



Medicaid Enterprise
Department of Human Services

For Human Services use only:
General Letter No. 8-AP-296
Employees' Manual, Title 8
Medicaid Appendix

March 13, 2009

LOCAL EDUCATION AGENCY MANUAL TRANSMITTAL NO. 09-1

ISSUED BY: Division of Medical Services

SUBJECT: **LOCAL EDUCATION AGENCY MANUAL**, Chapter III, *Provider Specific Policies*, Contents (pages 2 and 3), revised; pages 1, 9, 18, 24 through 34, 70 through 92, and 95, revised; pages 93, 94, 96, 97, and 98, reissued; and the following forms:

RC-0080 *Screening Components by Age*, revised
470-3969 *Claim Attachment Control*, reissued
(RA-1500) *Remittance Advice*, reissued
470-3816 *Medicaid Billing Remittance*, revised

Summary

This release implements the following:

- ◆ Clarification of documentation requirement for services that are billed by time.
- ◆ Removal of references to service coordination.

The Centers for Medicare and Medicaid Services has issued final regulations (CMS 2237) on Medicaid requirements for coverage of targeted case management services. Under these regulations:

- Case management services are designed to address populations with a medical diagnosis, and
- There are limits on coverage of administrative activities that are purely IDEA functions, such as the development, review, and implementation of the individualized education plan.

As local education agencies are not currently billing Medicaid for service coordination, the Department has decided to end Medicaid coverage of service coordination by local education agencies. Local school districts will continue to provide the activities of service coordination as an educational service, not a Medicaid service.

- ◆ Revision to the dental, hearing and vision information in the content of the EPSDT "Care for Kids" screenings.
- ◆ Removal of service coordination and procedure codes and addition of a group code in personal health and more codes for testing.
- ◆ Replacement of the list of Vaccines covered by the Vaccinations for Children program with a link to the Department of Health web site for the program.

- ◆ Update of instructions for completion of the claim form.
- ◆ Inclusion of the revised *Medicaid Billing Remittance*, which reflects that payments are to be made to the Iowa Department on Education instead of the Department of Human Services.

Pages 93, 94, and 96 through 98, form 470-3969, and the *Remittance Advice* are reissued to correct a printing error.

Date Effective

February 1, 2009

Material Superseded

Remove the following pages from **LOCAL EDUCATION AGENCY MANUAL** and destroy them:

<u>Page</u>	<u>Date</u>
Chapter III	
Contents (page 2,3)	September 1, 2007
1, 9, 18, 24-34	September 1, 2007
RC-0080	6/05
70-92	September 1, 2007
470-3969	7/07 (printed copy only)
93, 94	September 1, 2007 (printed copy only)
Remittance Advice	10/19/07 (printed copy only)
95	September 1, 2007
96-98	September 1, 2007 (printed copy only)
470-3816	12/06

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to IME, fiscal agent for the Department of Human Services.



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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CONDITIONS OF PARTICIPATION

Local education agencies eligible to participate in the Iowa Medicaid program are the public school districts accredited by the Iowa Department of Education, the Iowa Braille and Sight-Saving School, and the School for the Deaf.

The provider must agree to remit to the Iowa Department of Human Services an amount equal to the nonfederal share of the Medicaid payment.

1. Personnel

Services shall be provided by personnel who meet standards as set forth in Iowa Department of Education rule 281 Iowa Administrative Code 41.8(256B, 34CFR300), to the extent that their certification or license allows them to provide these services. Additionally, some practitioners are required to hold a professional license.

2. Records

Providers shall maintain complete and legible clinical records documenting that the services for which a charge is made to the Medicaid program are:

- ◆ Medically necessary,
- ◆ Consistent with the diagnosis of the patient's condition, and
- ◆ Consistent with professionally recognized standards of care.

The documentation for each "patient encounter" shall include the following (when appropriate):

- ◆ Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer.
- ◆ Specific procedures or treatments performed.
- ◆ Medications or other supplies.
- ◆ Patient's progress, response to and changes in treatment, and revision of diagnosis.
- ◆ Information necessary to support each item of service reported on the Medicaid claim form. NOTE: Time (including AM/PM) is required for services billed in units of time.



Local education agencies are limited to supplies and equipment of no more than \$25 per month. To provide durable medical supplies and equipment in excess of the \$25 limit, the agency may enroll in the Medicaid program as a medical equipment and supply dealer and bill for these supplies on the CMS-1500 claim form under a medical equipment and supply dealer number.

7. Medical Transportation and Escort Services

Expenses for transportation of a student to and from the site of medical services are covered when the medical need for transportation is on the student's IEP. This includes transportation services to a student who:

- ◆ Resides in a geographic area within which school bus transportation is not provided, or
- ◆ Requires transportation in a vehicle specially equipped or staffed to accommodate the student's special medical needs.

Escort services are a separate billable service allowed only in connection with medical transportation. Escort services must be indicated in the IEP as assistance required for the student during transportation due to the student's physical or behavioral disability and specific needs.

If a student is able to ride on a regular school bus, but requires escort assistance, the transportation cost is not billable, but the escort service can be paid if it is noted on the IEP.

Transportation may be billed only once per day. The student **must** have received a **medical service** on that day. Calculate the number of miles from the point of origin to the service location multiplied by the cost per mile times two if return trip is provided. The total cost for that day is billed. Claims that exceed the edits must be submitted with the mileage log.

Documentation for travel must be recorded in the treatment record of the student. Trip logs may be used. Documentation must include:

- ◆ The date of service,
- ◆ The location of service,
- ◆ The point of origin of travel (location),
- ◆ Location of return travel (if provided), and
- ◆ The approximate number of miles from the origin to the service location.
- ◆ The "time in" and "time out" for escort services to support 15-minute billing units and a short description of the child's status while escorted.



The therapist's unique expertise is often needed for staff and parent training related to the IEP goal or objective. Although the therapist is not the primary person responsible for carrying out these activities, the therapist's input is typically needed to determine:

- ◆ Appropriate expectations.
- ◆ Environmental modifications.
- ◆ Assistive technology.
- ◆ Possible learning strategies.

The intervention activities, which are delegated to others, do not require the therapist's expertise and should not be identified as occupational therapy.

d. Direct Occupational Therapy Service in a Group

Direct occupational therapy to a group includes the same models as described for direct occupational therapy service to an individual.

11. Personal Health Services

Personal health services primarily involve "hands on" assistance with a student's physical dependency needs. Services are related to a student's physical requirements for activities of daily living, such as assistance with eating, bathing, dressing, personal hygiene, bladder and bowel requirements, and taking medications.

The services must be included in a treatment plan developed by the licensed health care professional, but are provided by paraprofessional staff.

Personal health services may include assistance with communication, eating, personal hygiene, mobility, bladder and bowel requirements, and medication administration. Services may include assistance with preparation of meals but do not include the cost of the meals themselves.

NOTE: Use billing code T1020 when services are provided for 50% or more of a school day.



d. Direct Psychological Service in a Group

Direct psychological services to a group include the following services:

- ◆ **Group therapy** that is designed to enhance a student's socialization skills, peer interaction, expression of feelings, etc.
- ◆ **Family therapy**, which consists of sessions with one or more family members for the purposes of effecting changes within the family structure, communication, clarification of roles, etc.

14. Social Work Services

Social work services include assessment, diagnosis and treatment services including, but not limited to:

- ◆ Administration and interpretation of clinical assessment instruments.
- ◆ Psychosocial history.
- ◆ Obtaining, integrating, and interpreting information about student behavior.
- ◆ Planning and managing a program of therapy or intervention services.
- ◆ Providing individual, group, or family counseling.
- ◆ Providing emergency or crisis intervention services.
- ◆ Consultation services to assist other service providers or family members in understanding how they may interact with a student in a therapeutically beneficial manner.

Medicaid covers the following services when they are in the IEP or are linked to a service in the IEP and a licensed school social worker or guidance counselor provides them:

- ◆ **Screening**. Screening is the process of surveying a student through direct observation or group testing in order to verify problems and determine if further assessment is needed.



◆ **Individual assessment.** "Assessment" refers to the process of collecting data for the purpose of making treatment decisions. The initial assessment includes:

- Determining the need, nature, frequency, and duration of treatment.
- Deciding the needed coordination with others.
- Documenting these activities.

Additional activities include:

- **Treatment planning** means establishing treatment goals and procedures used to design an intervention plan.
- **Monitoring of treatment implementation** means activities and procedures designed to document student progress during treatment provision and to adjust the treatment plan as needed.
- **Treatment evaluation** means activities designed to evaluate the effects of an intervention after a significant period.

◆ **Direct service to an individual.** Services to an individual student involve individual therapy, which may utilize any model of therapy and clinical practice.

◆ **Direct service in a group.** Services to a group include the following therapeutic and related services:

- **Group therapy.** This service is designed to enhance socialization skills, peer interaction, expression of feelings, etc.
- **Family therapy.** This service consists of sessions with one or more family members, for the purposes of effecting changes within the family structure, communication, clarification of roles, etc. The student must be present when family therapy is provided.

Contracted services include clinical assessment and direct services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.



15. Speech-Language Therapy

The following speech-language services are covered when they are in the IEP or are linked to a service in the IEP:

- ◆ [Speech-language screening](#)
- ◆ [Individual speech-language assessment](#)
- ◆ [Direct speech-language service to an individual](#)
- ◆ [Direct speech-language service in a group](#)

To be covered, services must be provided by either:

- ◆ A licensed or certified speech-language pathologist, or
- ◆ A speech pathology assistant who is supervised by a licensed speech-language pathologist.

Contracted speech-language services include screening, assessment, and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged. Contracted speech-language services are covered only when provided by a licensed or certified speech-language pathologist.

a. Speech-Language Screening

Speech-language screening is the process of surveying a student through direct supervision by a speech-language pathologist in order to identify previously undetected speech and language problems such as:

- ◆ Articulation
- ◆ Receptive and expressive language
- ◆ Voice
- ◆ Fluency
- ◆ Oral motor functioning
- ◆ Oral structure



b. Individual Speech-Language Assessment

Individual speech-language assessment refers to the process of gathering and interpreting information through:

- ◆ The administering of tests or evaluative instruments.
- ◆ Observation.
- ◆ Record review.
- ◆ Interviews with parents, teachers, and others.

Results of the assessment may identify delay or disorder in one or more of the following areas:

- ◆ Articulation
- ◆ Language
- ◆ Fluency
- ◆ Voice
- ◆ Oral motor, feeding, or both

Based on these assessments, the student's needs are identified, planned for, and documented, including the amount of services.

c. Direct Speech-Language Service to an Individual

Speech-language services include various service delivery models, which may be used independently, in combinations, or with minor variations.

(1) Indirect Service Delivery Models

Indirect service delivery models indicate services provided to a student through the parent, teacher, or others in the student's environment, rather than by direct, routine contact with a speech-language pathologist.

- ◆ **Consultation** is used to remediate impairments by providing information, materials, demonstration teaching and bibliotherapy, usually through parents and teachers.
- ◆ **Parents** or other caregivers of a student with speech-language impairments are organized with the specific goal to provide information and material support as indicated in the IEP.



(2) Direct Service Delivery Models

The following direct service delivery models may be used for speech-language services:

- ◆ **Skill building:** Skill building is used for students learning a new skill, needing more intensive instruction, requiring drill and practice and shaping through progressive approximation by a professionally trained speech-language therapist.

Activities include implementing the interventions by teaching skill, providing drill, prompting, cueing, eliciting, modeling, reinforcing, modifying, and accommodating.

- ◆ **Integrated:** A communication skill has been trained but needs to be integrated and generalized to functional settings of the classroom, home, and community. Activities include:

- Enhancing carryover or generalization of communication skill from skill building level.
- Functionally integrating the established communication skill within the classroom, home, and community.
- Informing teachers of expectations to use communication skill.
- Implementing modifications of accommodations as needed to maintain the skill in classroom, home, or community.

- ◆ **Consultative:** Skill building occurs, but a provider other than the speech-language therapist guides the meaningful change and development of the target communication skills.

Activities include regularly scheduled monitoring, goals and objectives written by the speech-language therapist, brief demonstration teaching and material provided by the speech-language therapist, and continuous evaluation of successful or unsuccessful interventions.



d. Direct Speech Therapy Service in a Group

(1) Indirect Service Delivery

Services are provided to a student through the parent, teacher, or others in the student's environment rather than by direct, routine contact with a speech-language pathologist.

In a **parent group**, a group of parents or other caregivers of students with speech-language impairments is organized with the specific goal of providing information and material support.

(2) Direct Service Delivery Models

- ◆ **Skill building:** Skill building is used for students learning a new skill, needing more intensive instruction, requiring drill and practice and shaping through progressive approximation by a professionally trained speech-language therapist.

Activities include implementing the interventions by teaching skill, providing drill, prompting, cueing, eliciting, modeling, reinforcing, modifying, and accommodating.

- ◆ **Integrated:** A communication skill has been trained but needs to be integrated and generalized to functional settings of the classroom, home, and community. Activities include:
 - Enhancing carryover or generalization of communication skill from skill building level.
 - Functionally integrating the established communication skill within the classroom, home, and community.
 - Informing teachers of expectations to use communication skill.
 - Implementing modifications of accommodations as needed to maintain the skill in classroom, home, or community.



- ◆ **Co-teaching:** Skill building and generalization are taught to the student as a combined effort between the speech-language therapist and the regular education teacher. Activities include:
 - Planned training by the therapist and the classroom teacher.
 - Integration of target communication skills for group lesson.
 - Rotation between small or large groups.
- ◆ **Consultative:** Skill building occurs, but a provider other than the speech-language therapist guides the meaningful change and development of the target communication skills. Activities include:
 - Regularly scheduled monitoring,
 - Goals and objectives written by the speech-language therapist,
 - Brief demonstration teaching and material provided by the speech-language therapist, and
 - Continuous evaluation of successful or unsuccessful interventions.

Because the speech-language impairment is the student's primary handicapping condition, the IEP must reflect the greatest intervention for that disability.

The IEP must reflect goals and objectives directed to remediating the speech-language problem as carried out by the teacher and the speech-language pathologist. In most cases, an adjusted program report must be filed.



16. Vision Services

Vision services include:

- ◆ Identification of the range, nature, and degree of vision loss.
- ◆ Consultation with a student and parents concerning the student's vision loss and appropriate selection, fitting or adaptation of vision aids.
- ◆ Evaluation of the effectiveness of a vision aid.
- ◆ Orientation and mobility services.

Medicaid covers the following services when they are they are in the IEP or are linked to a service in the IEP and are provided by personnel who are licensed or certified to provide vision services:

- ◆ **Vision screening.** Screening is the process of assessing vision through direct observation in order to identify problems and determine if further assessment is needed.
- ◆ **Vision assessment.** Assessment refers to the process of collecting data for the purpose of making treatment decisions. Assessment activities include:
 - Determining the need, nature, frequency, and duration of treatment.
 - Determining the need for coordination with other providers.
 - Documenting these activities.
- ◆ **Direct services to an individual.** Individual intervention is designed to enhance vision or orientation and mobility skills of an individual student.
- ◆ **Direct services to a group.** Group services involve two or more students and are designed to enhance vision or orientation and mobility skills of the group.

Contracted vision services include vision assessment and direct services for an individual or group that are rendered by a qualified practitioner who is a contractor, rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain the same.



17. Service Exclusions

Iowa Medicaid does not cover the following services:

- ◆ Services that are provided but are not documented in the student's treatment plan (IEP) or linked to a service in the IEP.
- ◆ Services rendered that are not provided directly to the eligible student or to a family member on behalf of the eligible student.
- ◆ Scheduled services that are not provided.
- ◆ Initial evaluations, reevaluation, and IEP development. These are considered educational services.
- ◆ Services that are **solely** instructional in nature. Teaching Braille is considered an educational service.
- ◆ Consultation services that are not specific to an eligible student or are not consistent with the IEP.
- ◆ Services that are **solely** recreational in nature.
- ◆ Two Medicaid services provided simultaneously, except medical transportation and escort services.
- ◆ Services provided to students over age 20.
- ◆ Services included in plans under section 504 of the Rehabilitation Act of 1973.



Medicaid Enterprise
Department of Human Services

Provider and Chapter

Local Education Agency

Chapter III. Provider-Specific Policies

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Date

February 1, 2009

Page 33 is reserved for future use.



C. CONTENT OF SCREENING EXAMINATION

A screening examination must include at least the following:

- ◆ Comprehensive health and developmental history, including an assessment of both physical and mental health development. This includes:
 - A developmental assessment.
 - An assessment of nutritional status.
- ◆ A comprehensive unclothed physical examination. This includes:
 - Physical growth.
 - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- ◆ Appropriate immunizations according to age and health history as recommended by the Iowa Department of Public Health.
- ◆ Health education, including anticipatory guidance.
- ◆ Hearing and vision screening.
- ◆ Appropriate laboratory tests. These shall include:
 - Hematocrit or hemoglobin.
 - Rapid urine screening.
 - Lead toxicity screening for all children ages 12 to 72 months.
 - Tuberculin test, when appropriate.
 - Hemoglobinopathy, when appropriate.
 - Serology, when appropriate.
- ◆ Oral health assessment with direct dental referral for children over age 12 months.

To view RC-0080, *Screening Components by Age*, on line, click [here](#).

Screening Components by Age

Age	Infancy						Early Childhood						Middle Childhood				Adolescence					
	nb 1	by 1 m	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr	
HISTORY																						
Initial/Interval	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
PHYSICAL EXAM	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
MEASUREMENTS																						
Height/Weight	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Head Circumference	★	★	★	★	★	★	★	★	★	★												
Weight for Length	★	★	★	★	★	★	★	★	★													
Body Mass Index										★	★	★	★	★	★	★	★	★	★	★	★	
Blood Pressure	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	★	★	★	★	★	★	★	★	★	★	★	
NUTRITION ASSESS/EDUCATION	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
ORAL HEALTH²																						
Oral Health Assessment	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Dental Referral							★		★				Every six months									
SENSORY SCREENING																						
Vision	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	O	O	O	O	O	O	O	O	RA	O	O	
Hearing	O	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	O	O	O	O	O	RA	RA	RA	O	RA	
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT³																						
Developmental Screening						★			★		★											
Autism Screening									★	★												
Developmental Surveillance	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Psychosocial/Behav. Assess.	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Alcohol and Drug Use Assess.																	RA	RA	RA	RA	RA	
PROCEDURES																						
Hgb/Hct	⊕																⊕					
Urinalysis													★				⊕					
Metabolic screening ⁵																						
Lead Screening					RA	RA	★or RA		RA	★or RA	RA	RA	RA	RA								
Tuberculin Test		RA			RA		RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
Dyslipidemia Screening										RA		RA		RA	RA	RA	RA	RA	RA	RA	★	
STI Screening																	RA	RA	RA	RA	RA	
Cervical Dysplasia Screening-																	RA	RA	RA	RA	RA	

KEY: ★ To be performed
 ○ Objective, by a standard testing method
 ⊕ Perform test once during indicated time period
 RA Risk assessment to be performed, with appropriate action to follow if positive

Continued on next page.

HEMOGLOBINOPATHY	Only once (newborn screen) and offered to adolescents at risk.
TUBERCULIN TEST	Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of <i>Red Book: Report of the Committee on Infectious Diseases</i> . Testing should be done on recognition of high-risk factors.
LEAD	Starting at 12 months, assess risk for high dose exposure.
GYNECOLOGIC TESTING	Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history.
STI	All sexually active patients should be screened for sexually transmitted infections (STIs)
ANTICIPATORY GUIDANCE	Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> . 3 rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008)

- ¹ Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement “Breastfeeding and the Use of Human Milk” (2005) [URL: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496>]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement “Hospital Stay for Healthy Term Newborns” (2004) [URL: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434>].
- ² The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.
- ³ At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
- ⁴ An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.
- ⁵ The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, congenital adrenal hyperplasia, medium chain acyl Co-A dehydrogenase (MCAD) deficiency, biotinidase deficiency, hearing, cystic fibrosis, and any other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry.



- Family history of hyperlipidemias.
- Any behaviors intended to change body weight, such as self-induced vomiting, binging and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise.
- Physical examination. Abnormality of hair, skin, nails, eyes, teeth, or gums that indicates poor nutrition; disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

Source: *Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents*. U.S. Department of Health and Human Services, September 1991.

c. **Vision**

Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examination of children is recommended as a part of the regular plan for continuing care beginning at three years of age.

At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

(1) Birth To Age Three

Eye evaluations of infants and children birth to age three should include:

- ◆ Ocular history.
- ◆ Vision assessment
- ◆ External inspection of the eyes and lids.
- ◆ Ocular motility assessment.
- ◆ Pupil examination.
- ◆ Red reflex examination.



(2) Three and Older

In addition to all the eye evaluations listed for infants and young children, two additional measures should be included. Beginning as early as age 2½ to 3 years, children should receive objective vision testing using picture cards. (See the following [chart](#) for suggested tests.)

Three-year-old-children who are uncooperative when tested should be retested four to six months later. Make a referral for an eye examination if the test cannot be completed on the second attempt. The referral should be to an optometrist or ophthalmologist who is experienced in treating children.

In addition to visual acuity testing, children four years old may cooperate by fixating on a toy while the ophthalmoscope is used to evaluate the optic nerve and posterior eye structures.

(3) At Five Years and Older

Children five years and older should receive all the previously described eye examinations and screening described for younger children.

During the preschool years, muscle imbalance testing is very important. The guidelines above suggest assessing muscle imbalance by use of the corneal light reflex test, unilateral cover test at near and far distance, and random-dot-E test for depth perception.

As the child reaches school age, refractive errors that may require eyeglasses for correction become important. The most common refractive error is hyperopia or far-sightedness. Hyperopia can cause problems in performing close work. Therefore, referral to an eye care specialist is recommended. Uncorrected hyperopia is very common in learning-related vision problems.



In addition, the following behaviors may be indicative of myopia:

- ◆ Tendency to squint.
- ◆ Holding toys or books close to the eyes.
- ◆ Difficulty recognizing faces at a distance
- ◆ Failure to pass a school vision screening.
- ◆ Complaint that the classroom blackboard has become difficult to see.

Source: Hagan JF, Shaws JS, Duncan PM, eds. 2008, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, IL: American academy of Pediatrics, page 231.

VISION SCREENING GUIDELINES		
Function: Recommended Tests	Referral Criteria	Comments
<p>Distance visual acuity:</p> <ul style="list-style-type: none"> ◆ Snellen chart ◆ Tumbling E ◆ HOTV ◆ Picture tests <ul style="list-style-type: none"> • Allen cards • LH symbols 	<p>Ages 3-5 years:</p> <ol style="list-style-type: none"> 1. <4 of 6 correct on 20 ft line with either eye tested at 10 ft monocularly (i.e., <10/20 or 20/40) <li style="text-align: center;">or 2. Two-line difference between eyes, even within the passing range (i.e., 10/12.5 and 10/20 or 20/25 and 20/40) <p>Ages 6 years and older:</p> <ol style="list-style-type: none"> 1. <4 of 6 correct on 15 ft line with either eye tested at 10 ft monocularly (i.e., <10/15 or 20/30) 2. Two-line difference between eyes, even within the passing range (i.e., 10/10 and 10/15 or 20/20 and 20/30) 	<ol style="list-style-type: none"> 1. Tests are listed in decreasing order of cognitive difficulty. Use the highest test that the child is capable of performing. In general, the tumbling E or the HOTV test should be used for ages 3-5 years and Snellen letters or numbers for ages 6 years and older. 2. Testing distance of 10 ft is recommended for all visual acuity tests. 3. A line of figures is preferred over single figures. 4. The nontested eye should be covered by an occluder held by the examiner or by an adhesive occluder patch applied to eye. The examiner must ensure that it is not possible to peek with the nontested eye.



Function: Recommended Tests	Referral Criteria	Comments
Ocular alignment:		
◆ Corneal light reflex test		
◆ Simultaneous red reflex test (Bruckner)		
◆ Cross cover test at 10 ft or 3 m	Any eye movement	
◆ Random-dot-E stereo test at 40 cm (630 s of arc)	<4 of 6 correct	

Source: American Academy of Pediatrics Committee on Practice and Ambulatory Medicine; Section on Ophthalmology, American Association of Certified Orthoptists; American Association for Pediatric Ophthalmology and Strabismus; and American Academy of Ophthalmology. Eye examination in infants, children, and young adults by pediatricians. *Pediatrics*, 2003; 111:902-907, (page 902)

d. Hearing

Each child up to age 3 should have an objective hearing screen or documented parent refusal. Objective screening of hearing for all neonates is now recommended by the Joint Committee on Infant Hearing. See <http://www.jcih.org/posstatemts.htm>.

Objective hearing screening should be performed on all infants before age one month. Newborn infants who have **not** had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies.

Infants who do not pass the initial hearing screen and the subsequent rescreening should have appropriate audiology and medical evaluations to confirm the presence of hearing loss before 3 months.

All infants with confirmed hearing loss should receive intervention services before 6 months of age.



For information on audiologists in your area, see the early hearing detection and intervention system (EDHI) website, www.idph.state.ia.us/iaehdi/default.asp or call 1-800-383-3826.

An objective hearing screening should be performed on all infants and toddlers who do not have a documented objective newborn hearing screening or documented parental refusal. This screening should be conducted by a qualified screener during well-child health screening appointments according to the periodicity schedule.

Objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify those children with late onset hearing loss. In order to be alert to late onset hearing loss, health providers should also monitor developmental milestones, auditory and speech skills, middle ear status, and should consider parental concerns.

A child of any age who has not had objective hearing screening should be referred for audiology evaluation to rule out congenital hearing loss.

The following risk indicators are associated with either congenital or delayed-onset hearing loss. Heightened surveillance of all children with risk indicators is recommended. Risk indicators marked with an asterisk are greater concern for delayed-onset hearing loss.

- ◆ Caregiver concern* regarding hearing, speech, language, or developmental delay (Roizen, 1999)
- ◆ Family history* of permanent childhood hearing loss (Cone-Wesson et al., 2000; Morton & Nance, 2006).
- ◆ Neonatal intensive care of more than 5 days, or any of the following regardless of length of stay:
 - ECMO,*
 - Assisted ventilation,
 - Hyperbilirubinemia requiring exchange transfusion, and
 - Exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix).(Fligor et al., 2005; Roizen, 2003).
- ◆ In-utero infections, such as CMV,* herpes, rubella, syphilis, and toxoplasmosis (Fligor et al., 2005; Fowler et al., 1992; Madden et al., 2005; Nance et al., 2006; Pass et al., 2006; Rivera et al., 2002).



- ◆ Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies (Cone-Wesson et al., 2000).
- ◆ Physical finding, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss (Cone-Wesson et al., 2000).
- ◆ Syndromes associated with hearing loss or progressive or late-onset hearing loss, * such as neurofibromatosis, osteopetrosis, and Usher syndrome (Roizen, 2003). Other frequently identified syndromes include Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson (Nance, 2003).
- ◆ Neurodegenerative disorders, * such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).
- ◆ Culture-positive postnatal infections associated with sensorineural hearing loss, * including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).
- ◆ Head trauma, especially basal skull/temporal bone fracture* requiring hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).
- ◆ Chemotherapy* (Bertolini et al., 2004).

See Appendix D, *Hearing Screening Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents*, Second Edition, for additional information. www.brightfutures.org

D. BASIS OF PAYMENT

Local education agencies are reimbursed based on a fee schedule. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Bill all procedures in whole units of service. Except as noted in the coding chart, 15 minutes equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.



E. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied. Use the diagnosis code for the identified medical condition. Procedure codes applicable to local education agency services are as follows.

In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. Possible modifiers are shown below:

<u>Modifier</u>	<u>Definition</u>
AH	Clinical psychologist
AJ	Social worker
GN	Speech pathologist
GO	Occupational therapist
GP	Physical therapist
HO	Masters degree (use for guidance counselor)
HQ	Group setting
TD	RN
TE	LPN
TM	Individual Education Program contracted services
U9	Other health associate
UA	Audiologist

<u>Code</u>	<u>Modifier</u>	<u>Description</u>
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Audiology

V5008		Hearing screening per encounter
92506	UA	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status 15-minute unit
92507	UA	Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual 15-minute unit
92507	TM	Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual by contracted staff 15-minute unit
92508	UA	Treatment of speech, language, voice, communication, and/or auditory processing disorder, group 15-minute unit



Code Modifier Description

Behavior Services

T1023	Varies	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter. Use applicable modifier.
96150		Health and behavior assessment, per 15-minute unit
96152		Health and behavior intervention, per 15-minute unit
96152	TM	Health and behavior intervention by contracted staff, per 15-minute unit
96153		Health and behavior intervention, group (2 or more) per 15-minute unit

Medical Transportation

A0110		Non-emergency transportation and bus round trip
A0100		Non-emergency transportation: taxi round trip
A0130		Non-emergency transportation; wheelchair van round trip
A0090		Non-emergency transportation volunteer per mile
A0120		Non-emergency transportation mini-bus, mountain area transports, other non-profit transportation system round trip

Nursing Service

T1023	TD or TE	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter. (TD = RN TE = LPN)
T1001		Nursing assessment/evaluation, per 15-minute unit
T1002		RN services, per 15-minute unit
T1003		LPN services, per 15-minute unit
H0033		Medication administration, 15-minute unit
99199		Unlisted service, nursing, 60-minute unit
T1002	TM	RN services contracted services, 15-minute unit
T1003	TM	LPN services contracted services, 15-minute unit
T1002	HQ	RN services group, 15-minute unit
T1003	HQ	LPN services group, 15-minute unit
T1999		Miscellaneous therapeutic items and supplies (NOTE: This code is not payable for children who reside in nursing facilities. Use code T5999.)
T5999		Miscellaneous therapeutic items and supplies for children who reside in nursing facilities



Code Modifier Description

Occupational Therapy

T1023	GO	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
97003		Occupational therapy evaluation, 15-minute unit
97530	GO	Therapeutic activities, direct patient contact by the provider, 15-minute unit
97535	GO	Self-care or home management training, 15-minute unit
97537	GO	Community or work reintegration, 15-minute unit
97150	GO	Therapeutic procedures, group, 15-minute unit
97530	TM	Therapeutic activities, direct patient contact by the provider, contracted staff, 15-minute unit
97537	TM	Community or work reintegration by contracted staff, 15-minute unit
97535	TM	Self-care or home management training by contracted staff, 15-minute unit

Personal Health

T1019		Personal care services, 15-minute unit
T1019	HQ	Personal care services, group, 15-minute unit
T1020		Personal care services, per diem
T1020	HQ	Personal care services, group, per diem
T1019	TM	Personal care services, by contracted staff, 15-minute unit
T1020		NOTE: Use this code when services are provided for 50% or more of a school day

Physical Therapy

T1023	GP	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
97001		Physical therapy evaluation, per 15-minute unit
97530		Therapeutic activities, direct patient contact by the provider, 15-minute unit
97116		Gait training, per 15-minute unit
97535		Self-care or home management training, per 15-minute unit
97537		Community or work reintegration, per 15-minute unit
97150		Therapeutic procedures, group, per 15-minute unit
97530	TM	Therapeutic activities, direct patient contact by the provider, by contracted staff, 15-minute unit
97116	TM	Gait training by contracted staff, 15-minute unit



<u>Code</u>	<u>Modifier</u>	<u>Description</u>
97535	TM	Self-care or home management training by contracted staff, 15-minute unit
97537	TM	Community or work reintegration by contracted staff, 15-minute unit

Psychological Services

T1023	AH	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
96101		Psychological testing with interpretation and report, per 60-minute unit
90804	AH	Individual psychotherapy, 30-minute unit
90853	AH	Group psychotherapy, 30-minute unit
90804	TM	Individual psychotherapy by contracted staff, 30-minute unit

Speech Language

V5362		Speech screening per encounter
V5363		Language screening per encounter
92506	GN	Evaluation of speech, language, voice, communication, auditory process, and aural rehabilitation status, per 15-minute unit
92507	GN	Treatment of speech, language, voice, communication, or auditory processing disorder, individual, per 15-minute unit
92508	GN	Treatment of speech, language, voice, communication, or auditory processing disorder, group, per 15-minute unit
92507	TM	Treatment of speech, language, voice, communication, or auditory processing disorder, individual by contracted staff, per 15-minute unit

Social Work – Counseling Service

T1023	AJ or HO	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter. (AJ = social worker; HO = masters degree/counseling)
H0031		Mental health assessment by non-physician, per 15-minute unit
90804	AJ	Individual psychotherapy, 30-minute unit
90853	AJ	Group psychotherapy, 30-minute unit
H0046	HO	Mental health services by counselor, 15-minute unit
H0046	TM	Mental health services, not otherwise specified, by contracted staff, per 15-minute unit



Code Modifier Description

Vision Service

99173		Screening test of visual acuity, quantitative, bilateral, per 15-minute unit
99172		Visual function screening, per 15-minute unit
92012		Ophthalmological services, exam and evaluation, per 15-minute unit
92014		Comprehensive services, established patient, per 15-minute unit
92499		Unlisted service (vision services in a group setting), per 15-minute unit
92014	TM	Comprehensive services, established patient by contracted staff, per 15-minute unit

Orientation and Mobility

97139		Unlisted therapeutic procedure, 15-minute unit
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Vaccinations

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

For VFC vaccine, bill code 90471 and 90472 for vaccine administration in addition to the CPT code. The charges in box 24F should be "0." Charge your cost for 90471 and 90472.

Primary and Preventive Services

Preventive Services: New Patient

Initial preventive medicine evaluation and management including a comprehensive history, a comprehensive examination, counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new patient:

99381	Infant (age under 1 year)
99382	Early childhood (age 1 through 4 years)
99383	Late childhood (age 5 through 11 years)
99384	Adolescent (age 12 through 17 years)
99385	18-39 years



Preventive Services: Established Patient

Periodic preventive medicine reevaluation and management including a comprehensive history, comprehensive examination, counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient:

- 99391 Infant (age under 1 year)
- 99392 Early childhood (age 1 through 4 years)
- 99393 Late childhood (age 5 through 11 years)
- 99394 Adolescent (age 12 through 17 years)
- 99395 18-39 years

Primary Services: New Patient

Office or other outpatient visit for the evaluation and management of a new patient:

- 99201 Presenting problems are self limited or minor. Requires these three key components:
 - ◆ a problem-focused history;
 - ◆ a problem-focused examination; and
 - ◆ straightforward medical decision making.Practitioners typically spend 10 minutes face-to-face with the patient or family.
- 99202 Presenting problems are of low to moderate severity. Requires these three key components:
 - ◆ an extended problem-focused history;
 - ◆ an expanded problem-focused examination; and
 - ◆ straightforward medical decision making.Practitioners typically spend 20 minutes face-to-face with the patient or family.
- 99203 Presenting problems are of moderate severity. Requires these three key components:
 - ◆ a detailed history;
 - ◆ a detailed examination; and
 - ◆ medical decision making of low complexity.Practitioners typically spend 30 minutes face-to-face with the patient or family.



99204 Presenting problems are of moderate to high severity. Requires these three key components:

- ◆ a comprehensive history;
- ◆ a comprehensive examination; and
- ◆ medical decision making of moderate complexity.

Practitioners typically spend 45 minutes face-to-face with the patient or family.

99205 Presenting problems are of moderate to high severity. Requires these three key components:

- ◆ a comprehensive history;
- ◆ a comprehensive examination; and
- ◆ medical decision making of moderate complexity.

Practitioners typically spend 60 minutes face-to-face with the patient or family.

Primary Services: Established Patient

Office or other outpatient visit for the evaluation and management of an established patient:

99211 Presenting problems are minimal and may not require the presence of a physician. Typically, 5 minutes are spent performing or supervising these services.

99212 Presenting problems are self limited or minor. Requires at least two of these three key components:

- ◆ a problem-focused history;
- ◆ a problem-focused examination; and
- ◆ straightforward medical decision making.

Practitioners typically spend 10 minutes face-to-face with the patient or family.

99213 Presenting problems are of low to moderate severity. Requires at least two of these three key components:

- ◆ an extended problem-focused history;
- ◆ an expanded problem-focused examination; and
- ◆ medical decision making of low complexity.

Practitioners typically spend 15 minutes face-to-face with the patient or family.

99214 Presenting problems are of moderate to high severity. Requires at least two of these three key components:

- ◆ a detailed history;
- ◆ a detailed examination; and
- ◆ medical decision making of moderate complexity.

Practitioners typically spend 25 minutes face-to-face with the patient or family.



- 99215 Presenting problems are of moderate to high severity. Requires at least two of these three key components:
- ◆ a comprehensive history;
 - ◆ a comprehensive examination; and
 - ◆ medical decision making of high complexity.
- Practitioners typically spend 40 minutes face-to-face with the patient or family.
- Consultation Services:**
Office consultation for a new or an established patient:
- 99241 Presenting problems are self limited or minor. Requires these three key components:
- ◆ a problem-focused history;
 - ◆ a problem-focused examination; and
 - ◆ straightforward medical decision making.
- Practitioners typically spend 15 minutes face-to-face with the patient or family.
- 99242 Presenting problems are of low severity. Requires these three key components:
- ◆ an extended problem-focused history;
 - ◆ an expanded problem-focused examination; and
 - ◆ straightforward medical decision making.
- Practitioners typically spend 30 minutes face-to-face with the patient or family.
- 99243 Presenting problems are of moderate severity. Requires these three key components:
- ◆ a detailed history;
 - ◆ a detailed examination; and
 - ◆ medical decision making of low complexity.
- Practitioners typically spend 40 minutes face-to-face with the patient or family.
- 99244 Presenting problems are of moderate to high severity. Requires these three key components:
- ◆ a comprehensive history;
 - ◆ a comprehensive examination; and
 - ◆ medical decision making of moderate complexity.
- Practitioners typically spend 60 minutes face-to-face with the patient or family.



99245 Presenting problems are of moderate to high severity. Requires these three key components:

- ◆ a comprehensive history;
- ◆ a comprehensive examination; and
- ◆ medical decision making of moderate complexity.

Practitioners typically spend 80 minutes face-to-face with the patient or family.

Testing

Bill specific laboratory and testing services as follows:

- 10120 Incision and removal of foreign body, subcutaneous tissues, simple
- 11040 Debridement: skin partial thickness
- 16000 Initial treatment, first degree burn
- 16020 Dressing and debridement of partial-thickness burns, initial or subsequent; small
- 36415 Venipuncture (Can't be used with 99000)
- 65205 Removal of foreign body, external eye
- 69200 Removal of foreign body from external auditory canal
- 69210 Removal impact cerumen
- 81002 Urinalysis
- 81025 Urine pregnancy test, by visual color comparison
- 82270 Blood, occult, by peroxidase activity, qualitative
- 82962 Glucose, blood by glucose monitoring
- 85014 Hematocrit
- 85018 Hemoglobin
- 87070 Any other source except urine, blood or stool, aerobic with isolation and presumptive identification of isolates
- 87880 Streptococcus, group A
- 94200 Maximum breathing capacity, maximal voluntary ventilation
- 94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g., nebulizer)
- 94640-76 Nebulizer – more than one treatment performed on the same date
- 94760 Noninvasive ear or pulse oximetry for oxygen saturation
- 96110 Developmental testing, limited with interpretation and report
- 99000 Specimen handling and conveyance (can't be used with 36415/36416)
- 99173 Screening test of visual acuity, quantitative, bilateral



F. CLAIM FORM

Claims for local education agency services are billed on federal form CMS-1500, *Health Insurance Claim Form*. To view a sample of this form on line, click [here](#).

1. Instructions for Completing the CMS-1500 Claim Form

The table below follows the CMS-1500 claim form by field number and name, and gives 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.	CHECK ONE	REQUIRED. Check the applicable program block.
1a.	INSURED'S ID NUMBER	REQUIRED. Enter the Medicaid member's Medicaid number, found on the <i>Medical Assistance Eligibility Card</i> . The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	REQUIRED. Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	OPTIONAL. Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
5.	PATIENT'S ADDRESS	OPTIONAL. Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	REQUIRED, IF KNOWN. Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	SITUATIONAL. Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	REQUIRED, IF KNOWN. Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	<p>REQUIRED. If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed.</p> <p>If there is no other insurance, check "no."</p> <p>If you have received a denial of payment from another insurance, check both "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record.</p> <p>Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.</p> <p>NOTE: Auditing will be performed on a random basis to ensure correct billing.</p>
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	SITUATIONAL. Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	SITUATIONAL. Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	SITUATIONAL. Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		LEAVE BLANK. The claim will be returned if any information is entered in this field.
17b.	NPI	SITUATIONAL. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent laboratory, or durable medical equipment, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.
18.	HOSPITALIZATION DATES RELATED TO...	OPTIONAL. No entry required.
19.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	OPTIONAL. No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	REQUIRED. Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses. Do not enter descriptions. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
		56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	OPTIONAL. No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	REQUIRED. Enter the codes for each of the dates of service. Do not enter descriptions. Do not list services for which no fees were charged. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	REQUIRED. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3 (up to a maximum of four codes per claim). Do not write the actual diagnosis code in this field. Doing so will cause the claim to deny.
24. F	\$ CHARGES	REQUIRED. Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	REQUIRED. Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	SITUATIONAL. Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	LEAVE BLANK. The claim will be returned if any information is entered in this field.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	LEAVE BLANK REQUIRED. Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	OPTIONAL. No entry required.
26.	PATIENT'S ACCOUNT NUMBER	FOR PROVIDER USE. Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	OPTIONAL. No entry required.
28.	TOTAL CLAIM CHARGE	REQUIRED. Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	SITUATIONAL. Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	REQUIRED. Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	REQUIRED. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
32.	SERVICE FACILITY LOCATION INFORMATION	OPTIONAL. Enter the name and address associated with the rendering provider.
32a.	NPI	OPTIONAL. Enter the NPI of the facility where services were rendered.
32b.		LEAVE BLANK. The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	REQUIRED. Enter the complete name and address of the billing provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. The address must contain the ZIP code associated with the billing provider's NPI. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org .
33a.	NPI	REQUIRED. Enter the ten-digit NPI of the billing provider.
33b.		REQUIRED. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, access imeservices.org .

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Provider Name _____

NPI Billing Provider Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member Name _____

Member State ID Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Service ____/____/____

Type of Document

Return this document with attachments to:

IME Claims
P.O. Box 150001
Des Moines, IA 50315



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 ADVICE

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 the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

IAMC8000-R001 (CP-O-12)
AS OF 10/22/07

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 10/19/07

R E M I T T A N C E A D V I C E

4

TO: 1

R.A. NO.: 3 2 6

WARR NO.: 9 3 9

DATE PAID: 10/22/07 PROV. NUMBER: 5

PAGE: 6 1

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

*** CLAIM TYPE: HCFA 1500 7

*** CLAIM STATUS: PAID 8

ORIGINAL CLAIMS:

9

RECIP ID / TRANS-CONTROL-NUMBER	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
3-07290-00-015-0941-00	172.00	0.00	85.07	1.00				000 000
01 10/04/07 99242	172.00		85.07	1.00				F 000 000
3-07292-00-009-0053-00	69.00	0.00	32.36	0.00				000 000
01 07/06/07 99212	69.00		32.36	0.00				F 000 000
3-07288-00-010-0484-00	298.00	0.00	145.03	0.00				000 000
01 07/11/07 99212 25	69.00		32.36	0.00				F 000 000
02 07/11/07 29405	197.00		112.67	0.00				F 000 000
03 07/11/07 A4590	32.00		0.00	0.00				K 177 000
0-07281-22-009-0270-00	128.00	0.00	71.46	0.00				000 000
01 06/14/07 20550	122.00		68.06	0.00				F 000 000
02 06/14/07 J3301	6.00		3.40	0.00				F 000 000

4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS.. 667.00 0.00 333.92 1.00

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 2

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

* * * CLAIM TYPE: HCEA 1500 * * * CLAIM STATUS: DENIED

ORIGINAL CLAIMS:

LINE	SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S EOB EOB
	3-07289-00-011-0880-00			69.00	0.00	0.00	0.00		499 000
01	07/12/07	99212	1	69.00		0.00	0.00		K 000 000
1 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..				69.00	0.00	0.00	0.00		

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 3

28 REMITTANCE T O T A L S

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	4	-----	667.00	333.92
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	1	-----	69.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	-----	0.00	0.00
AMOUNT OF CHECK:	-----				333.92

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

29 177 THE PROCEDURE/SERVICE BILLED HAS BEEN DETERMINED TO BE NONCOVERED FOR THE DATE OF SERVICE SHOWN ON THE CLAIM. 1

499 INVALID OR MISSING MEDIPASS REFERRAL FOR RECIPIENT. 1



2. Remittance Advice Sample and Field Descriptions

To view a sample of the *Remittance Advice* on line, click [here](#).


NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's national provider identifier (NPI) number.
6.	Page:	<i>Remittance Advice</i> page number.
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: <ul style="list-style-type: none"> • Paid. Claims for which reimbursement is being made. • Denied. Claims for which no reimbursement is being made. • Suspended. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.



NO.	FIELD NAME	DESCRIPTION
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the <i>Remittance Advice</i> for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.



NO.	FIELD NAME	DESCRIPTION
27.	S	<p>Allowed charge source code:</p> <p>B Billed charge F Fee schedule M Manually priced N Provider charge rate P Group therapy Q EPSDT total screen over 17 years R EPSDT total under 18 years S EPSDT partial over 17 years T EPSDT partial under 18 years U Gynecology fee V Obstetrics fee W Child fee</p>
28.	Remittance totals	<p>(Found at the end of the <i>Remittance Advice</i>):</p> <ul style="list-style-type: none"> • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of denied original claims and the amount billed by the provider. • Number of denied adjusted claims and the amount billed by the provider. • Number of pended claims (in process) and the amount billed by the provider. • Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	<p>Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.</p>

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		Date September 1, 2007

H. MEDICAID BILLING REMITTANCE

The IME uses form 470-3816, *Medicaid Billing Remittance*, to notify providers of the amount of the non-federal share of the Medicaid reimbursement paid to the provider in the previous month. To view a sample of this form on line, click [here](#). It also includes the total of the non-federal share and 75% of the federal share.

Please send the payment for the non-federal share within 30 days of the date on the form. This form must accompany the payment for proper crediting.

- ◆ List the dollar amount of the non-federal share to be certified.
- ◆ List the month and year that the agency was paid.
- ◆ Enter an authorized signature and date.
- ◆ Enter the name of agency.

There will be detailed information provided with this form for your information.

MEDICAID BILLING REMITTANCE

[provider]

Provider NPI/Id: []

Invoice # []

Date []

[provider]

Section 1: The provider's share of the cost of the [provider] services. For the month of [month and year], your agency received \$[amount]. The total amount owed is \$[amount] [For AEA only: at 84% of the total is \$(amount)]. This form must accompany payment for proper crediting.

All payments should be made to the Iowa Department of Education at the following address:

Attn: Tana Mullen
Iowa Department of Education
Grimes Bldg., Third Floor
400 E. 14th Street
Des Moines IA 50319-0146

The amount of _____ for the month of _____ is enclosed.

Signature of Authorized Representative

Date

Agency Name

If you have questions or concerns please contact Steve Crew at steve.crew@iowa.gov or (515)281-6285. Payment is due within 30 days of the date of this notice. Thank you for your assistance and timely payment.

cc: DHS, DE