



Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-307**  
Employees' Manual, Title 8  
Medicaid Appendix

September 24, 2010

## **AREA EDUCATION AGENCY MANUAL TRANSMITTAL NO. 10-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: **AREA EDUCATION AGENCY MANUAL**, Chapter III, *Provider-Specific Policies*, pages 40 through 43, revised; and the following forms:

*Remittance Advice*, revised  
470-4978 *Medicaid Billing Remittance*, revised

### **Summary**

The 2010 General Assembly in Senate File 2291 amended Iowa Code section 256.B15(7) to mandate that the nonfederal share be submitted before payment of the Medicaid claims. The payment received by the area education agency (AEA) from claims submission is then retained by the AEAs. The *Medicaid Billing Remittance*, form 470-4978, has been renumbered and revised to reflect this change.

This revision also updates the sample and instructions for the *Remittance Advice*.

### **Date Effective**

July 1, 2010

### **Material Superseded**

This material replaces the following pages in the **AREA EDUCATION AGENCY MANUAL**:

<u>Page</u>	<u>Date</u>
40	June 1, 2007
Remittance Advice	10/19/07
41, 42	June 1, 2007
470-3816	7/08
43	July 1, 2008

### **Additional Information**

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

**[www.dhs.state.ia.us/policyanalysis](http://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 Iowa Medicaid Enterprise Provider Services Unit.



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.

## 2. 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

R.A. NO.: A  
00000000

WARRANT NUMBER: B  
00000000

C

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

---- NEWSLETTER UPDATE ----

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

E

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

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

TO: **C** PROVIDER NAME R.A. NO.: **A** 0000000 WARR NO.: **B** 0000000 DATE PAID: **G** XX/XX/XX PROV. NUMBER: **H** 1234567890 PAGE: **I** 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 \* \* \* CLAIM STATUS: PAID

ORIGINAL CLAIMS:

1	2	3	4	5	6	7	8	9
FIRST LAST Last First	1234567A	0-00000-00-000-0000-00	100.00	0.00	65.00	3.00	LF8888	000 000
	01 02 03	XX/XX/XX 99999 XX/XX/XX 9999X 25 XX/XX/XX 999XX	1 1 1	00.00 70.00 30.00	0.00 50.00 15.00	0.00 0.00 3.00	1234567890 1234567890 1234567890	Y F F
	10	11 12	13	14	15	16	17	18 19
<b>Q</b> 01 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..								
			<b>R</b> 100.00	<b>S</b> 0.00	<b>T</b> 65.00	<b>X</b> 3.00		

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

REMITTANCE TOTALS			
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	<span style="border: 1px solid red; padding: 2px;">J</span> 0 -----	<span style="border: 1px solid red; padding: 2px;">K</span> 0,000.00
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0 -----	0.00
PENDEd CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	<span style="border: 1px solid red; padding: 2px;">L</span> 0 -----	0.00
AMOUNT OF EFT DEPOSIT:	-----		<span style="border: 1px solid red; padding: 2px;">M</span> 0,000.00

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

COUNT:

<span style="border: 1px solid red; padding: 2px;">N</span> <span style="border: 1px solid red; padding: 2px;">O</span> 000	<span style="border: 1px solid red; padding: 2px;">P</span> EXPLANATION (EOB) OF DENIAL CODE	<span style="border: 1px solid red; padding: 2px;">1</span>
---	--	---



	Field Name	Field Description
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 remittance advice
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 third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status

1	Patient Name	Last, first name or initial of the member as shown on the Medical Assistance Eligibility Card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total member copayment on claim
8	Med Rcd Num	Medical record number or patient account number



Field Name		Field Description
9	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on this line
15	Paid by Mcaid	Amount paid by Medicaid on this line
16	Copay Amt.	Copayment amount on this line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number
18	S	Source of payment. 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

MEDICAID BILLING REMITTANCE  
AREA EDUCATION AGENCY

Provider NPI/Id: XXXXXXXXXXXX Invoice # XXXXXXXXXXXX Date XX/XX/XX

For the month of XX/XX, your agency received \$XXX.XX.

If you have questions or concerns please contact Steve Crew at  
[steve.crew@iowa.gov](mailto:steve.crew@iowa.gov) or (515)281-6285. Thank you for your assistance.

cc: DHS, DE



Field Name		Field Description
		0 APG
		1 No payment APG
		3 HMO/PHP rate
		4 System parameter rate
		5 Statewide per diem
		6 DRG auth or new
		7 Inlier/outlier adjust
		8 DRG ADR inlier
		9 DRG ADR
19	EOB	Explanation of benefits denial reason code

**G. MEDICAID BILLING REMITTANCE**

The IME uses form 470-4978, *AEA Medicaid Billing Remittance*, to notify providers of the amount received from Medicaid monthly. To view a sample of this form on line, click [here](#).

There will be detailed information provided with this form.