the visit on all unscheduled outpatient visits.
71.	PPS CODE	OPTIONAL. No entry required.
72.	ECI	OPTIONAL. No entry required.
73.	UNTITLED	OPTIONAL. No entry required.
74.	PRINCIPAL PROCEDURE CODE, DATE	SITUATIONAL. Required for the principal surgical procedure. Enter the ICD-9-CM procedure code and surgery date, when applicable.
74. A-E	OTHER PROCEDURE CODES, DATES	SITUATIONAL. Required for additional surgical procedures. Enter the ICD-9-CM procedure codes and surgery dates.
75.	UNTITLED	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
76.	ATTENDING	Provider name and identifiers.
	NPI	REQUIRED. Enter the NPI of the attending physician. EXCEPTION: For outpatient care, enter the NPI of the referring physician. Leave blank if the primary physician did not make the referral. Do not show treating physician information in this area.
	QUAL	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
	LAST	REQUIRED. Enter the last name of the attending physician.
77.	FIRST	REQUIRED. Enter the first name of the attending physician.
	OPERATING	Provider name and identifiers.
	NPI	SITUATIONAL. Required if the physician performing the principal procedure is different than the attending physician. Enter the NPI of the operating physician.
	QUAL	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
78.	LAST	SITUATIONAL. Enter the last name of the operating physician.
	FIRST	SITUATIONAL. Enter the first name of the operating physician.
	OTHER	Provider name and identifiers.
	NPI	SITUATIONAL. Required if the patient is in the lock-in program. Enter the NPI of the member's lock-in provider.
79.	QUAL	LEAVE BLANK. Entering information in this field will cause the claim to be returned.
	LAST	SITUATIONAL. Enter the last name of the member's lock-in provider.
	FIRST	SITUATIONAL. Enter the first name of the member's lock-in provider.
	OTHER	Provider name and identifiers.



FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
79.	OTHER NPI QUAL LAST FIRST	Provider name and identifiers. SITUATIONAL. Required if the patient is in the MediPASS program. Enter the NPI of the referring MediPASS physician. LEAVE BLANK. Entering information in this field will cause the claim to be returned. SITUATIONAL. Enter the last name of the referring MediPASS physician. SITUATIONAL. Enter the first name of the referring MediPASS physician.
80.	REMARKS	REQUIRED if a diagnosis other than the principal diagnosis is made. When applicable, enter one of the following: • Not a Medicare benefit. • Resubmit (list the original filing date). • Member is retro eligible and NOD is attached. (Attach the Notice of Decision setting the member's eligibility date.)
81.	CC	REQUIRED. Enter "B3" followed by the taxonomy code associated with the NPI of the billing entity (field 56). NOTE: The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the verified taxonomy code, go to imeservices.org

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2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ **Complete** form 470-3969, *Claim Attachment Control*. To view a sample of this form on line, click [here](#). Complete the “attachment control number” with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number.

If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

- ◆ **Staple** the additional information to the *Claim Attachment Control*. Do **not** attach a paper claim.
- ◆ **Mail** the *Claim Attachment Control* with attachments to:

Iowa Medicaid Enterprise
 PO Box 150001
 Des Moines, IA 50315

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

G. REMITTANCE ADVICES AND EXPLANATIONS

1. Remittance Advice Explanation

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 (member 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.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. 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 IME with questions. The IME Provider Services call center is available weekdays from 7:30 a.m. to 4:30 p.m. at 1-800-338-7909 (256-4609 in Des Moines). 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.



2. Part B Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

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
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



Field Name		Field Description
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	Patient	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient 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 patient account number
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



Field Name		Field Description
21	S	Source of payment. Allowed charge source codes are as follows: - 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 rate - 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 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
22	EOB	Explanation of benefits denial reason code. A full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.



3. Inpatient Crossover Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

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
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



Field Name		Field Description
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	Patient Nme	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient 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 patient 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.)

4. Outpatient Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

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



Field Name		Field Description
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
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	TIN	Total dollar amount allowed by Medicaid within same claim type or status
V	Total Allowed Charge	Total allowed charge for claim
X	Total Paid by Mcaid	Total dollar amount paid within same claim type or status



Field Name		Field Description
1	Patient Name	Name of the member as shown on the Medical Assistance Eligibility 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	Dollare 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
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. For more information, go to http://www.ime.state.ia.us/Providers/OutpatientHospital.html



Field Name		Field Description
21	S	Source of payment. Allowed charge source codes are as follows: - 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 rate - 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 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
22	EOB	Explanation of benefits denial reason code for each line



5. Outpatient Crossover Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

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
R	Medicare Paid Amt	Total dollar amount of Medicare payment
S	Deductible	Total deductible paid amount within same claim type or status



Field Name		Field Description
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	Patient Name	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient 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 patient 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.)