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ATE OF MINNESOTA

Department of Public Welfare

Medical Assistance Program

MENTAL HEALTH CENTERS

FOREWORD

Purpose of This Handbook

This handbook has been prepared for the information and guidance of providers who participate in the Minnesota Medical Assistance Program. The handbook is divided into three chapters and appendices.

CHAPTER I - general information and procedures which are applicable to all categories of providers.

CHAPTER II - explanations of policy and service coverage directed toward a specific type of provider.

CHAPTER III - detailed instructions concerning completion of claim forms, also directed toward a specific provider group.

Page changes and supplements to this handbook will be forwarded from time to time as needed and/or required.

Further Information

A. Policy and Procedure

All questions concerning policy and procedure with regard to the Medical Assistance Program should be directed to:

Provider Relations and Training Unit
Income Maintenance Division
Minnesota Department of Public Welfare
690 North Robert Street
Box 17038
St. Paul, Minnesota 55117
Telephone (612) 296-6714 (call collect)

B. Recipient Eligibility

Questions on client eligibility should be directed to the county welfare department in the county where the recipient resides.

NOTE: Names and places used in this handbook are fictitious.

GENERAL INFORMATION

CHAPTER I

100. MINNESOTA MEDICAL ASSISTANCE PROGRAM

Medicaid (Title XIX) is a federal-state program providing medical care for persons whose income and resources are inadequate to meet the cost of such care. In Minnesota, the program is called Medical Assistance. On May 24, 1973 the Minnesota State Legislature enacted legislation (Chapter 717) granting the Minnesota Department of Public Welfare the responsibility and authority to establish a statewide system for centralized disbursements of Medical Assistance payments to providers. The impact of this legislation is that medical bills will be paid by the Department of Public Welfare, instead of the county of financial responsibility, for persons eligible for Medical Assistance.

The Department is responsible for formulation of policy for the Medical Assistance Program in conformance with State and Federal requirements.

101. REQUIREMENTS OF PROVIDER PARTICIPATION

Federal regulations which govern the administration of the Medicaid Program specify the following requirements for provider participation:

101. REQUIREMENTS OF PROVIDER PARTICIPATION (Continued)

A. Providers must maintain such records as are necessary to fully disclose the extent of the services provided. Such records must be retained for a period of three years, or until an audit is completed and every exception is resolved, whichever period is longer. Providers must furnish to the Department, as requested, information regarding any claims for services rendered under the Medical Assistance Program.

B. Federal regulations require that all services and material to recipients of public assistance be provided in full compliance with Title VI of the Civil Rights Act of 1964, the Minnesota Statutes and any other laws, regulations or orders which prohibit discrimination.

C. It is required that each provider sign an agreement with the Department of Public Welfare in order to be paid. This may be accomplished by completing the provider enrollment form and signing the Provider Agreement.

D. Providers must accept as payment in full the amounts established by the Department of Public Welfare. Providers may not seek additional payment for any unpaid portion of a bill from a recipient of Medical Assistance except when required to meet spend-down requirements.

102. RECIPIENT ELIGIBILITY

Eligibility of all Medical Assistance recipients is determined initially and periodically by the county welfare department of the recipient's residence. Evidence of eligibility is demonstrated by the Medical Assistance card which is issued on a monthly basis by the Department of Public Welfare. This card should be examined on each occasion a service is requested. If a person is unable to pay for services, but appears to meet the requirements of eligibility for Medical Assistance, the provider may advise the patient or his representative to contact the local county welfare agency. The State cannot pay for services rendered to persons not enrolled in the Medical Assistance Program.

Any eligible individual has freedom of choice in obtaining medical care from any institution, agency, pharmacy, or person qualified by reason of a license or a medical prescription to perform the service(s) required.

If the client does not have a Medical Assistance Identification Card in his possession, the county welfare department should be contacted to determine eligibility. If the client is not eligible under the Medical Assistance Program, but is eligible under the Minnesota General Relief program, medical billings should be handled through the county welfare department.

103. BILLING LIMITATION

The Department will pay only those invoices which are received by the Department within one year of the date of service. For example,

103. BILLING LIMITATION (Continued)

an invoice for services provided on January 1, 1975, must be received by January 1, 1976, to be eligible for payment.

104. MAILING OF PAYMENT CHECKS

Payment of invoices correctly submitted will be mailed to the name and address associated with each respective provider number as maintained in the Department provider master file. Any changes in a provider's status, address, licensing, certification, board specialities, corporate name, or ownership should be reported immediately to the Provider Relations and Training Unit.

105. MEDICARE RELATIONSHIP TO MINNESOTA MEDICAL ASSISTANCE PROGRAM

Medicare is a Federal program which furnishes health insurance coverage for those individuals 65 years of age or older; or for those eligible for Medicare because of a disability. Medicare provides certain hospitalization (Part A) and medical (Part B) benefits.

Medicare - Medical Assistance crossover claims must be handled as follows:

Complete the Medicare 1490 form making sure to include the following:

1. Under item 5, "Insuring Organization or State Agency Name and Address", enter: Minnesota Medical Assistance Program, Department of Public Welfare, Box 30196, St. Paul, Minnesota 55175.

105. MEDICARE RELATIONSHIP TO MINNESOTA MEDICAL ASSISTANCE PROGRAM (Continued)

2. Under item 5, "Policy or Medical Assistance Number", enter: the recipient's 16 digit Medical Assistance identification number.

3. Under item 8, "Name and address of physician or supplier", enter: your name, address, and your seven digit Medical Assistance provider identification number.

Mail the completed original to Medicare. At the same time send either a carbon or photocopy of the Medicare 1490 to:

Minnesota Medical Assistance Program
Department of Public Welfare
Box 30196
St. Paul, Minnesota 55175.

Upon receipt of the Explanation of Medicare Benefits (EOMB), the Department will process these claims and reimburse the provider for any co-insurance and/or deductible owed by Medical Assistance for allowed charges.

Items which are covered by Medical Assistance but not by Medicare must be billed according to the instructions in Chapter III.

106. THIRD PARTY LIABILITY

The Minnesota Medical Assistance Program is designed to give assistance to the financially needy. Since these programs are supported by public funds, the State must be assured that all other resources for payment, including Medicare, are utilized. If the provider determines there is a source of payment other than Medical Assistance, then the amount billed Medical Assistance must be no more than the difference between the payment from the other source and the total bill.

It is the responsibility of the provider to determine from the recipient if there are any other resources (Medicare, private insurance, workmen's compensation, third party liability, etc.) that are available for payment of the services rendered to the recipient. If there are other resources available and the services rendered are known to be covered benefits, then these sources must be billed prior to billing Medical Assistance. If the claim is denied by these resources, then Medical Assistance may be billed.

It is not the intent of the Department to delay payment for covered services because of an outstanding third party liability which cannot be currently established or is not currently available to apply against the recipient's bill. Hence, if attempts to collect third party liability have been unsuccessful for 90 days, the provider may bill the State indicating the name and address of the possibly liable third party on a separate sheet or attached letter.

In cases where claims have been rejected or disputed, or contested liability exists in a court action involving an accident suit, a

106. THIRD PARTY LIABILITY (Continued)

pending accident settlement negotiation, or a workmen's compensation hearing, the provider may submit the bill, indicating the name and address of the possibly liable third party on a separate sheet or attached letter.

If the provider receives a third party payment after having received a Medical Assistance payment for the same items and services, the State must be reimbursed for the overpayment. The provider must submit an Adjustment Request (See Appendix I) to:

Medical Fiscal Management
Minnesota Medical Assistance Program
690 North Robert Street
Box 17038
St. Paul, Minnesota 55117

107. HOW TO REORDER FORMS AND HANDBOOKS

All requests for provider handbooks should be directed to:

Provider Relations and Training Unit
Minnesota Medical Assistance Program
690 North Robert Street
Box 17038
St. Paul, Minnesota 55117

All DPW Forms used in Medical Assistance under centralized disbursement must be ordered on Form DPW-121 (See Appendix C).

MENTAL HEALTH CENTERS

CHAPTER II

200. ELIGIBLE PROVIDERS

All mental health centers currently receiving grants-in-aid authorized by Minnesota Statutes 245.61-245.62 are qualified to participate in the Minnesota Medical Assistance Centralized Disbursement Program. In addition, the mental health center must sign a Provider Agreement.

201. COVERED SERVICES

The Medical Assistance Program will pay for those procedures indicated in Appendix D of this handbook.

201.1 SERVICE LIMITATIONS

The Medical Assistance Program does limit the number of times some services may be given in a calendar year. Appendix D, which lists the procedures, indicates when there are limitations and what these are.

201.2 SERVICES FOR NURSING HOME RESIDENTS

Bills for covered services to residents of nursing homes are to be sent to the Department of Public Welfare for payment, in the same manner as other covered services. For services provided to residents of nursing homes, the attending physician must be involved in the development of the treatment plan and in periodic assessment to help insure that treatment objectives are being met, or modified appropriately.

202. NON-COVERED SERVICES

A. Indirect services, such as the following, are not acceptable for Title XIX reimbursement:

1. Community Planning (both comprehensive and annual operational plan), including needs assessment.
2. Community consultation, program consultation.
3. Program and service monitoring and evaluation.
4. Public information and education.
5. Resource development (e.g., foster care recruitment development of D.A.C., detox center development, etc.).
6. Training and education (including staff development).
7. Research.

B. Failed Appointments.

203. REIMBURSEMENT

Reimbursement will be on the basis of actual costs as determined by the grants-in-aid section of the Community Programs Bureau of the Department of Public Welfare.

A utilization rate should be established for therapy provided in a group setting. Billing for group therapy will be done per individual client.

203.1 CANCELLATION AND RENEGOTIATION OF TITLE IV-A CONTRACTS

The implementation of Title XIX reimbursement for direct mental health services for individual eligible recipients will mean that, in those areas where Title IV-A social service contracts now exist to provide reimbursement for such services, such contracts must be

203.1 CANCELLATION AND RENEGOTIATION OF TITLE IV-A CONTRACTS (Continued)

terminated as of January 31, 1975. This leaves open the possibility that the buyer and seller of Social Service eligible services may renegotiate new specific contracts for any services eligible for Federal social service reimbursement that are not going to be provided under Title XIX.

BILLING PROCEDURES

CHAPTER III

300. GENERAL DESCRIPTION

Enrolled mental health centers must bill for services to eligible recipients on the Practitioner Invoice, DPW-1497 (6-74) (See Appendix A). This invoice is designed to include billing for all services furnished. It is used to bill for one individual recipient for single or multiple services. This invoice includes all information necessary for payment to be made.

Payment to providers will be made every two weeks. Each payment will be followed by a Remittance Advice, explaining the status of all invoices submitted. (See Appendix F for a detailed explanation of the Remittance Advice.)

301. SUBMISSION OF INVOICE

Invoices may be submitted daily, weekly, or monthly, but not more than one year after the date of service. To insure prompt payment of claims, follow these procedures when preparing invoices:

- Use the envelopes supplied by the State Department of Public Welfare for mailing invoices.
- Do not write on the back of an invoice. If explanatory information is absolutely necessary, attach the information to the invoice with a paper clip. (Do not staple)
- Do not fold, or otherwise mutilate the invoices.
- Before mailing the completed invoice, separate the original from the carbon copy. Remove the carbon paper and pinfeed strips from each invoice. Also separate the original copies from each other along the top and bottom edges.

301. SUBMISSION OF INVOICE (Continued)

- Do not submit a continuous sheet. Submit only the original (top) copy, and keep the carbon copy as a record of claim submittal.

- Place invoices in the envelopes so that they all face in the same direction.

- Insert as many invoices as possible in each envelope. A table of the required postal rates for the number of forms enclosed in each envelope is printed on the back of the envelopes.

- Mail invoices to:

MINNESOTA MEDICAL ASSISTANCE PROGRAM
Department of Public Welfare
Box 30166
St. Paul, Minnesota 55175

302. COMPLETION OF THE PRACTITIONER INVOICE DPW-1497 (6-74)

In order to facilitate computer processing and achieve prompt payment of claims, the Department of Public Welfare is using high-speed optical character reading equipment to process all claim data. An optical character reader is mechanical equipment that reads printed material without the intervention of the human eye. This equipment is designed to read black (or very dark) typewritten numbers and capital letters in all type styles except italic and script. It is necessary to TYPE all data except the signature on the invoice. If any part of the invoice except the signature is handwritten, or if the invoice is illegible, optical scanning cannot be employed, and manual data entry procedures must be used. Manual data input will delay payment of the claims. Before typing the invoice it is important to properly align each form in the typewriter, by using either the elite or pica labeled boxes provided at the top of each invoice. The typist should follow these procedures:

302. COMPLETION OF THE PRACTITIONER INVOICE DPW-1497 (6-74) (Continued)

- CAPITALIZE ALL LETTERS OF THE ALPHABET.
- Type only in the white areas. Do not type in the red shaded areas.
- Use very dark or preferably black ribbon only, and change ribbons as needed to ensure bold and dark characters.
- Strive for accuracy. When correcting errors, use correction fluid sparingly, or correction tape. Careful erasing is also acceptable if no trace of the first entry remains.
- All dates entered on the invoice are to be entered in the following format: the two-digit month, slash, (01/06/75), followed by the two-digit day, slash, (01/06/75), followed by the two-digit year, (01/06/75).
- All monetary amounts must be entered in the dollars and cents format (12.00), omitting the dollar ($) sign.

The Practitioner Invoice (DPW-1497) has been designed so that related information items are grouped together for ease of preparation and use. The groups as they appear on the invoice are:

Section 302.1	INVOICE HEADING
Section 302.2	PROVIDER INFORMATION
Section 302.3	RECIPIENT INFORMATION
Section 302.4	STATEMENT OF SERVICE RENDERED
	MEDICAL VISITS
	SUMMARY SECTION
Section 302.5	PROVIDER CERTIFICATION

Each box on the invoice is numbered, from Item 1 thru Item 105 (See Appendix A). The following is an item by item explanation of the boxes in numerical order.

302.1 INVOICE HEADING

The invoice heading contains the address to send invoices to, and the typewriter alignment tabs. It also contains:

302.1 INVOICE HEADING (Continued)

1. Claims Processing Document Control Number

Leave this space blank. The document control number is assigned to the invoice by the Minnesota Medical Assistance Program. This claim number will appear on the provider's remittance advice and is to be used by the provider in any inquiries regarding this invoice.

302.2 PROVIDER INFORMATION

2. Provider's Name

Enter the mental health center's name (punctuation may be omitted).

Example: 2 [ABC CLINIC]

3. Provider I.D.#

Enter the mental health center's Medical Assistance Identification Number.

Example: 3 [1001234]

4. Own Reference #

The provider may enter his own account reference number, which may include as many as 9 letters and/or numbers. Numbers are preferred for accuracy of scanning. This information is recommended and if furnished, will appear on the Remittance Advice to aid bookkeepers in tracing the information back to a specific invoice.

5. Billing Date

Enter the date the invoice is completed using two digits for the month, slash; two digits for the day, slash; and two digits for the year.

Example: 5 [01/02/75]

302.2 PROVIDER INFORMATION (Continued)

6. Prior Authorization Number

Leave this space blank.

7. Street Address

Enter the street address of the provider.

Example: 7 | 690 N ROBERT ST |

8. Referring Practitioner's Name

If the patient was referred to the provider's care by another practitioner, enter the name of the referring practitioner.

Example: 8 | SMITH JOHN L |

9. City/State/Zip Code

Enter the city, state and zip code of the provider.

Example: 9 | ST PAUL MN 55117 |

10. Name and City of Hospital or Nursing Home

If service was provided in a hospital or nursing home, enter the facility's name and city, abbreviating as necessary.

Example: 10 | ABC N H ST PAUL |

302.3 RECIPIENT INFORMATION

11. Recipient's Name (Last, First, Initial)

Enter the patient's full name, exactly as it appears on the recipient's Medical Assistance Identification Card, last name, then the first name, followed by the middle initial.

Example: 11 | DOE JANE J |

302.3 RECIPIENT INFORMATION (Continued)

12. Recipient's Medical Assistance Number

Enter the 16 digit number as shown on the patient's Medical Assistance Identification Card, DO NOT type in the dashes. They are already there. (See Appendix B for explanation of card).

Example: 12 [00-0-000-000-0000-000]

13. Sex

Enter the patient's sex: F = Female
M = Male
U = Unknown

Example: 13 [F]

14. Birthdate

Enter the patient's birthdate using 2 digits for the month, slash; 2 digits for the day, slash; and 2 digits for the year, exactly as it appears on the Medical Assistance Identification Card, even if the date is incorrect.

Example: 14 [02/01/55]

15. Hospitalization Insurance Company

Enter the 2 digit insurance company code number from Appendix F if company is known.

16. Hospitalization Insurance Policy Number

Enter the recipient's hospital insurance policy number if available. If it is a group policy, enter the group policy number.

17. Medical Insurance Company

Enter the 2 digit insurance company code number from Appendix F if applicable.

Example: 17 [10]

302.3 RECIPIENT INFORMATION (Continued)

18. Medical Insurance Policy Number

Enter the recipient's medical insurance policy number if applicable. If it is a group policy, enter the group policy number.

Example: 18 [123857980012]

19. Third Party Liability (TPL)

Enter the appropriate code to indicate handling of third party liabilities. This is necessary if the Medical Assistance Identification Card (Appendix B) indicates that TPL exists. Leave blank if no third-party coverage is known. A review of Chapter I, Section 106, may be helpful here. (Medicare is never reported as Third Party Liability, but is always reported in the Medicare Section.)

1 - One insurance company billed for part of claim's gross charges

2 - Two insurance companies billed for part of claim's gross charges

3 - Three or more insurance companies billed

4 - Patient or family will pay part of claim

5 - Patient's employer or union will pay part of claim

6 - Patient's known insurance policies do not cover any part of claim

7 - Patient's known insurance benefits applicable to this claim are exhausted

8 - Patient may be eligible for insurance, workmen's compensation, or other benefits but needs help in claiming them

9 - Patient's known insurance is no longer in force

A - Provider unable to secure necessary papers and/or signature from recipient to allow claim filing.

302.3 RECIPIENT INFORMATION (Continued)

20. Injury

Leave blank if this information is not known, otherwise enter the proper code:

1 = Problem not related to an accident or employment
2 = Work-related accident
3 = Possible occupational disease
4 = Auto accident occurring prior to 01/01/75
5 = Other potential tort liability
6 = Home accident
7 = Other accident not assignable to the codes above
8 = Auto injury for which expenses incurred exceed $20,000.00 Accident occurred after 01/01/75

21. Primary Diagnosis

Type in reason the patient is being seen.

Example: 21 [MENTAL HEALTH EVALUATION]

22. ICDA Code

Enter the ICDA code for the primary diagnosis from the table below.

Example: 22 [Y84.3]

H305.9	Psychoses Attributed to Physical Condition
H306	Schizophrenia
H307	Psychosis Specific to Childhood
H308	Major Affective Disorder (Mania, severe depression, etc.)
H309.9	Unspecified Psychoses
H310	Neuroses (Neurotic depression, anxiety, etc.)
H311	Personality Disorders
H312	Sexual Deviations and Disorders
H315	Psychophysiological disorders
H316	Special symptoms not elsewhere classified
H316.0	Stammering, Stuttering and Other Speech Disturbances
H317	Transient situational disturbance
H318	Behavior disorders of childhood and adolesence

302.3 RECIPIENT INFORMATION (Continued)

22. ICDA Code (Continued)

H792.6	Nervousness (Not elsewhere classifiable)
H792.7	Malaise and Fatigue
H793	Observation and/or evaluation for undefined mental condition
Y84.3	Referral for mental health evaluation
Y85.0	Family Disruption
Y85.1	Marital conflict
Y85.2	Parent-child conflict
Y85.3	Other Family maladjustment
Y85.4	Educational Problems
Y85.6	Social Persecution
Y85.7	Occupational maladjustment
Y85.9	Other Social maladjustment
Y86.5	Child Neglect and/or Abuse
Y86.8	Legal Problems

23. and 24. Secondary Diagnosis and ICDA Code

Enter any significant secondary diagnosis and its code.

302.4 STATEMENT OF SERVICES RENDERED

25. Individual Group Member Number

Leave this box blank.

26. Service Date

Enter the date the service was rendered, using 2 digits for the month, slash; 2 digits for the day, slash; and 2 digits

for the year. If the patient received one service two or more days during a calendar month, see instructions under medical visits, lines 79 through 96. If more than two repeated procedures are being billed, it is permissible to use the red space in lines 01 through 06 to show the first date service was rendered during the billing period. To do this, the first date of service must be typed in the red space starting at "pplicable" of the word "applicable". In other words the date must be lined up horizontally with boxes in the line and vertically with boxes 80 and 89 in order for the scanner to read the information. The last date of service would be shown in the "service date" box.

27. Procedure Code

Enter the appropriate procedure code from Appendix D.

28. Type

Leave this box blank.

302.4 STATEMENT OF SERVICES RENDERED (Continued)

29. Units

Note that for some procedures listed in Appendix D, i.e., Family Therapy, Psychological Evaluation, one session may last longer than an hour. To receive the correct reimbursement, it is necessary to designate the number of hours in the units box. Round up to the nearest whole number in reporting hours, but charge for the actual time involved.

In box 29 enter:

1 = for one hour or less

2 = more than one hour and up to and including two hours

3 = more than two hours and up to and including three hours

4 = more than three hours

Example: 29 [2]

30. Place

Enter the proper code for the place of service:

1 = Office or clinic

2 = Patient's home

3 = Inpatient hospital

4 = Hospital outpatient department

5 = Public health, family planning, or screening clinic

6 = Nursing home

7 = Independent laboratory or X-ray service

8 = Other

302.4 STATEMENT OF SERVICES RENDERED (Continued)

31. Charge

Enter the usual and customary charge for the service in the dollars and cents format, omitting the dollar ($) sign.

Example: 31 [6.50]

32. Delete

To delete a claim line containing errors, enter an X, otherwise, leave blank. When an X is present for line 01, all information in line 01A is also deleted. This also applies to lines 02-06. Enter the corrected data in the next available line.

Example: 32 [X]

33. Procedure Name

Type in procedure name.

Example: 33 [INTAKE EVALUATION]

34. - 78.

These items are the same as Item 25 through Item 33. They allow for up to six individual procedures. Each procedure requires similar information as the first one.

MEDICAL VISITS

Lines 07 and 08 (Items 79 through Items 96) are especially designed for services delivered more than once during a calendar month.

79. Indv. Grp. Member #

Leave this box blank.

302.4 STATEMENT OF SERVICES RENDERED (Continued)

MEDICAL VISITS (Continued)

80. From Date

This applies to the first day of the period covering the remedial services. Enter the beginning date using 2 digits for month, slash; 2 digits for the day, slash; and 2 digits for the year.

Example: 80 [02/01/75]

81. Through Date

This applies to the last day of the period covering the remedial services. Enter the end date using 2 digits for the month, slash; 2 digits for the day, slash; and 2 digits for the year.

Example: 81 [02/15/75]

82. Procedure Code

Enter the procedure code from Appendix D.

83. Type

Leave this box blank.

84. Units

Enter the number of days patient received services during the calendar month.

85. - 87.

These items are the same as Items 30 through Items 32.

302.4 STATEMENT OF SERVICES RENDERED (Continued)

MEDICAL VISITS (Continued)

88. - 90.

These items are the same as Items 79 through Items 81.

91. - 92.

These items are the same as Items 82 and 83.

93.

This item is the same as Item 84.

94. - 96.

These items are the same as Items 30 through Items 32.

SUMMARY SECTION

97. Total Number of Lines Used

Enter the total number of lines used and not deleted.

Note: 01 and 01A are defined as one line. Therefore, 01, 01A, 02, 02A and 07 = 3 lines.

Example: 97 [3]

98. Type of Bill (See Chapter I, Section 105)

Enter: 2 = Non-Medicare related bill.

4 = Bill for patient with Medicare coverage.

8 = Bill for patient with Medicare coverage for a Service covered by Medical Assistance but not by Medicare.

99. Total Units

Enter the total number of units from boxes 84 and 93, omitting a deleted line. If no units have been entered in boxes 84 or 93, then leave blank.

302.4 STATEMENT OF SERVICES RENDERED (Continued)

SUMMARY SECTION (Continued)

100. Gross Total Charges

Enter the total of the above charges in dollar and cents, omitting the dollar ($) sign. Omit charges from deleted lines.

Example: 100 [13.50]

101. Amount Received From Other Sources (See Chapter I, Section 106)

Enter the dollar and cents amount coming from other sources, such as workmen's compensation, recipient, recipient's family, insurance companies, etc., (excluding Medicare), omitting the dollar ($) sign.

Example: 101 [7.50]

102. Deductible (See Chapter I, Section 105)

Enter the exact amount of the Medicare Deductible owed by the patient, as reported on Medicare's "Explanation of Medicare Benefits", omitting the dollar ($) sign.

103. Amount Received from Medicare (See Chapter I, Section 105)

Enter the dollar and cents amount received from Medicare, which apply to the service dates and procedures on this invoice, omitting the dollar ($) sign.

104. Co-Insurance (See Chapter I, Section 105)

Enter the exact amount (example 12.00) of the co-insurance owed by the patient as calculated from information on the "Explanation of Medicare Benefits", omitting the dollar ($) sign.

302.4 STATEMENT OF SERVICES RENDERED (Continued)

SUMMARY SECTION (Continued)

105. Net Billed to M.A.

+ Gross Total Charges (Item 100)

- Amount Received From Other Sources (Item 101)

- Amount Received From Medicare (Item 103)

= Net Billed to M.A. (Item 105)

302.5 PROVIDER CERTIFICATION

The invoice must be signed so that it may be processed and payment made. A typed or a rubber stamp signature, or computer generated appropriate indicator, is acceptable.

SEND INVOICES TO: Minnesota Medical Assistance Program -- Department of Public Welfare, Box 30166, St. Paul 55175

PRACTITIONER INVOICE APPENDIX A

Claims Processing Document Control Number
1

ELITE PICA — TYPEWRITER ALIGNMENT — ELITE PICA
USE CAPITAL LETTERS ONLY

PROVIDER INFORMATION

2 Provider's Name | 3 Provider I.D. # | 4 Own Reference # | 5 Billing Date | 6 Prior Auth. #

7 Street Address | 8 Referring Practitioner's Name

9 City/State/Zip Code | 10 Name and City of Hospital or Nursing Home

RECIPIENT INFORMATION

11 Recipient's Name (Last, First, Initial) | 12 Recipient's Medical Assistance Number | 13 Sex | 14 Birthdate

15 Hospitalization Insurance Company | 16 Hospitalization Insurance Policy Number | 17 Medical Insurance Company | 18 Medical Insurance Policy Number | 19 TPL | 20 Injury

21 Primary Diagnosis | 22 ICDA Code

23 Secondary Diagnosis | 24 ICDA Code

STATEMENT OF SERVICES RENDERED

01 25	Individual Group Member Number / If Applicable	26 Service Date	27 Procedure Code	28 Type	29 Units	30 Place	31 Charge	32 Delete
01A 33	Procedure Name							
02 34	Individual Group Member Number / If Applicable	35 Service Date	36 Procedure Code	37 Type	38 Units	39 Place	40 Charge	41 Delete
02A 42	Procedure Name							
03 43	Individual Group Member Number / If Applicable	44 Service Date	45 Procedure Code	46 Type	47 Units	48 Place	49 Charge	50 Delete
03A 51	Procedure Name							
04 52	Individual Group Member Number / If Applicable	53 Service Date	54 Procedure Code	55 Type	56 Units	57 Place	58 Charge	59 Delete
04A 60	Procedure Name							
05 61	Individual Group Member Number / If Applicable	62 Service Date	63 Procedure Code	64 Type	65 Units	66 Place	67 Charge	68 Delete
05A 69	Procedure Name							
06 70	Individual Group Member Number / If Applicable	71 Service Date	72 Procedure Code	73 Type	74 Units	75 Place	76 Charge	77 Delete
06A 78	Procedure Name							
MEDICAL VISITS 07 79	Indv. Grp. Member #	80 From Date	81 Through Date	82 Procedure Code	83 Type	84 Units	85 Place	86 Charge	87 Delete
08 88	Indv. Grp. Member #	89 From Date	90 Through Date	91 Procedure Code	92 Type	93 Units	94 Place	95 Charge	96 Delete

97 Total Number Of Lines Used | 98 Type Of Bill | 99 Total Units

PROVIDER CERTIFICATION

This is to certify that the above medical services have been rendered. I understand that payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws.

X _____

MEDICARE

102 Deductible

104 Co-Insurance

100 GROSS TOTAL CHARGES

101 Amount Received From Other Sources

103 Amount Received From Medicare

105 NET BILLED TO MA

WHAT THE MEDICAL I.D. CARD MEANS

RECIPIENT IDENTIFICATION NUMBER
This is the number which the medical services Provider must enter accurately on the billing invoice. This allows the centralized processing system to perform various edits related to recipient eligibility, duplicate payments, and appropriateness of the service to the recipient's unique situation. In this example, note that the number on the front of the card refers to the person named below. All other family members eligible for medical services are listed under "Other Persons Covered" and have their own unique numbers.

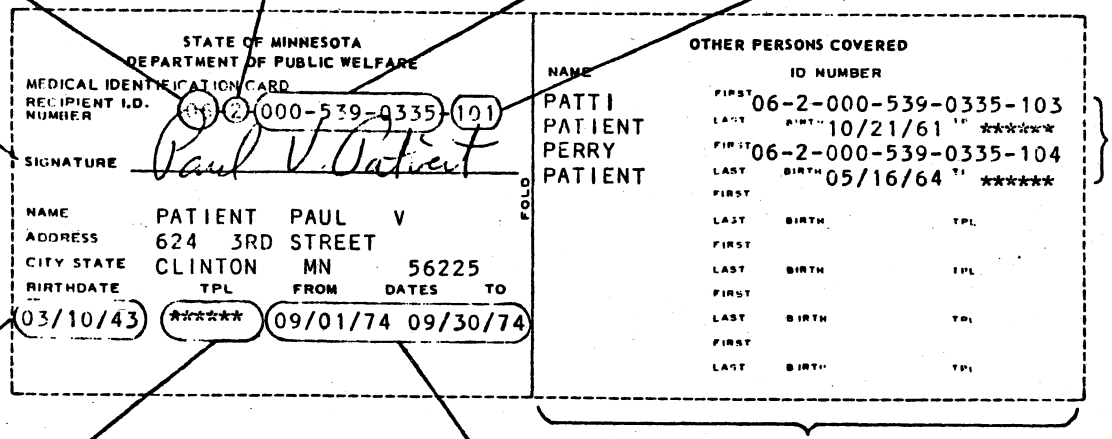
GRANTEE, SEQUENCE NUMBER
This number uniquely identifies each member of a family. The "101" is normally the head of the household, and higher numbers are other family members. Services rendered to a child, therefore, must be identified with the child's own number.

RESPONSIBLE COUNTY
These two digits refer to the county responsible for the recipient's financial payments (ie. 1 thru 87).

PROGRAM CODE
This code identifies the State/Federal program under which the recipient becomes eligible for medical services, ie,
1-OAA 3-AB 8-MA
2-AFDC 4-AD

CASE NUMBER
This number is assigned by the County Welfare Dept. to each case as they become eligible for assistance.

SIGNATURE
The person whose name is shown must have signed the card.



OTHER PERSONS COVERED
This section of the card, often folded backwards when carried in a wallet, contains the names, ID #'s, birthdates, and TPL information on other persons in the family covered by Medical Assistance. Note that the only difference in the ID # is normally in the last digit. BE SURE YOU USE THE CORRECT ID# AND BIRTHDATE FOR THE ACTUAL PERSON RECEIVING SERVICE. This is NOT always the person whose name and number appears on the front of the card. Failure to use the correct number forces manual handling of the invoice, almost certainly delaying prompt payment.

BIRTHDATE
This is the birthdate of the person listed above. This birthdate should be used when billing for this person regardless of differing information in your records. It is used primarily by the computer as a cross index to assist in case identification.

THIRD PARTY LIABILITY
Those numbers are Third Party Liability codes. They identify insurance companies or other sources which can be used to share the cost of covered medical procedures and supplies.
ie - the first two digits represent HMO codes.
- the middle two digits represent Hospitalization Insurance company codes.
- the last two digits represent Medical Insurance company codes,

DATES
Cards are issued to recipients each month, covering a one-month period ending the last day of the month. The Provider should be certain that the card is current by checking these dates. If the recipient's card appears to be out-of-date, and a more recent card cannot be produced, the Provider should then inquire with the County Welfare Department regarding the recipient's eligibility.

OTHER PERSONS COVERED
This portion of the card is normally folded back as the recipient carries it in a wallet, etc. Listed here are names of other eligible Family members, their birthdates, Third Party Liability codes, and unique Recipient Identification number.

REQUISITION FOR DPW FORMS FROM CENTRAL STORES

Mail this requisition

FORMS MANAGEMENT
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

APPENDIX C

FOR DPW APPROVAL

Send forms ordered to:

AGENCY OR NAME

ADDRESS

CITY STATE ZIP CODE

PLEASE SIGN REQUISITION HERE:

Your Signature

DATE

Form number	Form Title	Quantity	DPW or Central Stores use only ACTION TAKEN (see reverse)
DPW- 1497	Practitioner Invoice		
DPW- 1863	Practitioner Envelope		
DPW- 1854	Adjustment Request		
DPW- 1877	Adjustment Envelope		
DPW- 121	Requisition Form		
DPW-			
DPW -			
DPW-			
DPW -			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			

Send WHITE, LABEL, and BLUE copies with stub intact to DPW.
Retain PINK copy.

DPW-121
(8-74)

APPENDIX D

MENTAL HEALTH CLINICS

COVERED SERVICES AND SERVICE LIMITATIONS

CODE	DESCRIPTION	SERVICE LIMITATION
	Chemotherapy:	
Individual 90862-3 Group 90863-4	One hour or a proportion thereof of service with an individual (or with each of a group of individuals) where the mode of treatment is by the use of the general group of drugs, characterized as "psycho-active".	52 transactions per year
	Collateral Therapy:	
Individual 90800-5	One hour of service aimed at treatment of a primary patient by interviews, beyond the diagnostic level with collateral persons which focus on the problems of the patient. The primary patient is not necessarily seen.	10 transactions per year
	Day Treatment:	
90898-4	A unit of treatment for an individual lasting more than two hours but less than twenty-four hours; treatment which goes on for a significant portion of a day or night. Characteristically, this treatment form will employ group process, group or congregate living, possibly therapeutic community and related techniques. Individual therapy (psychological) may be a component. The various activities over the specified course of time in one twenty-four hour period for one person is the unit of service.	45 transactions per year
	Family Therapy:	
Group 90847-4	Up to two hours of service delivered directly to members of a group designated for treatment purposes as a family, possibly an extended family where the primary treatment modality consists of the application of various theoretical constructs which focus on family dynamics and interaction with the objective of remediating and strengthening aspects of family functioning.	52 transactions per year
	Group Psychotherapy:	
Group 90853-2	One hour of service delivered to members of a group where treatment is by the use of group process - group dynamics and group interaction.	20 transactions per year

APPENDIX D (Continued)

CODE	DESCRIPTION	SERVICE LIMITATION
	Hypnotherapy:	
Individual 90880-5	One hour of service delivered directly to the individual making use of hypnosis (with or without the use of drugs).	10 transactions per year
	Individual Psychotherapy:	
Individual 90841-9	One hour of service directly delivered to an individual, characteristically by individual interview, including: supportive psychotherapy, relationship therapy, psychoanalysis, counseling, play therapy, casework treatment, applications of learning theory and its principles - the general application of behavior modification.	52 transactions per year if under 21 years of age 10 transactions per year for age 21 and over
	Intake Evaluation:	
Individual 90015-8 Group 90016-9	Up to three hours of service delivered directly to a person with the objective of determining the type and extent of the problem of the individual seeking help, and suitability for own program.	1 transaction per year
	Mental Health Information and Referral:	
Individual 90831-7	One hour or a portion thereof of service to an individual by phone or direct contact, where the objective is giving information about availability of services and/or service which guides or links the recipient to own or other appropriate service.	2 transactions per year
	Neurological Examinations:	
Individual 90020-5	Up to two hours of service involving a complete examination of the central, peripheral and sympathetic nervous system with recorded observations and findings eventuating with a diagnosis, if appropriate.	1 transaction per year
	Non-Intake Evaluation:	
Individual 90010-3	Up to three hours of service delivered directly to a person with the objective of determining the type and extent of the problem of the individual seeking help, and suitability for others program, or "suitability" for some undertaking.	1 transaction per year

CODE	DESCRIPTION	SERVICE LIMITATION
Individual 90801-1	Psychiatric Evaluation: Up to three hours of direct service aimed at producing a psychiatric diagnosis, characteristically including a medical history and mental status examination which records attitudes, behavior, estimate of intellectual functioning, memory function orientation and an inventory of the patients' assets in a descriptive fashion, recording impressions and recommendations.	2 transactions per year
Group 90854-3	Psychodrama: One hour of service delivered to members of a group where psychodramatic technique is employed as the major mode of treatment.	20 transactions per year
Individual 90825-9 Group 90826-X	Psychological Evaluation: Up to four hours of evaluation and testing of the cognitive processes and emotions and the problems of adjustment in individuals or in groups, through administration and interpretation of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. Interview may be included.	1 transaction per year
Individual 90000-1 Group 90001-2	Social Evaluation: Up to two hours of service aimed at the determination and examination of the social situation of an individual related to: family background, family interaction, living arrangements, psycho- or socioeconomic problems, treatment evaluation (mode, etc.) and statement of goals and plans.	1 transaction per year
Individual 90002-3	Speech Therapy: One hour of direct service delivered to a client with the objective of remediating, modifying, or adjusting to a diagnosed speech disorder.	52 transactions per year
Group 90849-6	Therapy with Groups of Couples: Up to two hours of service delivered to members of a group of couples, where the use of group process - group dynamics is the primary treatment mode.	20 transactions per year

List of Insurance Carriers

00 - Other
01 - American National Insurance Company
02 - American Family Insurance
03 - American Republic Insurance
04 - American Fidelity Insurance
05 - Aetna Life and Casualty
06 - Associated Life Insurance
07 - Benefit Trust Life Insurance
08 - Bankers Life and Casualty Insurance
09 - Blue Cross of Minnesota
10 - Blue Shield of Minnesota
11 - Continental Casualty (CNA)
12 - Connecticut General Life
13 - Champus (Military Dependents)
14 - Crown Life Insurance
15 - Catholic Knights Insurance Society
16 - Equitable Life Assurance
17 - Federated Mutual Insurance
18 - Camble Alden Life Insurance
19 - Gold Star Plan
20 - Guardian Life Insurance
21 - John Hancock Mutual Life
22 - Liberty Mutual Insurance
23 - Lincoln National Life Insurance
24 - Minnesota Indemnity Inc.
25 - Minnesota Mutual Life Insurance
26 - Minnesota Protective Association
27 - Massachusetts Mutual Life Insurance
28 - Mutual of Omaha Insurance
29 - Metropolitan Life Insurance
30 - Mutual Service Insurance
31 - New York Life Insurance
32 - N P B A (Northern Pacific)
33 - N P A (National Postal Union)
34 - National Casualty Company
35 - National Home Life Insurance
36 - New England Mutual Life Insurance
37 - Northwestern National Life
38 - Occidental Life Insurance
39 - Philadelphia Insurance
40 - Prudential Insurance
41 - Physicians Mutual Insurance
42 - Pyramid Life Insurance
43 - Reserve Life Insurance
44 - Republic National Life Insurance
45 - St. Paul Hospital and Casualty
46 - Travelers Insurance
47 - United of Omaha
48 - United Beneficial Life
49 - Wisconsin Life Insurance
50 - Electrical Local 31
51 - Engineers Local 49
52 - Teamsters Local 120
53 - Laundry Local 150
54 - Teamsters Local 975
55 - HMO
56 - Delta Dental Insurance
57 - Minnesota Vision Services, Inc.

APPENDIX F

GENERAL INFORMATION

Appendix F consists of one Practitioner Invoice (Figure 1) filled out as they would be when submitted for payment, and the associated sample Remittance Advice (Figure 2).

The current status of all claims and adjustments processed in the past two weeks is shown on the provider's Remittance Advice. This report is mailed to each enrolled provider that had one or more claims or adjustments processed or in suspense at the time of the most recent check (warrant) printing.

The Remittance Advice explains in detail what claims have been paid, what charges if any have been reduced, what claims have been suspended for further processing, and what claims have been rejected. When claims or charges within claims are rejected, a code identifying the rejection reason is printed. These codes are explained in Appendix H.

The Remittance Advice provides answers to most questions regarding the processing and payment of bills submitted to the Centralized Medical Assistance Disbursement System. Once a claim has entered processing, its status will be reported on a Remittance Advice every two weeks until it has been paid or rejected.

The check (warrant) explained by the Remittance Advice is printed, signed and mailed separately by the State Department of Finance. It will be delivered by first class mail a few days before or after the Remittance Advice. If a provider has all claims rejected or in suspense during a payment cycle, the provider will get a Remittance Advice but no check.

GENERAL INFORMATION (Continued)

Payments, suspended claims, and rejected claims are reported in an alphabetical listing by patient name. Each claim status report identifies the claim by patient name, patient Medical Assistance ID number, provider's own reference number (if submitted on the invoice by the provider), a claim reference number generated by the State, and the date of the invoice. ALL INQUIRIES REGARDING CLAIMS MUST INCLUDE THE CLAIM REFERENCE NUMBER REPORTED ON THE REMITTANCE ADVICE.

DO NOT RESUBMIT SUSPENDED CLAIMS. They will be paid or rejected when all internal errors have been resolved in processing. Normally this will not take more than two weeks. If a claim is reported continually in suspense for over two months, please write or call collect to:

Provider Relations and Training Unit
Medical Assistance Section
Box 17038
St. Paul, Minnesota 55117
612-296-6714

HAVE THE APPROPRIATE REMITTANCE ADVICE AVAILABLE FOR REFERENCE WHEN CALLING.

Rejected claims may be resubmitted if the errors shown by the rejection reason codes and error codes can be eliminated. If there are questions, call the Provider Relations and Training Unit at the above number.

Inquiries about claims which have not been reported on a Remittance advice within thirty days of submission must include the provider's ID number, the patient's Medical Assistance ID number, date of service, date of billing and patient's name.

SEND INVOICES TO: Minnesota Medical Assistance Program -- Department of Public Welfare, Box 30166, St. Paul 55175

PRACTITIONER INVOICE

FIGURE 1
MENTAL HEALTH

Claims Processing Document Control Number
1.

ELITE PICA — TYPEWRITER ALIGNMENT — ELITE PICA
USE CAPITAL LETTERS ONLY

PROVIDER INFORMATION

2 Provider's Name	3 Provider I.D. #	4 Own Reference #	5 Billing Date	6
MENTAL HEALTH CENTER	1000001	OWNNUMBER	02/28/75	

7 Street Address	8 Referring Practitioner's Name
690 NORTH ROBERT STREET	
9 City/State/Zip Code	**10 Name and City of Hospital or Nursing Home**
ST PAUL MN 55117	

RECIPIENT INFORMATION

11 Recipient's Name (Last, First, Initial)	12 Recipient's Medical Assistance Number	13	14
DOE JANE J	00-0-000-000-0000-000	F	01/01/50

15 Hospitalization Insurance Company	16 Policy Number	17 Medical Insurance Company	18 Policy Number	19 TPL	20 Injury

21 Primary Diagnosis	22 ICDA Code
SCHIZOPHRENIA	H306
23 Secondary Diagnosis	**ICDA Code**

STATEMENT OF SERVICES RENDERED

	Individual Group Member Number / If Applicable	Service Date	Procedure Code	Type	Units	Place	Charge
01 25	26	02/10/75 27	908805 28	29	30	1 31	25.00
01A 33	Procedure Name: HYPNOTHERAPY						
02 34	35	02/26/75 36	908419 37	38	39	1 40	25.00
02A 42	Procedure Name: INDIVIDUAL PSYCHOTHERAPY						
03 43	44	45	46	47	48	49	
03A 51	Procedure Name:						
04 52	53	54	55	56	57	58	
04A 60	Procedure Name:						
05 61	62	63	64	65	66	67	
05A 69	Procedure Name:						
06 70	71	72	73	74	75	76	
06A 78	Procedure Name:						

MEDICAL VISITS	Indv. Grp. Member # / From Date	Through Date	Procedure Code	Type	Units	Place	Charge
07 79	80	81	82	83	84	85	86
08 88	89	90	91	92	93	94	95

97 Total Number Of Lines Used | 98 Type Of Bill | 99 Total Units

GROSS TOTAL CHARGES 100: 50.00

Amount Received From Other Sources 101:

Amount Received From Medicare 103:

NET BILLED TO MA 105: 50.00

PROVIDER CERTIFICATION

This is to certify that the above medical services have been rendered. I understand that payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws.

X (YOUR SIGNATURE)
Authorized Signature

MEDICARE
Deductible 102:
Co-Insurance 104:

DPW 1497 (6-74)

PROVIDER NUMBER: 1000001

MINNESOTA DEPARTMENT OF PUBLIC WELFARE
MEDICAL ASSISTANCE PROGRAM

REMITTANCE ADVICE

FIGURE 2

MENTAL HEALTH CENTER

DATE OF PAYMENT: 03/21/75

WARRANT NUMBER: 41046128

PAGE NUMBER: 001

PROVIDER'S OWN REFERENCE NO.	CLAIM REFERENCE NUMBER	DATE OF INVOICE	LINE ITEM CODE	DATE OF SERVICE	SERVICE CODE	CLIENT LIABILITY	AMOUNT FROM OTHER SOURCES	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
DOE	JANE	J = RECIPIENT NAME			RECIPIENT ID = 00-0-000-000-0000-000					PAY	
000055412	742960720040300	02/27/75		02/10/75 THRU 02/26/75							
			001	02/10/75	90880-5		Unit=00	25.00	25.00	S	
			02	02/26/75	90841-9		Unit=00	25.00	25.00	S	
* * PAID INVOICE * * * * * * * *						0.00	0.00	50.00	50.00	PAY	
GREEN	PAUL	R = RECIPIENT NAME			RECIPIENT ID = 00-0-000-000-0000-000					PAY	
000052687	742600090061100	02/27/75		02/04/75 THRU 02/04/75							
			01	02/04/75	90880-5			30.00	30.00	S	
* * PAID INVOICE * * * * * * * *						0.00	0.00	18.00	18.00	PAY	MEDICARE CROSSOVER
HARRISON	JANE	L = RECIPIENT NAME			RECIPIENT ID = 00-0-000-000-0000-000					SUS	
000048773	742360660040400	03/07/75		03/03/75 THRU 03/04/75							
* * SUSPENDED INVOICE - STILL IN PROCESS * * * * * * * * * *										SUS	
LYSICK	FRANK	R = RECIPIENT NAME			RECIPIENT ID = 00-0-000-000-0000-000					REJ	** 703,01703
000049210	742360050040300	03/11/75		02/24/75 THRU 02/24/75							
* * REJECTED INVOICE * * * * * * * * * *										REJ	
STALLWORTH	PAUL	G = RECIPIENT NAME			RECIPIENT ID = 00-0-000-000-0000-000					DEB	
000012345	742960320029500	WARRANT DATE = 02/27/75			CLAIM ADJUSTED = 7420107900389001						
			01		90898-4	REASON = 51		2.50-	2.50-	S	
*** DEBIT ADJUSTMENT **********						0.00		2.50-	2.50-	DEB	ADJUST

TOTALS FOR PAID INVOICES:

CLIENT LIABILITY	000,000.00
AMOUNT FROM OTHER SOURCES	000,000.00
AMOUNT BILLED	68.00

DEBIT BALANCE USED: 0.00

DEBIT BALANCE REMAINING: 0.00

PAGE TOTAL: 65.50

WARRANT TOTAL: 65.50

PROVIDER NAME AND ADDRESS:
MENTAL HEALTH CENTER
690 N ROBERT ST
ST PAUL MN 55117

DPW-1849 (6-74)
STOCK NO. 397

DETAILED DESCRIPTION--REMITTANCE ADVICE

The provider Remittance Advice is printed on a general purpose form used for all medical care providers. The Remittance Advice may be described as having three distinct sections.

A. HEADER INFORMATION (Items 1-4) includes provider number, date of payment, warrant numbers, and page numbers.

B. CLAIMS/ADJUSTMENTS STATUS INFORMATION (Items 5-50) includes all the necessary information relating to the status and action taken on any particular invoice or adjustment.

C. SUMMARY INFORMATION (Items 51-56) includes the necessary information regarding action taken on any debit balances, page and warrant totals, and the provider's name and address.

Figure 3 illustrates an example of a Remittance Advice which identifies the position of each item of information presented. Each item of information is defined as follows:

A. Header Information

Item 1. Provider Number

This is the seven digit provider's Medical Assistance ID number assigned by the State Department of Public Welfare at time of enrollment.

Item 2. Date of Payment

This is the date shown on the check (warrant) which this Remittance Advice explains. If no check is issued, this is the date the Remittance Advice was prepared. This date can be used

DETAILED DESCRIPTION--REMITTANCE ADVICE (Continued)

Item 2. Date of Payment (Continued)

to sequence the 26 Remittance Advices which most providers will receive each year.

Item 3. Warrant Number

This is the number of the check (if any) that this Remittance Advice explains.

Item 4. Page Number

This is the number of the page within the provider's Remittance Advice.

B. Claims/Adjustments Status Information

The detail listing of processed claims appears in the center portion of each page. See Figure 3. Each claim is broken down into four printline formats with different kinds of information in them, as follows:

Printline I -- Name Line

Printline II -- Claim Identification

Printline III -- Itemized Charges

Printline IV -- Claim Summary Line

Each adjustment is broken down into four printline formats:

Printline V -- Name Line (same as Printline I)

Printline VI -- Claim Identification

Printline VII -- Claim Adjustment Data

Printline VIII -- Claim Summary Line

These Printlines are explained in detail on the following pages.

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

B. Claims/Adjustments Status Information (Continued)

Printline I -- Name Line (Continued)

Item 5. Recipient Name

The patient's name as is shown on the Medical Assistance ID card. This name may differ from the name reported on the invoice, if the name submitted was not copied correctly from the ID card. The name will be absent if an invalid recipient ID number was reported on the invoice.

Item 6. Recipient ID

This is the patient's Medical Assistance ID number as reported on the invoice.

Item 7. Status

The codes for claim status are:

PAY = PAID
SUS = SUSPENDED
REJ = REJECTED

Item 8. Explanation Codes and Comments

These are codes indicating the reason for rejection of a claim and any other unresolved errors. See Appendix H for these codes.

Printline II -- Claim Identification

Item 9. Provider's Own Reference Number

This is the number the provider enters in the "Own Reference #" box on the invoice.

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

B. Claims/Adjustments Status Information (Continued)

Printline II -- Claim Identification (Continued)

Item 10. Claim Reference Number

This number is entered on the invoice by the State Department of Public Welfare when the invoice arrives for processing.

Item 11. Date of Invoice

This is the date reported in the "Billing Date" box on the invoice.

Item 12. From and Thru Dates

These are the earliest (From) and latest (Thru) dates shown on Invoice Line Items.

Printline III -- Itemized Charges

Item 13. Line Item Code

This is the line number from the invoice.

Item 14. Date of Service

This is the "Service Date" reported on the invoice. In the case of medical visits this date is the "From Date" reported on the invoice.

Item 15. Service Code

This is the "Procedure Code" reported on the invoice.

Item 16. Through Date

This is the "Through Date" reported on the invoice. This date will appear on the Remittance Advice line item, whenever the

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

B. Claims/Adjustments Status Information (Continued)

Printline III -- Itemized Charges (Continued)

Item 16. Through Date (Continued)

line item first procedure service date is different from the line item last procedure service date. It will appear in the column with the preprinted heading Client Liability.

Item 17. Units of Service

This is the line item units of service, used only with line item codes 07 and 08.

Item 18. Amount Billed

This is the "Charge" reported on the invoice for that line item.

Item 19. Amount Paid

This is the amount paid for this line item.

Item 20. Status

This is a code indicating the status of a line item as shown below.

S = PAID AS SUBMITTED
A = PAID ALLOWABLE CHARGE
R = REJECTED

Item 21. Explanation Codes and Comments

This is a continuation of Item 8 above.

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

B. Claims/Adjustments Status Information (Continued)

Printline IV -- Claim Summary Line

Item 22. Action Taken

A statement of whether an invoice was paid, suspended for further processing or rejected.

Item 23. Client Liability

The portion of the bill, if any, to be collected from a patient on "Spend-down". This amount will usually be blank. It may have a value where part of a patient's spend-down remains on the first day of eligibility or where a patient is on monthly spend-down.

Item 24. Amount From Other Sources

This is the amount reported on the invoice as "Amount Received from Other Sources".

Item 25. Amount Billed

This is the "Net Billed to MA" as reported on the invoice.

Item 26. Amount paid

This is the amount paid by Medical Assistance on this individual invoice.

Item 27. Status

This is a code indicating whether the claim is paid, rejected, or suspended for further processing. This item is identical to Item 7 discussed previously.

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

B. Claims/Adjustments Status Information (Continued)

Printline IV -- Claim Summary Line (Continued)

Item 28. Explanation Code and Comments

If this is a Medicare related claim, "Medicare Crossover" is printed here. For rejected claims this field may contain a continuation of error codes; otherwise it is blank.

Printline V -- Adjustment Printlines

Adjustment reports have the same first printline as Claim Status Reports (Printline I).

Item 29. Recipient Name

See Item 5 above.

Item 30. Recipient ID #

See Item 6 above.

Item 31. Status

See Item 7 above. For adjustments transactions, there are two additional status codes.

DEB = MONEY OWED TO THE STATE
HST = TRANSACTION GOING INTO HISTORY

Item 32. Explanation Codes and Comments

See Item 8 above.

Printline VI -- Adjustment Identification

Item 33. Provider's Own Reference Number

This is the provider's own reference number that was reported on the claim that is being adjusted.

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

B. Claims/Adjustments Status Information (Continued)

Printline VI -- Adjustment Identification (Continued)

Item 34. Claim Reference Number

This is the number assigned by the State to the adjustment document at the beginning of processing.

Item 35. Warrant Date

This is the date that appears on the provider's check.

Item 36. Claim Adjusted

This is the claim reference number of the claim being adjusted.

Item 37. Explanation Codes and Comments

See Item 8 above.

Printline VII -- Adjustment Information

Item 38. Line Item Code

See Item 13 above. For adjustment transactions, a TP may appear in this column. This is a credit or debit to a provider for insurance reported collectable on a previous claim, but found to be not collectable.

Item 39. Service Code

This is the corrected service code for a line item.

Item 40. Reason Code

This is a two digit code giving the reason for the adjustment. See Appendix I.

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

B. Claims/Adjustments Status Information (Continued)

Printline VII -- Adjustment Information (Continued)

Item 41. Amount Billed

This is the line item amount of adjustment requested, credited or debited to the provider. Debits are marked with a minus sign.

Item 42. Amount Paid

This is the line item amount credited or debited to the provider. Debits are marked with a minus sign.

Item 43. Status

See Item 20 above.

Item 44. Explanation Codes and Comments

See Item 8 above.

Printline VIII -- Adjustment Summary Line

Item 45. Action Taken

See Item 22 above. For adjustments an additional message may appear "Debit Adjustment". See Item 31 above.

Item 46. Client Liability

This is the claim recipient resources amount.

Item 47. Amount Billed

Sum of Item 41 above.

Item 48. Amount Paid

Total of Item 42 above.

Item 49. Status

See Items 7 and 31 above.

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

B. Claims/Adjustments Status Information (Continued)

Printline VIII -- Adjustment Summary Line (Continued)

Item 50. Explanation Codes and Comments

See Item 8 above. For adjustment transactions, some informational messages may appear. "Adjust" for a debited or credited adjustment.

"Process Manually"

"Process Manually (Check Recvd)"

C. Summary Information -- Remittance Advice

Item 51. Provider Totals

Three totals will appear on the last page of a provider's remittance advice in the lower left-hand corner. The totals for all a provider's adjudicated transactions are -- client liability, amount from other sources and amount billed -- the cumulative totals of items 23, 24 and 25 (See above).

Item 52. Debit Balance Used

The net debt of the provider to the Medical Assistance Program, if any, left over from previous payment cycles' adjustment transactions which was deducted from the amount to be paid to the provider on this payment cycle. This field is usually blank except when a provider has previously collected an amount of insurance for services previously paid for by Medical Assistance. When there is a debit balance

DETAILED DESCRIPTION -- REMITTANCE ADVICE (Continued)

C. Summary Information -- Remittance Advice (Continued)

Item 52. Debit Balance Used (Continued)

used, the amount is printed out only on the last page of the Remittance Advice.

Item 53. Page Total

The total net dollars reported paid on the given page.

Item 54. Debit Balance Remaining

The net remaining debt of the provider to the Medical Assistance Program, if any, as of the Date of Payment. Any remaining debt will be deducted from future payments to the provider. This amount prints out only on the last page of the Remittance Advice.

Item 55. Warrant Total

This is the net amount paid to the provider on the date of payment, as shown on the check. This amount prints out only on the last page of the Remittance Advice.

Item 56. Provider Name and Address

This is the name and "pay to" address of the provider as currently recorded in the computer file of provider enrollment information.

APPENDIX G

REJECTION REASON AND ERROR CODES

The following codes may appear on the Remittance Advice in the Explanation Codes and Comments column. They indicate errors or processing problems present in a claim at the time it was rejected for payment or further processing. The first code printed, marked by two asterisks (e.g. **703) is the reason for rejection of the claim. This code is followed by the error codes for unresolved errors remaining in the claim data at the time of rejection.

The error codes as printed consist of five digits. The first two digits are the line number, if applicable. The last three digits are the error code itself.

Example: **147, 07173, 07188, 07189

**147 = the claim was rejected because the patient's M.A. ID number is missing

07173 = the units of service reported on line 07 of the invoice is not numeric

07188 = the From Date reported on line 07 of the invoice is invalid

07189 = the Through Date reported on line 07 of the invoice is invalid

If a claim is paid but a line item is rejected, the error code for the reason will appear in the Comments column, but without the asterisks.

If the problems indicated by the rejection reason codes and error codes can be eliminated by correcting the invoice, resubmit a correct invoice on a new form. Where the reason for rejection was patient ineligibility and where the patient's M.A. ID number was correctly reported on the original invoice, other sources of payment should be sought or an inquiry should be sent to the patient's county welfare department to find out why the patient was reported as ineligible.

If a line item(s) is rejected on an invoice otherwise paid, and the problems in that line item can be corrected, resubmit a new invoice for the corrected line item(s) only.

APPENDIX G: REJECTION REASONS AND ERROR CODES (Continued)

ERROR CODES

051-074 These error codes indicate technical processing problems and can generally be ignored by the provider.

075 Total line-item count is missing or in error.

100 Provider ID Number is not numeric.

101 Billing Date is invalid.

102 Procedure Code is missing.

103 Responsible County Code in the Recipient's M.A. ID Number is invalid (digits 1 and 2 of the ID Number).

104 Program code in the recipient's M.A. ID Number is invalid (digit 3 of the ID Number).

105 Grantee code in the Recipient's M.A. ID Number is invalid (digit 14 of the ID Number).

107 Prior Authorization Number is not numeric.

115 Amount Received From Other Sources is not numeric.

125 The H-ICDA Code for the Primary Diagnosis is missing.

126 The submitted Procedure Charge is missing.

127 The submitted Procedure Charge is not numeric.

129 Third Party Liability Code is invalid.

130 The H-ICDA Code for the Primary Diagnosis is invalid (impossible format or value).

131 The Secondary Diagnosis Code is invalid.

132 The Total Gross Charges is missing.

134 The Total Gross Charges is not numeric.

135 The Net Billed is not numeric.

136 The Net Billed is missing.

137 Place of Service is invalid.

147 Recipient's M.A. ID Number is missing.

151 Type of Service Code (if submitted) is invalid.

155 Group Member Provider Number (if submitted) is not numeric.

157 Service Classification invalid.

158 Provider billing Medicare Crossover on improper invoice type.

162 Medical Insurance Company Number is not numeric.

163 Medical Insurance Policy Number is missing.

173 Units of Service (if submitted) is not numeric.

188 Service Date or From Date is invalid.

189 Service Date or Through Date is invalid.

213 Provider ID Number is missing.

214 Provider Number check digit is invalid.

216 Group Member Provider Number check digit is invalid.

218 Recipient Sex code is invalid.

219 Patient's Birthdate is invalid (wrong format or impossible number).

221 Injury Code is invalid.

233 Procedure or Service Code is not numeric (first five of six digits).

234 Procedure or Service Code fails check digit audit.

301 Provider could not be located on the file (not enrolled).

303 First Date of Service subsequent to current date.

304 Total of Gross Charges less the Amount Received from Other Sources does not equal Net Billed to M.A.

305 Procedure Code is not on reference file (i.e. code is invalid).

306 From Date is subsequent to Through Date.

307 Through Date is subsequent to current date.

308 Billing Date is subsequent to the current date.

309 Place of Service conflicts with Procedure Code.

310 MRVI modifier is not consistent with the Procedure Code.

313 Sum of all submitted Procedure Charges does not equal Gross Total Charges.

352 "By Report" procedure which requires manual review by DPW.

353 Procedure requires Prior Authorization, and no Prior Authorization number is given on the invoice.

354 None of the provider effective dates precede the service date.

355 Modifier is equal to "C" (Unusual Service), and manual review is necessary.

397 Incompatible Modifier in Type of Service item.

398 Recipient Sex is not compatible with the Procedure Code's sex indicator.

399 Recipient Sex is not compatible with Diagnosis Code's sex indicator.

400 Sex indicator conflicts on Procedure and Diagnosis records.

401 Procedure precedes authorized start-up date.

403 Invalid procedure status code.

409 Provider is not eligible on earliest service date on invoice.

410 Provider is not eligible on latest service date on invoice.

411 Provider suspended on earliest service date.

412 Provider suspended on latest service date.

413 Provider's claims are to be reviewed before payment.

414 Provider is dis-enrolled.

415 Provider was terminated on the earliest service date.

416 Provider was terminated as of the latest service date.

450 Provider is not a member of the billing group.

451 Authorized category of service on the provider file does not agree with the invoice type.

461 Provider type prefix of the Provider Number is invalid.

462 Unable to determine category of service.

463 Date of Service precedes authorized start-up date. Please bill the county welfare department.

470 - 475 Technical processing problem within DPW. Can generally be ignored by the Provider.

500 Provider's payment was rejected by DPW.

701 Patient's reported Birthdate does not match birthdate in eligibility file. This makes the patient ID Number suspect as probably incorrect, especially the last two digits which identify separate family members.

702 Patient's reported Sex does not match the sex shown in the eligibility file. This makes the patient ID Number suspect as probably incorrect, especially the last two digits which identify separate family members.

703 Patient was ineligible for payment on the earliest date of service.

704 Patient was ineligible for payment on the last date of service.

705 Eligibility file indicates patient has applicable insurance coverage, but no Amount Received from Other Sources is shown and no code has been put in the Third Party Liability ("TPL") box to explain the exclusion.

707 The invoice has a code for collectable insurance in the TPL box but no Amount Received from Other Sources is shown.

708 Patient is restricted to a specified physician. In this case, this specified provider is neither the billing physician nor referring physician, nor is any supporting documentation on record to indicate that care provider was emergency care.

720 Maximum number of billings (services) for this item has been exceeded.

721 Provider ID Number on invoice does not match ID Number of provider prior-authorized to provide the services billed.

722 Number of prior-authorized billings has been exceeded.

723 Procedure billed was not on list of prior-authorized procedures. If no prior authorization is required, it may be rebilled on a separate invoice.

724 Submitted Prior Authorization Number is not on Prior-Authorization File.

725 Duplicate Prior Authorization on file.

729 Prior Authorization File shows inactive status.

APPENDIX H

CLAIM ADJUSTMENTS

If a provider has been paid too much or too little for a claim (because of errors, failure of insurance carriers to pay as expected, etc.) the amount paid may be corrected by an adjustment. Adjustments may be initiated by the State or by the provider. If a provider wishes to request an adjustment in the amount paid for a particular claim or part of a claim, the Adjustment Request form (DPW-1854) should be used. Adjustments may be requested only for paid claims which have been reported on a Remittance Advice as paid. Where a claim has been paid with denial of payment for a particular service within the claim, the Adjustment Request form may be used to seek reconsideration of the partial denial.

Adjustments are processed with invoices and are considered in determining how much a provider is to be paid at each pay cycle. Credits to providers are added into payment amounts. Debits in favor of the State are subtracted. Where debits exceed the amount owed to a provider at the end of a given pay cycle, the remaining debit balance is held over to be deducted from future payments to the provider. Providers should not submit checks to the State for adjustments in the State's favor unless instructed to do so.

Approved adjustments will be reported on the provider's Remittance Advice. Rejected adjustments will be reported either on the Remittance Advice or by letter.

CONDITIONS REQUIRING SUBMISSION OF AN ADJUSTMENT REQUEST FORM

1. Third Party Collections. When a provider receives third party payments on a claim amounting to more than the "Amount Received or Receivable from

CONDITIONS REQUIRING SUBMISSION OF AN ADJUSTMENT REQUEST FORM (Continued)

Other Sources" reported on the invoice to Medical Assistance, the excess over the amount reported on the invoice must be reported to the State on an Adjustment Request form.

2. Failure of Third Parties to Pay. If a provider has billed the State for part of a patient's bill, showing the balance as collectible from third party payers, that portion of the "Amount Received or Receivable from Other Sources" shown on the bill to Medical Assistance which is not received after ninety days may be reported on an Adjustment Request form for payment by the State.
3. Overpayment by the State. If the State pays a provider more than the provider's billed amount for an invoice or for a particular service, the overpayment must be reported on an Adjustment Request form.
4. Mistakes on Original Invoice. If a provider discovers substantial errors on an invoice submitted to the State and already paid, an Adjustment Request form must be submitted.
5. Apparent Errors in Payment by the State. If it appears that the State has made a mistake in processing a claim, an Adjustment Request form may be submitted. Overpayments must be reported (cf. # 3 above).

SUBMISSION OF ADJUSTMENT REQUEST FORMS

Completed Adjustment Request forms should be sent to:

MINNESOTA MEDICAL ASSISTANCE PROGRAM
Department of Public Welfare
Box 30197
St. Paul, Minnesota 55175

Keep the carbon copy. Remove carbon paper and edge strips. Attach supporting documentation with paper clips; do not write on the back of forms. Use a large envelope. Do not fold Adjustment Request forms, as portions of them may be read mechanically on the OCR scanning machine.

SEND REQUESTS TO: Minnesota Medical Assistance Program -- Department of Public Welfare, Box 30197, St. Paul 55175

ADJUSTMENT REQUEST

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER

1 .

ELITE PICA

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

ELITE PICA

PROVIDER INFORMATION

PROVIDER'S NAME 1

2

STREET ADDRESS

6

CITY/STATE/ZIP

7

3

8

RECIPIENT INFORMATION

RECIPIENT'S NAME (LAST, FIRST, INITIAL)

11

	ORIGINAL LINE NUMBER	REASON FOR CHANGE	CORRECTED SERVICE CODE					
1	16	17						
2	24	25						

THIRD PARTY ADJUSTMENTS ONLY

IF CONTINUATION

PAGE 35 OF 36

TOTALS

FOR OFFICE USE ONLY
DO NOT COMPLETE THESE ITEMS

DO NOT HAND WRITE OR MARK

EXPLANATION OR COMMENTS

PROVIDER CERTIFICATION

This is to certify that the information given above is correct. I understand that any payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws.

X

44 Authorized Signature

FOR DEPARTMENT USE ONLY

X

45 Approved by

DPW 1854 (8 74)

COMPLETION OF THE ADJUSTMENT REQUEST FORM DPW-1854

PROVIDER INFORMATION. Fill out this section the way an invoice would be filled out. Note, however, that there are three new boxes:

8. Claim Reference Number of Original Invoice to Be Adjusted. Enter the Claim Reference Number of the original invoice, as it was printed on the Remittance Advice which reported payment.
9. Own Reference Number from Original Invoice. Enter the account or patient number (if any) that was entered on the original invoice. This number appears on the carbon copy of the original invoice and on the Remittance Advice which reported payment.
10. Warrant Date from Remittance Advice. Enter the Warrant Date shown on the Remittance Advice which reported the original invoice as paid. This is the same as the date of payment on the Remittance Advice.

RECIPIENT INFORMATION

Fill out this section the way an invoice would be completed.

SERVICE CHARGE ADJUSTMENT INFORMATION

Fill out this section to request adjustment of the payment amount for particular services. If adjustment is requested for more than two service charges continuation pages may be used according to the instructions on the last page of the appendix.

15. Original Line Number. Enter the line number or line item code used on the original invoice for the service charges to be adjusted. This number appears on the Remittance Advice as well as on the original invoice.
16. Reason for Change. Enter one of the adjustment reason codes given in Appendix I. Do not use codes 01 and 51.
17. Corrected Service Code. Enter the corrected procedure code for the service actually rendered, if the code on the original invoice was wrong. Otherwise leave blank.

SERVICE CHARGE ADJUSTMENT INFORMATION (Continued)

18. Corrected Type (of Service). Enter the corrected modifier, or designator for family planning and early periodic screening for the service rendered, if applicable. Otherwise leave blank.

19. Corrected Units (of Service). Enter the corrected number of visits or other units of service, if applicable. Otherwise leave blank.

20. Requested Increase. Enter the amount of additional payment requested for the service in question, if any. If the service code originally reported was incorrect, show the amount by which the requested reimbursement for the correct service exceeds that already received for the incorrectly reported service. (i.e. show requested charge minus amount already paid.)

21. Requested Decrease. Enter the amount of overpayment for the service in question. If the wrong service was originally reported, and the requested charge for the service actually rendered is less than was paid, show the difference: paid amount minus requested amount.

22. Delete. An X entered here will cause the line of information to be disregarded. Use this box if the line cannot reasonably be corrected in typing. Then re-enter in the line below or on a continuation page.

23-30. These items are the same as Item 15 through Item 22. They allow a second service charge adjustment on the Adjustment Request form.

THIRD PARTY ADJUSTMENT INFORMATION

Fill out this line to report collections of insurance or other third party payments for services previously paid for by Medical Assistance. Also use this line to request increased State payment to cover anticipated insurance payment amounts which were refused.

31. Reason for Change. Enter one of the following codes to indicate the reason for adjustment:

THIRD PARTY ADJUSTMENT INFORMATION (Continued)

01 = Previous bill to Medical Assistance was reduced by an expected payment from a third party payer. This payment has not been made within ninety days of billing the third party, or payment was less than expected.

51 = Insurance or other payments have been collected to cover service billed to Medical Assistance, and the amount of these payments exceeds the amount originally subtracted (if any) from the bill to the State.

32. Third Party Underpayment. Enter the amount by which the "Amount Received or Receivable from Other Sources" entered on the original invoice exceeds what was actually paid by third parties.

33. Third Party Overpayment. Enter the amount by which third party payments exceeded the amount reported to the Medical Assistance program on the original invoice.

34. Delete. Enter an X in this box to cause this line to be disregarded by the OCR scanning machine. A new form must be used if an error is made in entering third party adjustment information.

TOTALS SECTION

35. Page Number. When more than one form is used for an adjustment, enter the page number here.

36. Number of Pages. Enter the total number of Adjustment Request forms used, if more than one page is needed for an adjustment request.

37. Sum of Requested Increases. Enter the total of service charge adjustment requested increases (Boxes 20 and 28) and third party underpayments (Box 32). If multiple forms are used, this total must include service charge adjustment requested increases from continuation pages. In other words when several pages (forms) are used, the final page should show the grand total in this box.

TOTALS SECTION (Continued)

38. Sum of Requested Decreases. Enter the total of service charge adjustment requested decreases (Boxes 21 and 29) and third party overpayments (Box 33). This total must also include service charge adjustment requested decreases from continuation pages.

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Leave this section entirely blank.

EXPLANATION OR COMMENTS SECTION

Explain in narrative form why an adjustment is being requested. If other materials or exhibits are attached, indicate that here.

PROVIDER CERTIFICATION

The applicant's signature is required here. Adjustment Request forms with typewritten, computer printed, or rubber stamp signatures will not be processed.

CONTINUATION ADJUSTMENT REQUEST FORMS

If adjustment is requested for more than two service charges, additional forms may be attached to the first Adjustment Request form to accommodate as many as eight service charge adjustments in all. (This means as many as four forms may be used if no service charge adjustment lines are deleted). Enter page number (Box 35) and number of pages (Box 36) on all forms.

On continuation pages the following information must be entered in the provider section: provider's name, provider's identification number, provider's own reference number, submission date, and claim reference number of original invoice to be adjusted (Boxes 2, 3, 4, 5 and 8). Enter the additional service charge adjustments below. Third party adjustment requests are made on the first form only. The totals information on continuation pages may be left blank since the

CONTINUATION ADJUSTMENT REQUEST FORMS (Continued)

sum of requested increases and sum of requested decreases on the first form include service charge adjustments on continuation forms. Other information may be left blank on continuation pages.

Attach all continuation pages to the first Adjustment Request form with a paper clip.

APPENDIX I

List of Reason for Adjustment Codes

*01 = Previous bill to Medical Assistance was reduced by an expected insurance payment by a third party which has not come through fully in 90 days. Credit provider.

02 = Credit provider for underpayment caused by claims processing system.

03 = Credit provider for underpayment caused by too-low State allowed charge.

04 = Original bill asked for too little. Credit provider.

05 = Original bill showed wrong service. Credit provider.

06 = Original bill showed wrong number of units. Credit provider.

*07 = Previous bill to Medical Assistance was reduced by expected payment from Workman's Compensation which has not come through fully in 90 days. Credit provider.

*08 = Previous bill to Medical Assistance was reduced by expected payment from family resources, which has not come through fully in 90 days. Credit provider.

*09 = Credit provider for gross adjustment caused by claims processing system.

*51 = Insurance payments have come in for services already paid for by Medical Assistance. Debit provider.

52 = Debit provider for payments made incorrectly on behalf of ineligible recipient.

53 = Debit provider for overpayment caused by claims processing system.

54 = Debit provider for overpayment caused by too-high State allowed charge.

55 = Debit provider for overpayment caused by use of wrong service code and charge on original invoice.

56 = Debit provider, miscellaneous reasons.

*57 = Workman's Compensation payment has been received for services already paid by Medical Assistance. Debit provider.

*58 = Family resources payment has been received for services already paid by Medical Assistance. Debit provider.

*59 = Debit provider for gross adjustment caused by claims processing system.

*60 = Debit provider for adjustment caused by other than processing system.

*Third Party Adjustment codes are 01, 07, 08, 09, 51, 57, 58, 59 and 60. Do Not use on line item adjustments.