STATE OF MINNESOTA

Department of Public Welfare

Psychological Services Handbook

Medical Assistance Program

PSYCHOLOGICAL SERVICES

GENERAL PSYCHOLOGICAL SERVICES

The general philosophy of this policy is to provide maximum benefits to the most recipients within budget limitations. This policy is intended to provide for the earliest reasonable intervention, to avoid hospitalization whenever possible, to encourage problem solving within a family setting, to encourage availability of community resources, and to encourage more intensive efforts to be aimed at adolescents and children.

ELIGIBLE PROVIDERS

All individuals currently licensed by the State of Minnesota Board of Examiners of Psychologists to practice within the field of psychological counseling and therapy as licensed consulting psychologists are eligible to participate in the Minnesota Medical Assistance Centralized Disbursement Program. The psychologist must also have completed a Medical Assistance Program Provider Agreement.

COVERED SERVICES

The Medical Assistance Program will pay for those procedures indicated in Psychological Services Bulletin No. 2.

SERVICE LIMITATIONS

The Medical Assistance program does limit the number of times some services may be given within specific time periods. Subsequent

SERVICE LIMITATIONS (Continued)

services given over these limits during the time period will not be reimbursed.

REIMBURSEMENT

Billing for services rendered should be according to the psychologist's usual and cutomary charge. The usual and customary charge is defined as that amount the practitioner charges in the majority of cases for a specific procedure or service.

The Social Security Amendments of 1972 (PL 92-603, Section 224) limit payments under Medical Assistance to the Medicare 75th percentile "prevailing charge" for any given service. This federal limitation is further spelled out in Title 45-Code of Federal Regulations (Section 250.30). The prevailing charge is defined as the range of charges made by providers with similar abilities and experience for like services rendered within the same socio-economic geographic area.

Note: This means that the Medical Assistance Program cannot pay more than Medicare. This does not mean that Medical Assistance pays only 75% of the Medicare maximum. The Medicare maximum is established at the 75th percentile of prevailing fees.

The Medical Assistance Program will reimburse psychologists for their usual and customary charges for services unless these amounts exceed the 75th percentile prevailing charges. In this case an automatic reduction will be made at the time of invoice payment. The amount of this reduction will be reflected on the remittance advice, which explains each payment check.

PROVIDERS MUST ENROLL

Providers must be enrolled in the Medical Assistance Program to receive payment for services rendered to Medical Assistance recipients. An eligible provider shall complete and sign a Provider Agreement. Failure to comply with federal and state statutes, rules and regulations pertinent to the M.A. program will result in termination of enrollment.

MEDICAL ASSISTANCE MAKES PAYMENT FOR ELIGIBLE RECIPIENTS ONLY

The Medical Assistance Program pays only for services rendered to eligible recipients.

a. Recipients should show a current MA/ID card (See example of card included) each time a service is provided. Eligibility can change on a month to month basis.

b. If recipient does not have a current MA/ID card, the provider can contact the local agency by phone or use Form DPW-1960 (See All Provider #15 Bulletin, copy enclosed), to verify eligibility and MA/ID number.

c. If the patient is eligible under Minnesota General Assistance Relief Program, or the state agency where indicated, bill the local welfare agency. (See All Provider #16 Bulletin enclosed.)

FEES PAID BY MEDICAL ASSISTANCE PROGRAM MUST BE REGARDED AS PAYMENT IN FULL

The provider must consider the fee paid by the Medical Assistance Program, in accordance with State maximum allowable limits, as payment in full. He/she is prohibited by law from requesting or receiving additional payment from the recipient or his/her relatives for authorized services or services in excess of those authorized.

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

BILLING LIMITATION

The Medical Assistance Program will pay only those bills submitted within one year of Date of Service. Medicare/Medicaid Assistance claims will be honored within Medicares time limit.

MEDICAL ASSISTANCE PROGRAM: PAYOR OF LAST RESORT

The Medical Assistance Program is payor of last resort.

The Physician and Osteopath may choose to have this program collect Third Party insurance, excluding Medicare. This is done by properly completing invoice forms as described in instruction for Invoice DPW-1497.

Payment will be made to provider in the usual manner while this agency is collecting from the insurance company. If the provider chooses to bill insurance directly, a ninety day waiting period is required prior to billing MA.

ASSIGNMENT OF MEDICARE BENEFITS MANDATORY FOR MA PAYMENT

If a provider of service who is eligible to accept Medicare assignments wishes to be paid by the M.A. program, such provider shall accept assignments on Medicare billings and shall bill Medicare prior to billing the M.A. program.

SURVEILLANCE OF CLAIMS

All claims submitted to the Medical Assistance Program are to accurately reflect the medical care actually provided. They are to include only services which are medically necessary and which are allowed under MA policy.

The Surveillance and Utilization Review Division with recipient consent, is authorized to have access to all Medical records of Medical Assistance recipients for purposes of investigating the propriety of claims submitted. Medical records obtained are private data as defined in Minnesota statutes.

Claims paid by the Program may be reviewed and verified with the recipients receiving the services and/or with records maintained by the provider. Misrepresentation of services provided may result in administrative or legal action.

MAILING OF PAYMENT CHECKS

Checks will be mailed bi-weekly from the Department of Finance. Providers must report any change in status, address, licensing, certification, board specialities, corporate name, or ownership to the claims processing unit, either by phone or by mail.

PHYSICIAN BILLING PROCEDURES

GENERAL DESCRIPTION

Enrolled physicians must bill for services to eligible recipients on the Practitioner Invoice, DPW-1497 (6-74). This invoice is designed to include billing for all services rendered to an individual recipient.

SUBMISSION OF INVOICE

In order to facilitate computer processing and achieve prompt payment of claims, the Department of Public Welfare is using a highspeed optical character reading equipment to process all claim data. This equipment is designed to read black (or very dark) typewritten numbers and capital letters in all type styles except italic and script.

1. Type only in white area except dates of service.
2. USE ONLY BLACK INK and change ribbons as needed to ensure bold and dark characters.
3. Properly align each form in the typewriter, by using the elite or pica label box provided at the top of each invoice.
4. Do not type over errors made. Use correction fluid neatly and sparingly or delete line by placing an "X" in delete box.
5. All dates entered on the invoice are to be entered in the following format: (01/06/75).
6. All monetary amounts must be entered in the dollars and cents format (12.55).

COMPLETION OF DPW-1497

Submitting a Practitioner Invoice is a request for payment of services rendered. The invoice has information grouped together.

SEND INVOICES TO: Minnesota Medical Assistance Program -- Department of Public Welfare, Box 43166, St. Paul 55164

PRACTITIONER INVOICE

Claims Processing Document Control Number

1

ELITE PICA — TYPEWRITER ALIGNMENT — ELITE PICA

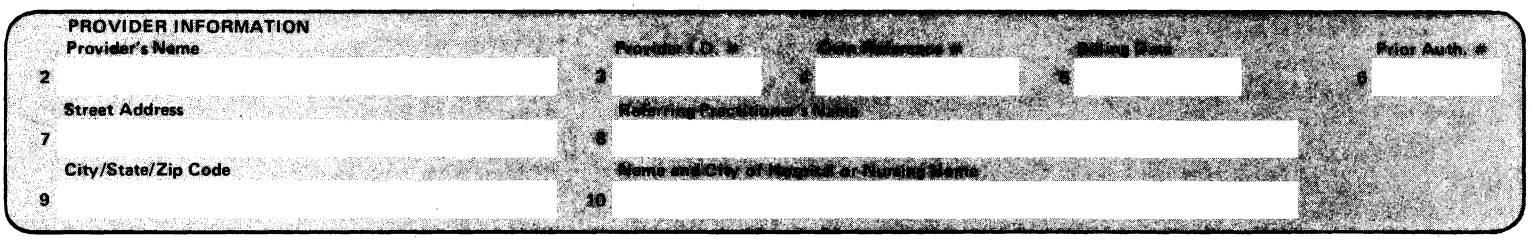
USE CAPITAL LETTERS ONLY

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

Claims Processing Document Control Number (Box 1)

Leave blank.

PROVIDER INFORMATION



Provider's Name (Box 2)

Enter the physician's name. If the provider doing the billing is a group, enter the name of the group.

Provider I.D. Number (Box 3)

Enter the physician's individual or group 7 digit indentification number.

Own Reference Number (Box 4)

The provider may enter his own account reference number, which may include as many as 9 letters and/or numbers, to accommodate individual filing systems. Numbers are preferred for accuracy of scanning. This information is not mandatory but, if furnished, will appear on the Remittance Advice.

PROVIDER INFORMATION Con't.

Billing Date (Box 5)

Enter the date the invoice is completed .

Prior Authorization Number (Box 6)

Leave blank unless the services were prior authorized.

Street Address (Box 7)

Enter the street address of the provider.

Referring Practitioner's Name (Box 8)

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

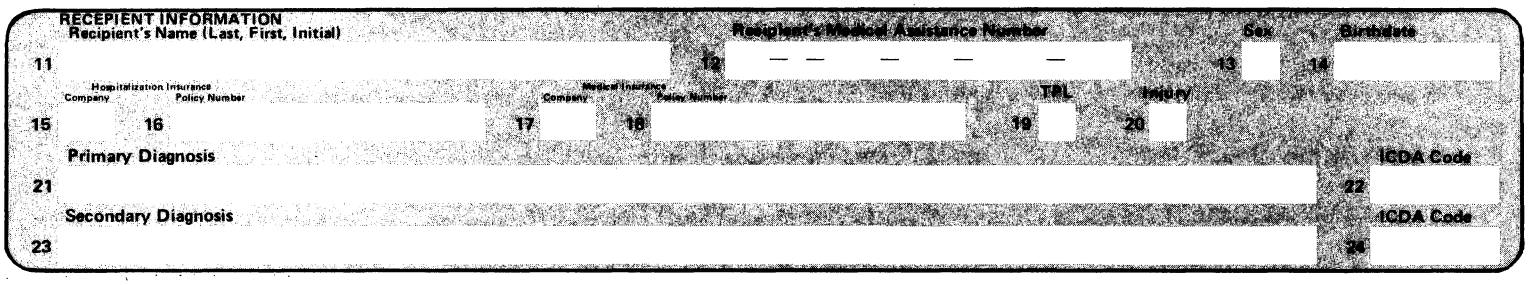
City/State/Zip Code (Box 9)

Enter the city, state and zip of the provider.

Name and City of Hospital or Nursing Home (Box 10)

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

RECIPIENT INFORMATION



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

Enter the recipient'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.

Recipient's Medical Assistance Number (Box 12)

Enter the 16 digit number as shown on the recipient's Medical Assistance identification card, DO NOT TYPE IN THE DASHES. They are provided on the form.

RECIPIENT INFORMATION (Continued)

Sex (Box 13)

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

Birthdate (Box 14)

Enter the patient's birthdate exactly as it appears on the MAID card.

Hospitalization Insurance Company (Box 15)

Leave blank.

Hospitalization Insurance Policy Number (Box 16)

Leave blank.

Medical Insurance Company (Box 17)

Leave blank.

Medical Insurance Policy Number (Box 18)

Leave blank.

TPL Codes (Box 19)

Fill in the appropriate code to indicate third party liability.

1. No insurance company indicated on Medical Assistance Identification Card.
2. One or more insurance companies billed.
3. Patient's insurance company billed, but no amount was received as deductible amount had not been met.
4. Patient's known insurance policies do not cover any part of claim.
5. Patient's known insurance benefits applicable to this claim are exhausted.
6. Patient's known insurance no longer in force.
7. Insurance company reject-reason unknown.
8. Provider unable to secure necessary papers and/or signature from recipient to allow claims filing.
9. No insurance company indicated on Medical Assistance Identification Card, but provider feels insurance coverage may exist.

RECIPIENT INFORMATION (Continued)

Injury (Box 20)

All invoices must indicate an Injury Code:

1. *Problem not related to accident or employment.
2. Work-related accident or disease.
3. Accident.
4. Auto accident.
5. Auto accident occurring after 1/1/75 for which incurred expenses exceed $20,000 or contractual liability.
6. *Billing from pathologists, radiologists and anesthesiologists, (new code, effective 9/1/75).

*Injury Code 1 and 6 are only necessary to assure that the injury code field on the invoice is not blank.

Anesthesiologists, radiologists and pathologists must use injury code 6 and their invoices must reflect the name of the referring physician.

Primary Diagnosis (Box 21)

In current medical terminology, describe the medical condition for which the patient is being treated.

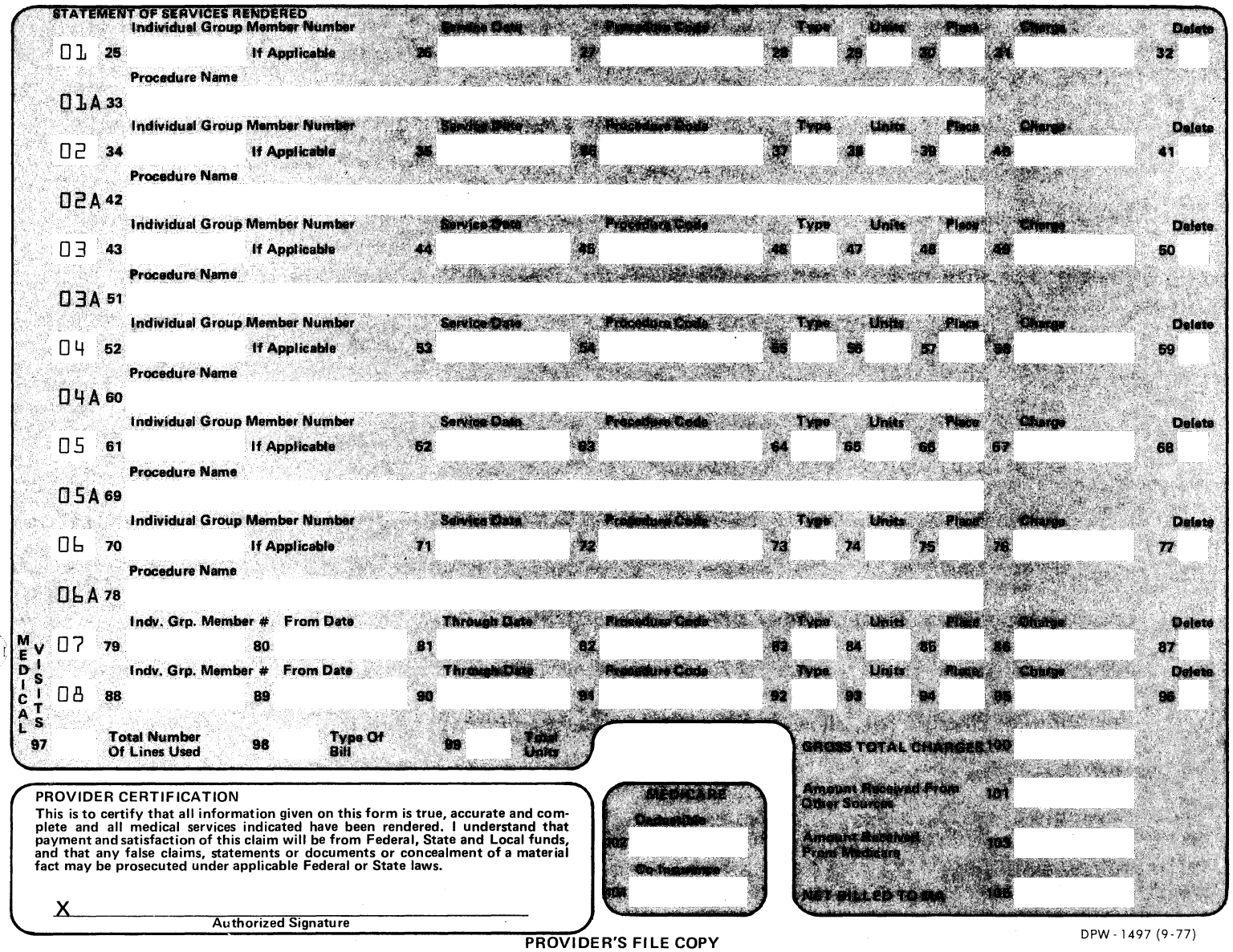
ICDA Code (Box 22)

It is preferable to enter the ICDA code for the primary diagnosis as found in the Second Edition of the H-ICDA. Codes from the H-ICDA-2 must be prefixed with an "H". The primary diagnosis as found in the Eighth Revision of the International Classification of Diseases Adapted for Use in the United States (ICDA) will be acceptable. Codes from the ICDA-8 should not be prefixed with an H.

Secondary Diagnosis and ICDA Code (Box 23 and 24)

Enter any significant secondary diagnosis and its code.

STATEMENT OF SERVICES RENDERED



Individual Group Member Number (Box 25)

Enter the ID Number of the individual practitioner who performed or supervised the procedure.

Service Date (Box 26)

Enter the date the service was rendered.

Procedure Code (Box 27)

Enter the appropriate code from the Current Procedural Terminology Third Edition (CPT3) for the procedure involved.

STATEMENT OF SERVICES RENDERED Con't.

Type (Box 28)

Use this space for reporting modifiers. A complete list of modifiers is found on pages 371 and 372 of the CPT3.

Units (Box 29)

It is necessary to complete the number of the times a service was rendered during a span of time.

Place (Box 30)

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

Charge (Box 31)

Enter the charge for the service, omitting the dollar ($) sign.

Delete (Box 32)

To delete a claim line containing errors, enter and "X".

Procedure Name (Box 33)

Use Current Procedural Terminology to describe the service rendered.

STATEMENT OF SERVICES RENDERED (Continued)

Boxes 34. - 96.

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.

SUMMARY SECTION

Box 97. Total Number of Lines Used

Leave blank.

Box 98. Type of Bill

Enter: 2 = None-Medicare related bill.

8 = Medicare Non-covered Service

Box 99. Total Units

Leave blank.

Box 100. Gross Total Charges

Enter the total of the above charges, omitting the dollar ($) sign.

Box 101. Amount Received From Other Sources

Enter the amount from other sources.

Box 102. Deductible

Leave blank.

Box 103. Amount Received from Medicare

Leave blank.

Box 104. Co-insurance

Leave blank.

Box 105. Net Billed to M.A.

+ Gross total charges

- Amount received from other sources

= Net Billed to M.A.

PROVIDER CERTIFICATION

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

BILLING PROCEDURES FOR RECIPIENTS ENTITLED TO BOTH MEDICARE AND MEDICAL ASSISTANCE

MEDICARE COVERED SERVICES

If the service provided is covered or partially covered by Medicare, you must bill Medicare directly as follows:

1. Fill out Request for Medicare Payment, Form SSA-1490. On line 5 indicate Minnesota Medical Assistance. This will enable Medicare to send an tion of Medicare Benefits (EOMB) to the Medical Assistance Program.
2. Accept assignment.
3. Mail original 1490 to Medicare carrier.

Upon receipt of the EOMB from the Medicare carrier, the Medical Assistance Program will automatically pay deductible, co-insurance and certain non-covered services to the provider of service.

MEDICARE NON-COVERED SERVICES

If you are sure that the service provided is never covered under Medicare and if the service was rendered separately (i.e. flu injections) you may bill Medical Assistance directly as follows:

1. Fill out Physician Invoice, DPW-1497.
2. Put "8" in type box 98.

If you are not sure whether a service provided is covered under Medicare, bill Medicare directly as a Medicare Crossover Claim.

MAILING 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:

MAILING OF INVOICE (Continued)

1. Use the envelopes supplied by the State Department of Public Welfare for mailing invoices.
2. 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.)
3. Do not fold, or otherwise mutilate the invoice.
4. 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.
5. Do not submit a continuous sheet.

SEND INVOICES TO: Minnesota Medical Assistance Program -- Department of Public Welfare, Box 43166, St. Paul 5510

PRACTITIONER INVOICE

Claims Processing Document Control Number
1

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

PROVIDER INFORMATION

Provider's Name	Provider I.D. #	Own Reference #	Billing Date	Prior Auth. #
2 MEDICAL CENTER, P.A.	3 2100659	4 92183578	5 10/14/77	6

Street Address: 7 690 NORTH ROBERT STREET
Referring Practitioner's Name: 8
City/State Zip Code: 9 ANYTOWN, MN 55164
Name and City of Hospital or Nursing Home: 10

Recipient's Name (Last, First, Initial)	Recipient's Medical Assistance Number	Sex	Birthdate
11 ANDERSON, JANE	12 27-2- 000 004 2644 101	13 F	14 11/26/55

Medical Insurance Company	Medical Insurance Policy Number	TPL	Injury
15 16	17 18	19	20 1

Primary Diagnosis: 21 PNEUMONIA, VIRAL — ICDA Code: 22 H480
Secondary Diagnosis: 23 — ICDA Code: 24

STATEMENT OF SERVICES RENDERED

	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Date
01 25	201290X	26 10/03/77	90050	28	29	30 1	31 15.00	
	Procedure Name							
01A 32	LIMITED OFFICE VISIT							
	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Date
02 34	201290X	35 10/03/77	71020	37	38	39 1	40 14.50	
	Procedure Name							
02A 42	CHEST X-RAY PA AND LATERAL							
	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Date
03 43	201290X	44 10/03/77	85050	46	47	48 1	49 5.50	
	Procedure Name							
03A 51	HGB							
	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Date
04 52	210290X	53 10/10/77	90040	55	56	57 1	58 10.00	
	Procedure Name							
04A 60	BRIEF OFFICE - RECHECK OF PNEUMONIA							
	Individual Group Member Number	Service Date	Procedure Code	Type		Place	Charge	Date
05 61	210290X	62 10/10/77	71020	64		1 67	14.50	
	Procedure Name							
05A 69								
	Individual Group Member Number If Applicable	Service Date	Procedure Code		Units	Place	Charge	Date
06 70		71	72		74	75	76	77
	Procedure Name							
06A 78								
MEDICAL VISITS	Indv. Grp. Member # From Date	Through Date	Procedure Code	Type	Units	Place	Charge	Date
07 79	80	81	83	84	85	86		87
08 88	Indv. Grp. Member # From Date 89		Procedure Code 91	Type 92	Units 93	Place 94	Charge 95	Date 96

EXAMPLE OF PRACTITIONER INVOICE

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

GROSS TOTAL CHARGES 100 59.50

Amount Received From Other Sources 101

Amount Received From Medicare 103

NET BILLED TO MA 105 59.50

PROVIDER CERTIFICATION

This is to certify that all information given on this form is true, accurate and complete and all medical services indicated 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 _____
Authorized Signature

MEDICARE
Deductible 102
Co-Insurance 104

DPW 1497 (9-77)
741988

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

PRACTITIONER INVOICE

APPENDIX F
Figure 1A

Claims Processing Document Control Number
1 750437800

ELITE XXX PICA

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

ELITE XXX PICA

PROVIDER INFORMATION

Provider's Name	Provider I.D. #	Own Reference #	Billing Date	Prior Auth. #
2 BALDINGER JOSEPH L	3 4200010	4 29984	5 03/10/75	6

Street Address	Referring Practitioner's Name
7 123 OAKWOOD AVE	8 JONES WILLIAM Q
City/State/Zip Code	Name and City of Hospital or Nursing Home
9 ST PAUL MN 55100	10

RECEFIENT INFORMATION

Recipient's Name (Last, First, Initial)	Recipient's Medical Assistance Number	Sex	Birthdate
11 BENDIX ROBERT H	12 62-8-000-021-4771-101	13 M	14 04/02/46

Hospitalization Insurance Company	Hospitalization Insurance Policy Number	Medical Insurance Company	Medical Insurance Policy Number	TPL	Injury
15	16	17	18	19	20 1

Primary Diagnosis	ICDA Code
21 SOCIOPATHIC PERSONALITY	22 H311.7
Secondary Diagnosis	ICDA Code
23	24

STATEMENT OF SERVICES RENDERED

	Individual Group Member Number / If Applicable	Service Date	Procedure Code	Type	Units	Place	Charge	Delete
01	25	26 03/07/75	27 908259	28	29	30 1	31 45.00	32
	Procedure Name							
01A	33 PSYCHOLOGICAL TESTING EVALUATION REPORTS AND HOSP RECORDS							
02	34	35	36	37	38	39	40	41
	Procedure Name							
02A	42							
03	43	44	45	46	47	48	49	50
	Procedure Name							
03A	51							
04	52	53	54	55	56	57	58	59
	Procedure Name							
04A	60							
05	61	62	63	64	65	66	67	68
	Procedure Name							
05A	69							
06	70	71	72	73	74	75	76	77
	Procedure Name							
06A	78							

MEDICAL VISITS	Indv. Grp. Member # / From Date	Through Date	Procedure Code	Type	Units	Place	Charge	Delete
07	79 80	81	82	83	84	85	86	87
08	88 89	90	91	92	93	94	95	96

97 1 Total Number Of Lines Used | 98 4 Type Of Bill | 99 0 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 JOSEPH L. BALDINGER
Authorized Signature

MEDICARE

Deductible
102 00.00
Co-Insurance
104 9.00

GROSS TOTAL CHARGES	100	45.00
Amount Received From Other Sources	101	
Amount Received From Medicare	103	36.00
NET BILLED TO MA	105	9.00

DPW 1497 (6 74)

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

PRACTITIONER INVOICE

APPENDIX F
FIGURE 1B

Claims Processing Document Control Number
1 750426650

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

PROVIDER INFORMATION

Provider's Name	Provider I.D. #	Own Reference #	Billing Date	Prior Auth. #
2 BALDINGER JOSEPH L	3 4200010	4 33728	5 03/10/75	6

Street Address	Referring Practitioner's Name
7 123 OAKWOOD AVE	8 JONES WILLIAM Q
City/State/Zip Code	Name and City of Hospital or Nursing Home
9 ST PAUL MN 55100	10 GENERAL HOSPITAL ST PAUL

RECIPIENT INFORMATION

Recipient's Name (Last, First, Initial)	Recipient's Medical Assistance Number	Sex	Birthdate
11 CASEY BEATRICE O	12 62 8 000 010 2579 101	13 F	14 11/13/37

Hospitalization Insurance Company	Hospitalization Insurance Policy Number	Medical Insurance Company	Medical Insurance Policy Number	TPL	Injury
15 00	16 2817394056	17	18	19 1	20 1

Primary Diagnosis	ICDA Code
21 SCHIZOPHRENIA SCHIZO-AFFECTIVE TYPE	22 H306.7
Secondary Diagnosis	ICDA Code
23	24

STATEMENT OF SERVICES RENDERED

	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Delete
01	25 If Applicable	26 03/09/75	27 908011	28	29 1	30 3	31 30.00	32
	Procedure Name							
01A	33 DIAGNOSTIC INTERVIEW EXAM WITH HISTORY, PSYCH STUDIES							
	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Delete
02	34 If Applicable	35	36	37	38	39	40	41
	Procedure Name							
02A	42							
	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Delete
03	43 If Applicable	44	45	46	47	48	49	50
	Procedure Name							
03A	51							
	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Delete
04	52 If Applicable	53	54	55	56	57	58	59
	Procedure Name							
04A	60							
	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Delete
05	61 If Applicable	62	63	64	65	66	67	68
	Procedure Name							
05A	69							
	Individual Group Member Number	Service Date	Procedure Code	Type	Units	Place	Charge	Delete
06	70 If Applicable	71	72	73	74	75	76	77
	Procedure Name							
06A	78							
	Indv. Grp. Member # From Date	Through Date	Procedure Code	Type	Units	Place	Charge	Delete
MEDICAL VISITS 07	79 80	81	82	83	84	85	86	87
	Indv. Grp. Member # From Date	Through Date	Procedure Code	Type	Units	Place	Charge	Delete
08	88 89	90	91	92	93	94	95	96

97 1 Total Number Of Lines Used — 98 2 Type Of Bill — 99 1 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 JOSEPH L. BALDINGER
Authorized Signature

MEDICARE

102 Deductible

104 Co-Insurance

GROSS TOTAL CHARGES	100	30.00
Amount Received From Other Sources	101	15.00
Amount Received From Medicare	103	
NET BILLED TO MA	105	15.00

DPW 1497 (6-74)

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

PRACTITIONER INVOICE

APPENDIX F
FIGURE 1C

Claims Processing Document Control Number
1 750425700

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

PROVIDER INFORMATION

Provider's Name	Provider I.D. #	Own Reference #	Billing Date	Prior Auth. #
2 BALDINGER JOSEPH L	3 4200010	4 26739	5 03/15/75	6

Street Address: 7 123 OAKWOOD A VE
Referring Practitioner's Name: 8
City/State/Zip Code: 9 ST PAUL MN 55100
Name and City of Hospital or Nursing Home: 10

RECIPIENT INFORMATION

Recipient's Name (Last, First, Initial)	Recipient's Medical Assistance Number	Sex	Birthdate
11 HENNING LORNA R	12 62 2 000 019 6636 101	13 F	14 07/31/35

Hospitalization Insurance Company / Policy Number: 15 / 16
Medical Insurance Company / Policy Number: 17 / 18
TPL: 19
Injury: 20 1

Primary Diagnosis: 21 NEURASTHENIC NEUROSIS
ICDA Code: 22 H310.6
Secondary Diagnosis: 23
ICDA Code: 24

STATEMENT OF SERVICES RENDERED

	Individual Group Member Number / If Applicable	Service Date	Procedure Code	Type	Units	Place	Charge	Delete
01	25 / 26	03/14/75	27 908419	28	29 4	30 1	31 30.00	32
	Procedure Name							
01A	33 INDIVIDUAL PSYCHOTHERAPY							
02	34 / 35		36	37	38	39	40	41
	Procedure Name							
02A	42							
03	43 / 44		45	46	47	48	49	50
	Procedure Name							
03A	51							
04	52 / 53		54	55	56	57	58	59
	Procedure Name							
04A	60							
05	61 / 62		63	64	65	66	67	68
	Procedure Name							
05A	69							
06	70 / 71		72	73	74	75	76	77
	Procedure Name							
06A	78							

MEDICAL VISITS

Indv. Grp. Member #	From Date	Through Date	Procedure Code	Type	Units	Place	Charge	Delete
07 79	80	81	82	83	84	85	86	87
08 88	89	90	91	92	93	94	95	96

97 1 Total Number Of Lines Used
98 2 Type Of Bill
99 4 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 JOSEPH L. BALDINGER
Authorized Signature

MEDICARE

Deductible 102
Co-Insurance 104

GROSS TOTAL CHARGES	100	30.00
Amount Received From Other Sources	101	
Amount Received From Medicare	103	
NET BILLED TO MA	105	30.00

DPW 1497 (6-74)

SEND REQUESTS TO: Minnesota Medical Assistance Program -- Department of Public Welfare, Box 43170, St. Paul 55164

ADJUSTMENT REQUEST

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER
1

ELITE PICA — TYPEWRITER ALIGNMENT — ELITE PICA

USE CAPITAL LETTERS ONLY

PROVIDER INFORMATION

PROVIDER'S NAME	PROVIDER ID #	OWN REFERENCE #	SUBMISSION DATE
2	3	4	5

STREET ADDRESS
6

CITY/STATE/ZIP	CLAIM REFERENCE NUMBER OF ORIGINAL INVOICE TO BE ADJUSTED	OWN REFERENCE NUMBER FROM ORIGINAL CLAIM	WARRANT DATE FROM REMITTANCE ADVICE
7	8	9	10

RECIPIENT INFORMATION

RECIPIENT'S NAME (LAST, FIRST, INITIAL)	RECIPIENT'S MEDICAL ASSISTANCE NUMBER	SEX	BIRTHDATE
11	12 — — — — —	13	14

	ORIGINAL LINE NUMBER	REASON FOR CHANGE	CORRECTED SERVICE CODE	CORRECTED TYPE	CORRECTED UNITS	REQUESTED INCREASE	REQUESTED DECREASE	DELETE
1	15	16	17	18	19	20	21	22
2	23	24	25	26	27	28	29	30

THIRD PARTY ADJUSTMENTS ONLY

	REASON FOR CHANGE	THIRD PARTY UNDERPAYMENT	THIRD PARTY OVERPAYMENT	DELETE
	31	32	33	34

IF CONTINUATION — PAGE 35 OF 36

	SUM OF REQUESTED INCREASES	SUM OF REQUESTED DECREASES
TOTALS	37	38

FOR OFFICE USE ONLY

DO NOT COMPLETE THESE ITEMS 39 40 41 42 43

DO NOT HAND WRITE OR MARK ABOVE THIS LINE

EXPLANATION OR COMMENTS

PROVIDER CERTIFICATE

I certify that all information given on this form is true, accurate and complete and all medical services indicated 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
44 Authorized Signature

FOR DEPARTMENT USE ONLY

X
45 Approved by

DPW-1854 (8-7)
73721

COMPLETION OF ADJUSTMENT FORM

Submitting an Adjustment Request is a request for an adjustment to a paid claim. The Adjustment Request, DPW 1854, has information items grouped together.

ADJUSTMENT HEADING

END REQUESTS TO: Minnesota Medical Assistance Program -- Department of Public Welfare, Box 43170, St. Paul 55164

ADJUSTMENT REQUEST

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER

1

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

The heading contains the address to which all adjustments must be sent and the typewriter allignment tabs. It also contains:

1. Claims processing document Control Number.

   Do not complete this item

PROVIDER INFORMATION

PROVIDER INFORMATION

PROVIDER'S NAME	PROVIDER ID #	OWN REFERENCE #	SUBMISSION DATE
	3	4	5
STREET ADDRESS			
CITY/STATE/ZIP	CLAIM REFERENCE NUMBER OF ORIGINAL INVOICE TO BE ADJUSTED	OWN REFERENCE NUMBER FROM ORIGINAL CLAIM	WARRANT DATE FROM REMITTANCE ADVICE
	8	9	10

2. Provider's Name

   Enter the physician's name as enrolled

3. Provider ID #

   Enter the number as it appeared on the Remittance Advice which reported the invoice paid.

4. Own Reference #

   The provider may enter his own account reference number, which may include as many as 9 letters and/or numbers to accommodate individual filing systems. This information is not mandatory but, if furnished, will appear on the Remittance Advice.

5. Submission Date

   Enter the Current Date

6. Providers Address

   Enter the street address of the provider

7. City/State/Zip

Enter city, state and zip code

8. Claims Reference Numbers of Orginal Invoice to be Adjusted

Enter the 15 digit claim reference number of the invoice being adjusted exactly as it appeared on the Remittance Advice which reported the invoice as paid. The adjustment cannot be processed if this number is inaccurate.

9. Own Reference Number from Original Invoice

Enter the account or patient number (if any) that was entered on original invoice.

10. Warrant Date from Remittance Advice

Enter the date of payment on the Remittance Advice which reported the original claim as paid.

RECIPIENT INFORMATION

RECIPIENT INFORMATION RECIPIENT'S NAME (LAST, FIRST, INITIAL)	RECIPIENT'S MEDICAL ASSISTANCE NUMBER	SEX	BIRTHDATE
11	12 — — — — —	13	14

11 - 14 Recipient Information

Enter the recipient's name and Medical Assistance number exactly as it appeared on Remittance Advice. Even though this information may have changed, it must be reported as it appeared at the time the claim was paid.

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 services charges, continuation pages may be used according to the instructions on last page of this section.

	ORIGINAL LINE NUMBER	REASON FOR CHANGE	CORRECTED SERVICE CODE	CORRECTED TYPE	CORRECTED UNITS	REQUESTED INCREASE	REQUESTED DECREASE	DELET
1	15	16	17	18	19	20	21	22
2	23	24	25	26	27	28	29	30

15. Original Line Number

Enter the line number or line item code used on original invoice for the service charge to be adjusted. This number appears on the Remittance Advice as well as on the original invoice.

16. Reason for Change

Enter the adjustment reason codes given at the end of this section.

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.

18. Corrected Type (of service)

Enter the corrected modifier 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.

21. Requested Decrease

Enter the amount of overpayment for the service in question.

22. Delete

To delete a line containing errors, enter an X.

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

THIRD PARTY ADJUSTMENT INFORMATION

Fill out this section when an adjustment is being made to an entire Invoice rather than a line item.

THIRD PARTY ADJUSTMENTS ONLY	REASON FOR CHANGE 31	THIRD PARTY UNDERPAYMENT 32	THIRD PARTY OVERPAYMENT 33	DELETE 34

31. Reason for Change

Use only the asterisked reason codes.

32. Third party underpayment

Enter the amount of underpayment.

33. Third party overpayment

Enter the amount of the overpayment

34. Delete

A new form must be completed if an error is made in entering third party adjustment information

TOTAL SECTION

IF CONTINUATION PAGE 35 OF 36		SUM OF REQUESTED INCREASES	SUM OF REQUESTED DECREASES
	TOTALS 37	38	

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 Requests used if more than one page is needed for an adjustment request.

37. Sum of Requested Increases

Enter the total requested increase (boxes 20 and 28). Please note that a third party adjustment and a line item adjustment cannot be done on the same adjustment request.

38. Sum of Requested Decrease

Enter the total requested decrease (boxes 21 and 29)

FOR OFFICE USE ONLY

FOR OFFICE USE ONLY					
DO NOT COMPLETE THESE ITEMS	39	40	41	42	43

DO NOT HAND WRITE OR MARK ABOVE THIS LINE

39 - 43 Leave this Section Blank.

EXPLANATION OR COMMENTS

EXPLANATION OR COMMENTS

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

PROVIDER CERTIFICATION

PROVIDER CERTIFICATION
This is to certify that all information given on this form is true, accurate and complete and all medical services indicated 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
44 Authorized Signature

FOR DEPARTMENT USE ONLY

X
45 Approved by

DPW 1854 (8-76)
737205

The Adjustment Request must be signed by the provider. 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. Enter page number (box 35) and number of pages (box 36) on all forms. Provider information must be completed on all continuation pages. The totals information and continuation pages may be left blank since the sum requested increases or decreases on the first form include charges adjustment on continuation form.

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

CREDIT TO PROVIDER

I. Provider Errors
Underpayment due to:
*10 Misc. (explanation must be included)
11 Incorrect service code
12 Incorrect number of units
13 Incorrect modifier or type
14 Incorrect submitted charge
*15 Overstated Medicare collection

II. System Errors
Underpayment due to:
31 Reference file (fee schedule)
32 Computer misscan
*33 Medicare coinsurance/deductible
*39 Misc. (explanation must be included)

III. Third Party Collections
Underpayment due to:
*21 Overstated health insurance recovery
*24 Overstated Workmen's Compensation recovery
*29 Other (explanation must be included)

DEBIT TO PROVIDER

I. Provider Errors
Overpayment due to:
*60 Misc. (explanation must be included)
61 Incorrect service code
62 Incorrect number of units
63 Incorrect modifier or type
64 Incorrect submitted charge
*65 Later collection from Medicare

II. System Errors
Overpayment due to:
*80 Duplicate payment
81 Reference file (fee schedule)
82 Computer misscan
*83 Medicare coinsurance/deductible
*87 Payment to wrong provider
*88 Payment for ineligible recipient
*89 Misc.(explanation must be included)

III. Third Party Collections
Overpayment due to:
*71 Health insurance recovery
*74 Workmen's Compensation recovery
*75 Auto insurance recovery
*79 Other (explanation must be included)

* These codes are to be used in Box 31 only.

ADJUSTMENT REQUEST

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER
1

ELITE XXX PICA — TYPEWRITER ALIGNMENT — ELITE XXX PICA

USE CAPITAL LETTERS ONLY

PROVIDER INFORMATION

PROVIDER'S NAME	PROVIDER ID #	OWN REFERENCE #	SUBMISSION DATE
2 CYRUS SMITH MD	3 2034567	4 123	5 09/26/75

STREET ADDRESS
6 690 NORTH ROBERT STREET

CITY/STATE/ZIP	CLAIM REFERENCE NUMBER OF ORIGINAL INVOICE TO BE ADJUSTED	OWN REFERENCE NUMBER FROM ORIGINAL CLAIM	WARRANT DATE FROM REMITTANCE ADVICE
7 ST. PAUL MN 55164	8 75239079001110	9 46	10 09/15/75

RECIPIENT INFORMATION

RECIPIENT'S NAME (LAST, FIRST, INITIAL)	RECIPIENT'S MEDICAL ASSISTANCE NUMBER	SEX	BIRTHDATE
11 BETTY JONES	12 62-8-000-000-4444-101	13 F	14 02/16/33

	ORIGINAL LINE NUMBER	REASON FOR CHANGE	CORRECTED SERVICE CODE	CORRECTED TYPE	CORRECTED UNITS	REQUESTED INCREASE	REQUESTED DECREASE	DELETE
1	15 03	16 11	17	18	19 10	20 50.00	21	22
2	23	24	25	26	27	28	29	30

THIRD PARTY ADJUSTMENTS ONLY

REASON FOR CHANGE	THIRD PARTY UNDERPAYMENT	THIRD PARTY OVERPAYMENT	DELETE
31	32	33	34

IF CONTINUATION PAGE 35 OF 36

	SUM OF REQUESTED INCREASES	SUM OF REQUESTED DECREASES
TOTALS 37	50.00	38

FOR OFFICE USE ONLY
DO NOT COMPLETE THESE ITEMS 39 40 41 42 43

DO NOT HAND WRITE OR MARK ABOVE THIS LINE

EXPLANATION OR COMMENTS

We billed for 2 units when we should have billed for 10 units.

EXAMPLE OF ADJUSTMENT REQUEST FORM

PROVIDER CERTIFICATE
This is to certify that all information given on this form is true, accurate and complete and all medical services indicated 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.

44 X Your Signature
Authorized Signature

FOR DEPARTMENT USE ONLY

45 X
Approved by

DPW-1854 (8-76)
737209

PRIOR AUTHORIZATION

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER
1

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

PROVIDER INFORMATION

2 PROVIDER'S NAME
3 PROVIDER ID #
4 OWN REFERENCE #
5 DATE SUBMITTED
6 STREET ADDRESS
7 CITY/STATE/ZIP
8 NAME AND CITY OF HOSPITAL OR LTC FACILITY
9 PRIOR AUTHORIZATION # 0975771

RECIPIENT INFORMATION

10 PATIENT'S NAME
11 PATIENT'S MEDICAL ASSISTANCE NUMBER
12 SEX
13 BIRTHDATE

REQUESTED AUTHORIZATION

	SERVICE NAME	SERVICE CODE	TRANSACTION	PROPOSED CHARGE	REQ. # OF BILLINGS	DELETE	ALLOWED # BILLINGS	APPROVED	DENIED	AUTHORIZED CHARGE
1	14	15	16	17	18	19	20	21	22	23
2	24	25	26	27	28	29	30	31	32	33
3	34	35	36	37	38	39	40	41	42	43
4	44	45	46	47	48	49	50	51	52	53
5	54	55	56	57	58	59	60	61	62	63

54 TOTAL NUMBER OF LINES ENTERED
55 OFFICE USE ONLY
56 TOTAL PROPOSED CHARGES
57 TOTAL AUTHORIZED CHARGES

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

Reviewed By (For Department Use Only)

x Your Signature
Provider's Signature

SERVICES AUTHORIZED (AS INDICATED ABOVE). HOWEVER, PAYMENT DEPENDS UPON RECIPIENT BEING ELIGIBLE AT THE TIME SERVICE IS PROVIDED

SUBMIT ALL COPIES TO ABOVE ADDRESS

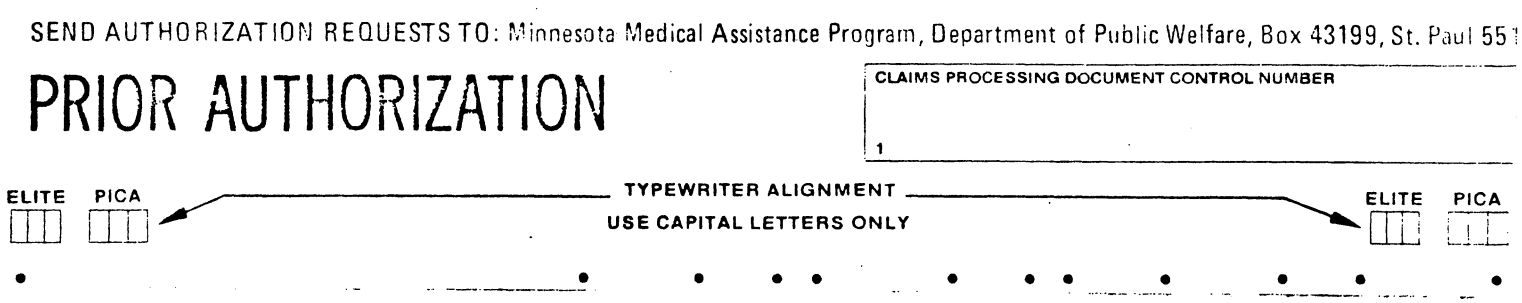
PZ-01855-02
DPW-1855 (10-
740767

COMPLETION OF THE PRIOR AUTHORIZATION FORM DPW-1855

Submitting a Prior Authorization is a request for approval of a procedure, service or material. Approval is not a guarantee of payment. Payment can only be made if recipient is eligible on the DATE(S) OF SERVICE.

The Prior Authorization Form, DPW-1855, has information items grouped together.

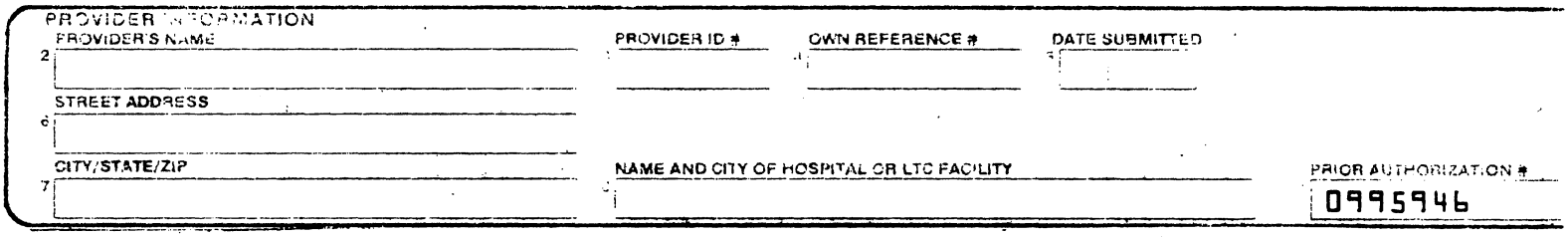
PRIOR AUTHORIZATION FORM HEADING



The heading contains the address to which all Prior Authorization Requests must be sent and the typewriter alignment tabs. It also contains:

1. Claims Processing Document Control Number.

   Do Not complete this item.



PROVIDER INFORMATION

2. Provider's Name

   Enter the physician's or clinic's name as enrolled.

3. Provider ID#

   Enter the physician's individual or group 7 digit identification number.

4. Own Reference #

   The provider may enter his own account reference number, which may include as many as 9 letters and/or numbers to accommodate individual filing system. Numbers are preferred for accuracy of scanning. This information is not mandatory but, if furnished, will appear on the Remittance Advice.

5. Date Submitted

Enter the date the request is submitted using two digits for the month, day and year. Use a six digit format for this and any other date on this form. Do NOT use slashes, dashes or spaces to separate month, day and year. The printed vertical bars serve as separations.

6. Street Address

Enter the street address of the provider.

7. City/State/Zip Code

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

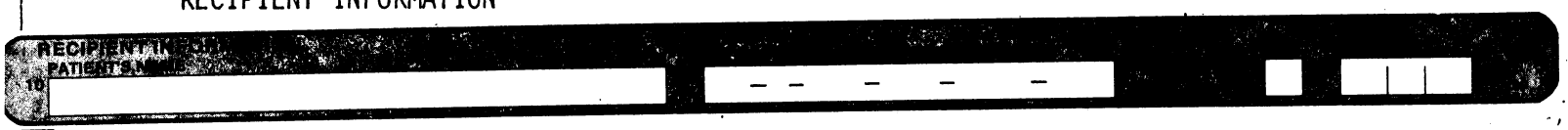
8. Name and City of Hospital or LTC Facility

If the service is rendered in a hospital or long term facility, enter the facility's name and address.

9. Prior Authorization #

This number will appear preprinted on the form and should be used by the provider when making inquiries regarding the authorization request. If the requested authorization is approved, this prior authorization # must be entered in block 6 on the Practitioner Invoice, DPW-1497. Do NOT alter this number.

RECIPIENT INFORMATION



10. Patient's Name

Enter the patient's full name, exactly as it appears on the M.A. identification card; last name, first name, middle initial. Use all capital letters.

11. Patient's Medical Assistance Number

Enter the 16 digit number as shown on the recipient's Medical Assistance identification card. Do NOT type in the dashes; they are provided on the form.

12. Sex

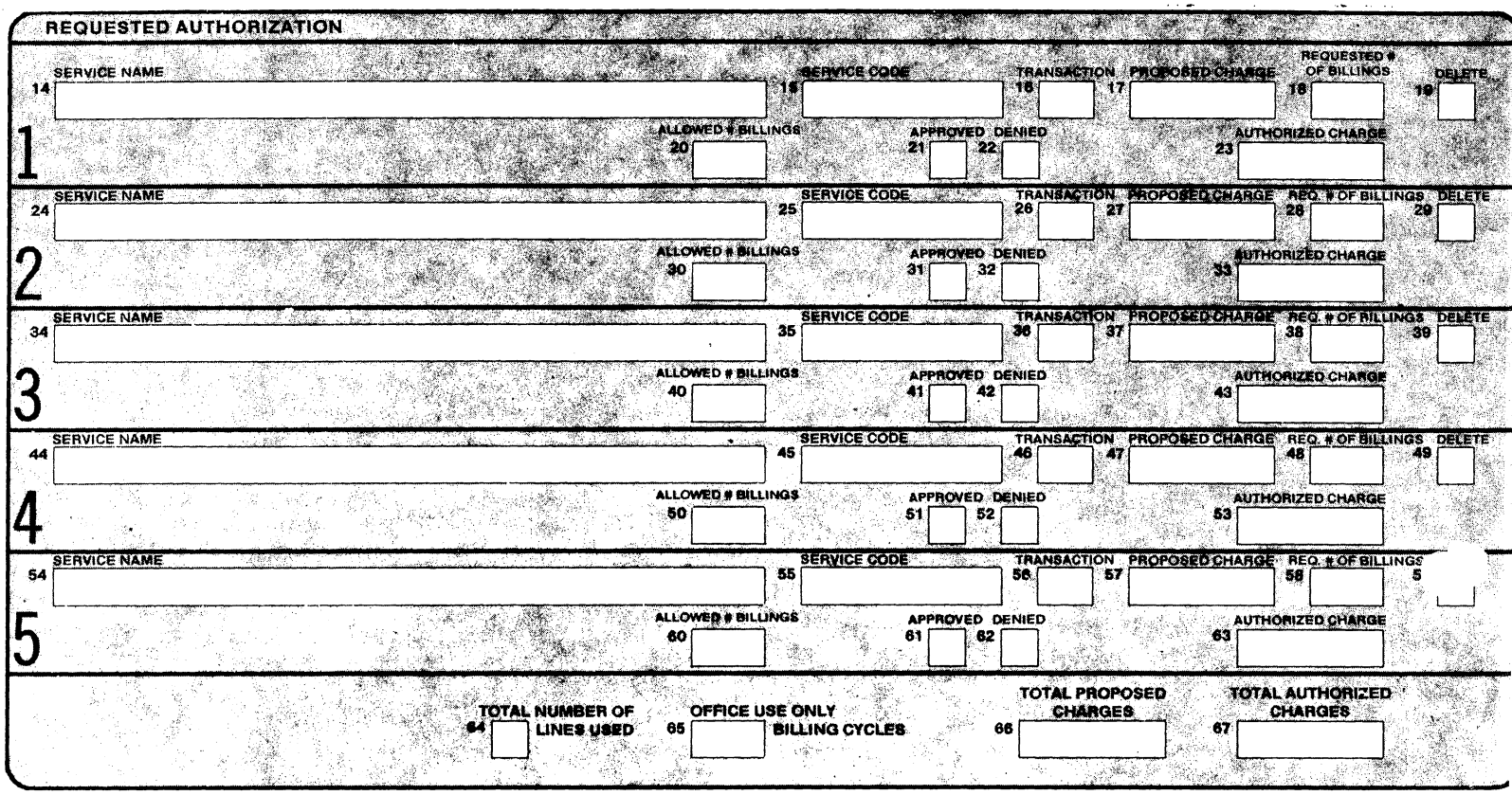
Enter the recipient's sex: M = Male

F = Female

13. Birthdate

Enter the six digits of the recipient's birth as it appears on the MA/ID card. Do NOT use dashes, slashes or spaces. The printed vertical bars separate month, day and year.

REQUESTED AUTHORIZATION



There are five lines provided in the Requested Authorization Section. This enables the provider to request authorization for up to five procedures for one patient on the same request form.

14. Service Name

Enter the name of procedure requested.

15. Service Code

Enter the appropriate procedure code.

16. Transaction

Leave blank.

17. Proposed Charge

Enter the usual and customary charge for procedure. Do not use the dollar sign.

18. Requested # of Billings

Enter the number of sessions requested for Psychological service. Enter number one (1) for surgical procedures.

19. Delete

To delete a claim line containing errors use an X.

20. Allowed # of Billings

Leave blank. When the request is returned the allowed number of billings will be indicated.

21. Approved

Leave blank. When approved request is returned the approval will be indicated with an X in this space.

22. Denied

Leave blank. When a denied request is returned the denial will be indicated with an X in this space.

23. Authorized Charge

Leave blank. Payment will be based on "maximum allowable charge" for services.

24-63.

Follow the same format as Items 14-23.

64. Total Number of Lines Used

Enter the total lines used. Do not include deleted lines.

65. Office Use Only - Billing Cycles

Leave blank.

66. Total Proposed Charges

Enter the sum of all proposed charges.

67. Total Authorized Charges

Leave blank. See box 23.

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

X_____
Reviewed By (For Department Use Only)

X Your Signature
Provider's Signature

SERVICES AUTHORIZED (AS INDICATED ABOVE). HOWEVER, PAYMENT DEPENDS UPON RECIPIENT BEING ELIGIBLE AT THE TIME SERVICE IS PROVIDED.
SUBMIT ALL COPIES TO ABOVE ADDRESS DPW1855 (4-77)

For each procedure listed under Requested Authorization section, give supporting evidence why this procedure is medically necessary.

If more space is needed, attach reports with a paper clip to the Prior Authorization Form before submitting.

Insufficient information will cause delay in evaluating the request.

P.A. FOR PSYCHIATRIC CARE

The revised Prior Authorization form must be submitted in addition to the letter for extended Psychiatric care. Follow the instructions for completing the form. The letter must include information pertaining to recipient's diagnosis, prognosis, expected behavioral changes, medications, present condition, and follow-up plans.

Provider's Signature

The Prior Authorization must be signed by the requesting physician before the form can be reviewed by the department.

Reviewed By

Leave blank.

SUBMISSION OF PRIOR AUTHORIZATION REQUEST

The completed Prior Authorization request must be sent intact (both copies and carbon) to the Medical Assistance Program at the address indicated at the top of the form. When the request has been reviewed, one copy will be returned to the provider. If the request is approved, the Practitioner Invoice must be completed to bill for the service. Enter the pre-printed Prior Authorization number (box 9) on the Practitioner Invoice (box 6).

SEND AUTHORIZATION REQUESTS TO: Minnesota Medical Assistance Program, Department of Public Welfare, Box 43170 St. Paul 55164

PRIOR AUTHORIZATION

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER

ELITE PICA XXX

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

ELITE PICA XXX

PROVIDER INFORMATION

2 PROVIDER'S NAME: DOCTORS MEDICAL CLINIC
3 PROVIDER ID #: 2121345
4 OWN REFERENCE #:
5 DATE SUBMITTED: 103077
6 STREET ADDRESS: 202 MAIN STREET
7 CITY/STATE/ZIP: HOMETOWN, MN 55123
8 NAME AND CITY OF HOSPITAL OR LTC FACILITY:
9 PRIOR AUTHORIZATION #: 0995948

RECIPIENT INFORMATION

10 PATIENT'S NAME: GUNDERSON, OLIVE
11 PATIENT'S MEDICAL ASSISTANCE NUMBER: 62-4-000-002-4099-101
12 SEX: F
13 BIRTHDATE: 071548

REQUESTED AUTHORIZATION

	SERVICE NAME	SERVICE CODE	TRANSACTION	PROPOSED CHARGE	REQUESTED # OF BILLINGS	DELETE	ALLOWED # BILLINGS	APPROVED	DENIED	AUTHORIZED CHARGE
1	14 GASTRIC BYPASS	15 43635	16	17 900.00	18 1	19	20	21	22	23
2	24 PANNICULECTOMY	25 17499	26	27 500.00	28 1	29	30	31	32	33
3	34	35	36	37	38	39	40		42	43
4	44		46	47	48	49		51	52	53
5	54	55	56	57	58	59	60	61	62	63

EXAMPLE OF PRIOR AUTHORIZATION FORM

TOTAL NUMBER OF LINES USED	OFFICE USE ONLY BILLING CYCLES	TOTAL PROPOSED CHARGES	TOTAL AUTHORIZED CHARGES
64 2	65	66 1300.00	67

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

Give supporting evidence that requested procedure is medically necessary.

X _____
Reviewed By (For Department Use Only)

X Your Signature
Provider's Signature

SERVICES AUTHORIZED (AS INDICATED ABOVE). HOWEVER, PAYMENT DEPENDS UPON RECIPIENT BEING ELIGIBLE AT THE TIME SERVICE IS PROVIDED.
SUBMIT ALL COPIES TO ABOVE ADDRESS

DPW1855 (4-77)

DETAILED DESCRIPTION - REMITTANCE ADVICE

The Remittance Advice is printed on a general purpose form. It reports the current status of submitted claims and adjustment requests. Claims are reported as either paid, rejected, or suspended. Adjustment requests are shown as either credits or debits to the providers account. The following is a line by line explanation of the Remittance Advice report of paid, rejected and suspend claims, and adjustment requests submitted for processing. Refer to the sample Remittance Advice contained in the Appendix.

PAID INVOICE - CLAIM SUBMITTED ON DPW-1497

Line 1

The first line contains the recipient's name as associated on file with the MA/ID number reported on the invoice by the provider. It also indicates the status of the claim as paid (PAY).

Line 2

The second line contains the recipient's name as reported on the invoice by the provider.

Line 3

The third line contains the provider reference number (if given) and the 15-digit claim reference assigned to the invoice by the centralized payment system. It also shows the billing date and the service period billed for on the invoice.

Line 4

The fourth line of the Remittance Advice reflects the billing information submitted on the invoice by the provider: line item number, beginning date of service, procedure code, ending date of service (if any), units of service provided, amount billed, amount paid, and status of that line item as either paid as submitted (S), paid as allowed (A), paid as customary (C), or rejected (R) and reject reason code. If the invoice contained more than one line of billed services, the same information is printed for each line.

Line 5

The fifth line indicates ~~that~~ the claim has been paid. It also shows the amount of any client liability, amount received from other sources, total amounts billed and paid, and the status of the claim as paid (PAY).

PAID INVOICE - MEDICARE CROSSOVER CLAIM PROCESSED FROM AN EOMB OR DATA RECEIVED DIRECTLY FROM MEDICARE

Line 1

The first line contains the recipient's name and MA/ID number assigned to the claim by the centralized payment system. It also indicates the status of the claim as paid (PAY).

Line 2

The second line contains the recipient's name as reported on the Explanation of Medicare Benefits (EOMB).

Line 3

The third line contains the 15-digit claim reference number assigned to the claim by the centralized payment system, the billing date (date of EOMB), and the service period billed for.

Line 4

The fourth line of the Remittance Advice reflects the billing information referred to MA by Medicare: line item number, beginning date of service, procedure code (if any), ending date of service (if any), units of service provided, amount billed, amount paid (for Medicare covered items this amount equals zero, 0.00), and status of that line item as covered by Medicare (M), paid as submitted (S), paid as allowed (A), paid as customary (C), or rejected (R) and reject reason code. If the claim contained more than one line of billed services, the same information is printed for each line.

Line 5

The fifth line shows the amount applied toward the recipient's annual deductible, the co-insurance amount, the amount paid by Medicare, and indicates that the clair is a Medicare Crossover.

Line 6

The sixth line of the invoice contains the recipient's name as reported on the EOMB, the intermediary control number (ICN), the provider's medicare number, and the recipient's health insurance claim number (HIC).

Line 7

The seventh line indicates that the claim has been paid. It also shows the amount of any client liability, the amount Medicare paid, the total amount paid, and the status of the claim as paid (PAY).

SUSPENDED INVOICE

Line 1

The first line contains the recipient's name as associated on file with the MA/ID number reported on the claim. It also indicates the status of the claim as suspended (SUS).

Line 2

The second line contains the recipient's name as reported on the invoice by the provider or by Medicare on the EOMB.

Line 3

The third line reports the provider's own reference number (if given), the 15-digit claim control number assigned to the claim by the centralized payment system, the billing date or date of EOMB (for Medicare Crossovers), and the service period billed for.

Line 4

The fourth line indicates that the claim is currently in suspense in the system. Providers should not submit duplicate claims for those still in process.

REJECTED INVOICE

Line 1

The first line contains the recipient's name as associated on file with the MA/ID number reported on the claim. It also indicates the status of the claim as

rejected (REJ) and the specific reject reason code. Refer to Appendix _____ for detailed explanation reject reason and error codes.

Line 2

The second line lists the recipient's name as reported on the invoice by the provider or by the Medicare intermediary on the EOMB.

Line 3

The third line shows the provider's own reference number (if given), the 15-digit claim reference number, the billing date or date of EOMB (for Medicare Crossovers), and the service period billed for * (see below)

Line 4

The fourth line reports that this entire claim has been rejected. Providers may submit a new claim if the reason for rejection can be corrected.

ADJUSTMENT

Line 1

The first line contains the recipient's name as associated on file with the MA/ID number reported on the adjustment. It also contains the status of the adjustment as debit or credit.

Line 2

The second line reports the 15-digit claim reference number, the warrant date and claim reference number of the claim being adjusted.

Line 3

The third line indicates whether this claim is a debit or credit adjustment, the two digit reason code for adjustment (refer to Appendix ___ for detailed description of adjustment codes), any third party liability, the request adjustment amount, and the amount actually debited or credited to the provider.

* it also contains the original date the claim was paid in the event the claim was rejected as a duplicate.

PROVIDER NUMB.
2143849

MINNESOTA DEPARTMENT OF PUBLIC WELFARE
MEDICAL ASSISTANCE PROGRAM

REMITTANCE ADVICE

DATE OF PAYMENT: 05/01/77

WARRANT NUMBER: 48761938

PA UMBER: 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
ALLISON	DAVID = RECIPIENT NAME			RECIPIENT I.D. = 62-8-000-034-8616-101						PAY	
ALLISON, DAVE	= INVOICE NAME										
T44134729	770766010117800	02/28/77		08/06/76	THRU 09/28/76						
			01	08/06/76	90801		UNIT =001	100.00	0.00	R	814
			02	08/07/76	90898	09/28/76	UNIT=0531	1113.00	954.00	C	
			03	08/09/76	70260		UNIT=001	16.00	12.00	A	
			04	08/09/76	71020		UNIT=001	9.00	7.50	A	
			05	08/09/76	95820		UNIT=001	18.00	18.00	S	
PAID INVOICE ********						0.00	0.00	1156.00	991.50	PAY	
BOLEMAN	KATHY Y = RECIPIENT NAME			RECIPIENT I.D. = 27-2-000-004-2012-101						PAY	
BOLEMAN, KATHY	= INVOICE NAME										
KATBOLEMAN	770950570346800	03/29/77		03/04/77	THRU 03/04/77						
			01	03/04/77	82270		UNIT=001	2.00	2.00	S	
			02	03/04/77	87010		UNIT=001	4.00	4.00	S	
			03	03/04/77	71010		UNIT=001	13.00	12.00	C	
			04	03/04/77	93000		UNIT=001	15.00	15.00	S	
			05	03/04/77	88100		UNIT=001	7.00	7.00	S	
			06	03/04/77	99000		UNIT=001	7.00	4.50	A	
PAID INVOICE ********						0.00	0.00	48.00	44.50	PAY	
GUNDERSON	OLIVE = RECIPIENT NAME			RECIPIENT I.D. = 62-4-000-002-4099-101						PAY	
GUNDERSON, OLIVE	= INVOICE NAME										
	770885930299500	03/14/77		12/07/76	THRU 12/07/76						
			01	12/07/76	09330		UNIT=001	10.00	0.00	M	
	CASH DED = 0.00			COINS AMT = 2.00				8.00			MEDICARE CROSSOVER
	INVOICE NAME = GUNDERSON OLIVE			ICN = 706106534			MEDICARE NO. = 133610217				HIC = 477017352C3
PAID INVOICE ********						0.00	8.00	0.00	2.00	PAY	
GUNDERSON	OLIVE = RECIPIENT NAME			RECIPIENT I.D. = 62-4-000-002-4099-101						PAY	
GUNDERSON, OLIVE	= INVOICE NAME										
	770885930299600	03/16/77		11/05/76	THRU 11/05/76						
			01	11/05/76	00023		UNIT=001	35.00	0.00	M	
	CASH DED = 0.00			COINS AMT = 7.00				28.00			MEDICARE CROSSOVER
	INVOICE NAME = GUNDERSON OLIVE			ICN = 706806898			MEDICARE NO = 133610217				HIC = 477017352C3
PAID INVOICE ********						0.00	28.00	0.00	7.00	PAY	

DEBIT BALANCE USED

DEBIT BALANCE REMAINING

PAGE TOTAL: 1,045.00

WARRANT TOTAL

PROVIDER NAME AND ADDRESS

STATE PHYSICIAN CLINIC, P.A.
690 NORTH ROBERT ST.
ST. PAUL, MINNESOTA 55175

DPW-1549 (6-74)
STOCK NO. 397

PROVIDER NUMBER: 2143849

MINNESOTA DEPARTMENT OF PUBLIC WELFARE
MEDICAL ASSISTANCE PROGRAM

REMITTANCE ADVICE

DATE OF PAYMENT: 05/01/77 | WARRANT NUMBER: 48761938 | PAGE NUMBER: 002

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
LAWYER JANICE		= RECIPIENT NAME		RECIPIENT I.D. = 34-8-000-005-7240-101						PAY	
LAWYER, JANICE		= INVOICE NAME									
OOOLAWYER	770870800024100	02/02/77		01/23/76 THRU 12/30/76							
			01	01/23/76		09/16/76	UNIT=001	63.00	0.00	M	
			02	02/09/76	99001		UNIT=001	6.00	6.00	S	
			03	02/10/76			UNIT=001	9.50	0.00	M	
			04	10/12/76			UNIT=001	18.00	0.00	M	
			05	10/13/76	90785		UNIT=001	4.00	4.00	S	
			06	10/28/76		12/30/76	UNIT=001	21.00	0.00	M	
	CASH DED = 60.00	COINS	AMT = 10.30					41.20			MEDICARE CROSSOVER
INVOICE NAME = JANICE LAWYER			ICN =				MEDICARE NO =				HIC =
PAID INVOICE********						0.00	41.20	0.00	80.30	PAY	
MORIARTY EMELINE		= RECIPIENT NAME		RECIPIENT I.D. = 34-2-000-019-1855-101						SUS	
MORIARTY, EMELINE		= INVOICE NAME									
OOMORIARTY	770690800151000	03/01/76		10/03/75 THRU 10/03/75							
SUSPENDED INVOICE - STILL IN PROCESS********										SUS	
NORDQUIST KILMER B		= RECIPIENT NAME		RECIPIENT I.D. = 09-3-000-048-0573-101						REJ	**715, 01715, 05715
KILMER NORDQUIST		= INVOICE NAME									
OONORDQUIST	770690800143400	01/17/77		10/18/76 THRU 12/22/76							
REJECTED INVOICE********										REJ	**664, 01668, 01664
RICHARDS ALMA		= RECIPIENT NAME		RECIPIENT I.D. = 08-2-000-049-6327-101							
ALMA RICHARDS		= INVOICE NAME									
000469832	770770800045700	06/26/75		11/15/74 THRU 11/15/74		ORIG DATE PAID = 11/20/76					
REJECTED INVOICE********										REJ	
TUTTLE LETHA		= RECIPIENT NAME		RECIPIENT I.D. = 27-4-000-0E9-6099-101						REJ	**648, 01658
LETHA TUTTLE		= INVOICE NAME									
	770730800033400	03/01/76		09/19/75 THRU 09/19/75		ORIG DATE PAID = 01/14/77					
REJECTED INVOICE********										REJ	
WARREN RICHARD H		= RECIPIENT NAME		RECIPIENT I.D. = 47-4-000-073-2779-101						DEB	
	770540450654900	WARRANT DATE = 02/02/77		CLAIM ADJUSTED = 770210530731400							
DEBIT ADJUSTMENT********				(80)**********		0.00		35.00	35.00-	DEB	DEBIT ADJUSTMENT
ZUNDEL CATHERINE		= RECIPIENT NAME		RECIPIENT I.D. = 14-2-000-792-9542-101						PAY	
	770750800288704	WARRANT DATE = 00/00/00		CLAIM ADJUSTED = 783555930137500							
CREDIT ADJUSTMENT********				(10)**********		0.00		3.00	3.00	PAY	CREDIT ADJUSTMENT

DEBIT BALANCE USED:

DEBIT BALANCE REMAINING:

PAGE TOTAL: 48.30

WARRANT TOTAL: 1,093.30

PROVIDER NAME AND ADDRESS:

STATE PHYSICIAN CLINIC, P.A.
690 NORTH ROBERT ST.
ST. PAUL, MINNESOTA 55175

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

When an invoice or part of an invoice is rejected a code or series of codes will appear in the Explanation Codes or Comments column of the Remittance Advice. They will indicate the primary reason the invoice or line was rejected and any other error or processing problems present in the claim at the time of rejection.

A. Primary Reject Reason – Entire Claim

When an entire claim is rejected the first code will be preceded by two asterisks (**147). This is the main reason for rejection of the claim. It alone would cause the claim to be rejected. Find the code in this appendix and take whatever correction action is necessary before resubmitting the claim.

B. Reject Reason – Single Line

When a line from an invoice is rejected, that line will be printed and followed by the three digit reason code in the Explanation column. Find this code in this appendix and take necessary corrective action before resubmitting the line on a new invoice.

C. Supplemental Error Codes

When an entire claim is rejected a series of additional five digit codes may follow the primary reject reason code. One of these codes will usually be a repetition of the three digit reject reason preceded by two zeroes (00147). The additional codes, if any, point to other possible errors on the invoice. Some of these may have been caused by the claims processing system and others may be caused by errors on the invoice as submitted.

The first two digits indicate the line number with which the error is associated. If the error is not line related 00 will precede the three digit code.

The last three digits indicate a code in this appendix. Find this code and check your file copy of the invoice to see if the error appears there. Correct any errors you find before resubmitting a new invoice. If you do not find the error on your file copy you may assume the error was caused during claims processing and resubmit as before (remember this is for supplemental error codes only – primary reject reasons must be corrected before resubmission).

D. Example: **147, 00147, 07188, 00209

**147 The claim was rejected because the Recipient's Medical Assistance Number was missing or incomplete. This must be corrected on any new invoice submitted.

00147 Repetition of primary reject reason.

07188 Service Date on line 07 is invalid. Check your file copy to see if the date was on the invoice and that it is a possible calendar date. If it is alright on the file copy resubmit the same way (this would mean that the error code was caused within the claims processing system and would be corrected for an invoice with a Recipient's Medical Assistance Number).

00209 Technical processing problem. This requires no action on the part of the provider.

E. Rejects for Eligibility Reasons

If the primary reject reason indicates the person was ineligible at time of service, or not listed on the State's Case Information File, check your file copy to make sure the Recipient's Medical Assistance Number was properly reported. If the number was correct other sources of payment should be sought or an inquiry made to the County Welfare Department to verify the client's welfare status.

F. Definitions

For use in understanding the explanations of Reject Reasons and Codes the following terms are defined.

1. Not numeric – is not 0, 1, 2, 3, 4, 5, 6, 7, 8, or 9.

2. Invalid – a) is an incorrect item for that location on the invoice. Example: Codes specified in the Handbook must be used – TPL Codes, Insurance Company Codes, Injury Codes, Place of Service Codes, etc.

b) data is not presented according to the correct format for that location on the invoice. Example: Dates must be 12/05/75 not 12/05/975 and not 12/5/75.

c) data is impossible. Example: There is no such date as 12/41/75.

3. Technical Processing Problem – an Error Code which may appear on the Remittance Advice but is solely for DPW use in the Invoice Processing System. If a Primary Reject Reason or Line Item Reject Reason is listed as a technical processing problem in the following pages, call for clarification and/or correction.

051-069 These error codes indicate technical processing problems and can generally be ignored by the provider.

071 There are no line items on this invoice.

072 Maximum number of line items has been exceeded (billings cannot be continued from one invoice to another).

073 A line item number was repeated on the invoice.

074 Technical processing problem – provider may ignore this code.

075 Total Number of Lines Used is missing or in error.

076 Gross Total Charges is not equal to sum of line item charges.

100 Provider ID# is not numeric.

101 Billing Date is invalid or missing.

102 Procedure Code is missing.

103 First two digits of Recipient's Medical Assistance Number must be 01 through 89.

104 Third digit of Recipient's Medical Assistance Number is not a valid Medical Assistance program code.

105 Fourteenth digit of Recipient's Medical Assistance Number is not valid.

106 Last two digits of Recipient's Medical Assistance Number are not numeric or do not represent the person named on the invoice.

107 Prior Authorization number is not numeric.

109 Attending Physician's ID# is not numeric.

111 Date Dispensed invalid.

112 Drug Code or Supply Code is missing.

113 Quantity is missing.

115 Amount Received from Other Sources is invalid.

116 From Date is invalid.

117 Through Date is invalid.

118 Prescription Number is missing.

119 Procedure/Service Code is missing.

120 Service Code is missing.

121 Days Supply is not numeric.

122 Refill is not numeric.

124 Item Code is invalid.

125 Primary Diagnosis Code is missing.

126 Charge for the line item is missing.

127 Charge for the line item is not numeric.

129 TPL Code (Third Party Liability) is invalid.

130 Primary Diagnosis Code is invalid – wrong format or value. (Remember if H-ICDA Codes are used an H must precede the code.)

131 Secondary Diagnosis Code is invalid. (See 130 above.)

132 Gross Total Charges is missing.

133 Drug Code format is invalid.

134 Gross Total Charges is not numeric.

135 Net Billed to MA is not numeric.

136 Net Billed to MA is missing.

137 Place of service is invalid.

138 Date of Pickup is invalid.

139 # Persons Sharing Ride is not numeric.

141 Submitted Rate/Mile is not numeric.

142 Type Code is invalid.

143 Destination Code is invalid.

144 MD's ID# is not numeric.

145 MD's ID# is invalid.

146 Supply Code is not numeric.

147 Recipient's Medical Assistance Number is missing or incomplete. Must contain 16 digits.

148 Admission Date is invalid.

149 Total Days is not numeric or is missing.

150 Supply Code is invalid.

151 Type (modifier) code is invalid.

155 Individual Group Member Number is zeroes, or not numeric.

156 Tooth number is invalid or missing where required. A thru T or 1 thru 32 are valid.

157 Service Code (2 digit code) is invalid.

158 Type of Bill is 4 (Medicare Crossover claim was submitted on a Practitioner invoice.)

162 Refill number is missing.

164 Claim Reference Number of Original Invoice to be Adjusted is invalid.

165 Warrant Date From Remittance Advice is invalid. This refers to the warrant date of the original claim which you are trying to adjust.

167 Pints of Blood Furnished is missing.

168 Pints of Blood Furnished is not numeric.

169 Pints of Blood Not Replaced is missing.

170 Pints of Blood Not Replaced is not numeric.

171 Charge Per Pint of Blood is missing.

172 Charge Per Pint of Blood is not numeric.

173 Units is not numeric or is invalid.

174 Rate is not numeric.

176 Gross Charge is missing from line item.

177 Gross Charge is not numeric on line item.

178 Not covered charge is not numeric.

179 Units/Days or Units/Miles is missing.

180 Rate is missing from line item where required.

183 Type of Bill is invalid or missing.

184 Leave Days is not numeric.

185 Reason for Final Bill is invalid.

186 Discharge Code is invalid.

187 Destination Facility ID# is not numeric.

188 Service Date (or From Date) is invalid.

189 Service Date (or Through Date) is invalid.

190 Technical processing problem – provider may ignore this code.

191 Allowed # Billings is zero or missing.

192 Total Authorized Charges is not numeric.

193 Allowed # Billings is not numeric.

194 Authorized Charge is not numeric.

195 Technical processing problem – provider may ignore this code.

196 Medicare Deductible amount is not numeric.

197 Service date is invalid.

198 Co-Insurance amount is not numeric.

199 Amount Received from Medicare is not numeric.

200 Sum of Requested Increase does not equal computed sum of increases.

201 Sum of Requested Decreases does not equal computed sum of decreases.

202 Reason for Change for Third Party Adjustment is invalid.

203 Third Party Underpayment is not numeric.

204 Third Party Underpayment is zero when Reason for Change indicates otherwise.

205 Third Party Overpayment is not numeric.

206 Third Party Overpayment is zero when Reason for Change indicates otherwise.

207 Third Party Overpayment and Third Party Underpayment both contain amounts.

208-210 Technical processing problems – provider may ignore these codes.

211 Original Line Number is missing or not numeric.

212 Technical processing problem – provider may ignore this code.

213 Provider ID# is missing.

214 Provider ID# is invalid.

215 Attending/Referring/Prescribing Physician ID# is invalid.

216 Individual Group Member Number is invalid.

217 Destination Facility ID# is invalid.

218 Recipient Sex code is invalid or missing.

219 Recipient Birthdate is invalid or missing.

220 Date Ins. Billed is invalid.

221 Injury Code is invalid or missing.

222 Line item Requested Increase is not numeric.

223 Line item Requested Increase is zero when Reason for Change indicates otherwise.

224 Line item Requested Decrease is not numeric.

225 Line item Requested Decrease is zero when Reason for Change indicates otherwise.

226 Line item Requested Increase and Requested Decrease both contain amounts.

227 Technical processing problem – provider may ignore this code.

228 Prescriber ID# is missing or not numeric.

229 Prescriber ID# is invalid.

230 Submitted Base Rate is not numeric.

231 Procedure Date is invalid.

233 Procedure Code or Service Code is not numeric.

234 Procedure Code or Service Code is invalid.

235 Total of Non-Covered Charges is not numeric.

236 Amount of Other Payments for Non-Covered Charges is not numeric.

237-239 Technical processing problems – provider may ignore these codes.

240 Date of screen is invalid.

241 Screen code is not numeric.

242 Normal/Abnormal code is invalid.

246 Prescribing MD# is not numeric.

247 Code (for Family Planning/Nursing Home) is not 1, 3, 5, Ø, or blank.

248 Prescribing MD# is invalid.

249 Quantity is invalid.

250 Prescribing MD# is missing.

251 Days Supply is missing or is equal to zero.

252 Prescribing MD# is invalid.

280-282 Technical processing problems – provider may ignore these codes.

301 Provider ID# is not on file with DPW.

302 Primary Diagnosis Code is invalid.

303 Service Date is after current date.

304 Gross Total Charge less Amount Received from Other Sources is not equal to Net Billed to MA.

305 Procedure Code or Service Code is not on file of valid codes.

306 Through Date is prior to From Date.

307 Processing Date is prior to Through Date.

308 Processing Date is prior to Billing Date.

309 Place of service conflicts with Procedure Code or Service Code.

310 Type (MRVI modifier) conflicts with Procedure Code.

311 Technical processing problem – provider may ignore this code.

312 Secondary Diagnosis Code is invalid.

313 Sum of all Charges is not equal to Gross Total Charges.

314 Drug Code or Supply Code is not on file.

315 Procedure Code or Service Code is invalid for this provider type.

316 Date Dispensed is after the processing date.

317 Technical processing problem -- provider may ignore this code.

318 From Date is after Through Date.

319 From Date is before Admission Date.

320 Final Net Billed to MA is incorrectly calculated. (Check to see that correct type of bill was submitted.)

321 Blood Pints Furnished is less than Blood Not Replaced.

322 Total Days is not equal to sum of accommodation days charged on line items. The line item days for Nursery should not be included in Total Days if this billing includes mother and baby charges.

323 Invalid Item Code on a billing for late charges. Room charges may not be billed as late charges.

325 Units/Days of Service times Rate does not equal line-item Not Covered charge.

326 Line-item total charges are less than the line-item non-covered charges.

327 Through Date is after processing date.

328 From Date is after processing date.

329 The sum of line-item Not Covered Charges is not equal to the Total of Non-Covered Charges.

330 Date of Pick-up is after the processing date.

331 Recipient's Age is incompatible with the Primary Diagnosis Code.

332 Recipient's Age is incompatible with the Secondary Diagnosis Code.

333 Blood Not Replaced times Charge/Pint is not equal to the line-item Gross Charge.

334 Sum of Column A (Gross Charge) is not equal to Total of Gross Charges.

335 Through Date minus From Date minus Leave Days does not equal Total Days on a final bill OR Through Date minus From Date minus Leave Days does not equal Total Days minus one day on an interim bill.

336 Sum of line item Gross Charges is not equal to Gross Total Charges.

337 Technical processing problem – provider may igno. this code.

338 Admission Date is after processing date.

339 Provider's rate is not on record for this service.

340 Technical processing problem – provider may ignore this code.

341 Amount of Other Payments for Non-Covered Charges exceeds Total of Non-Covered Charges.

342 Amount of Other Payments for Non-Covered Charges exceeds Amount Received or Receivable from Other Sources.

343 Technical processing problem – provider may ignore this code.

344 Supply Code is invalid for this provider type.

345 Technical processing problem – provider may ignore this code.

346 The Submitted Charge is less than one dollar.

347 Prescribing MD# is not on file with DPW.

348 Refill exceeds maximum allowable number.

349 Prescription Number must contain three significant digits.

350 Technical processing problem – provider may ignore this code.

351 Recipient's Age is incompatible with the Procedure Code.

352 Technical processing problem – provider may ignore this code.

353 Procedure or Service requires Prior Authorization and no Prior Authorization # is on the invoice.

354 The provider's effective dates do not precede Service Date.

355 Procedure Code or Service Code does not require Prior Authorization.

356 Provider ID# designates pharmacist or medical supplier and Claim Reference Number of original Invoice to be Adjusted does not end in 01 thru 08.

or

Provider ID# does not designate pharmacist or medical supplier and Claim Reference Number of Original Invoice to be Adjusted does not end in 00.

357 Warrant Date from Remittance Advice is after Submission Date.

358 This service is not covered by Medical Assistance.

359 Pharmacist or supplier can only adjust one claim per Adjustment Request.

360 Provider used a restricted Third Party Adjustment Reason Code.

361 Corrected Service Code is invalid for the type of provider.

362 Line item Requested Increases plus Third Party Underpayment does not equal Sum of Requested Increases.

363 Technical processing problem – provider may ignore this code.

364 Same Original Line Number may not be adjusted more than once.

365-367 Technical processing problems – provider may ignore these codes.

368 Third Party Reason for Change code is invalid.

369 Reason for Change is invalid.

370 Service Code (2 digit code) is invalid.

371 Third Diagnosis is invalid.

372 Billing Date precedes the Date of the Screen.

373 Screen Code must be 015, 070, 080, 114, 115 or 200.

374 Referral provider type is not valid for screening code listed.

375 Billing Date precedes the Service Date.

376 Technical processing problem – provider may ignore this code.

377 Total Claim Charge is not equal to the Sum of the physical, laboratory and immunization charges.

378 Disregard this claim since it was generated from the mechanized Medicare Part B Payment System, and it is a duplication of the charges you submitted on your Hospital Invoice.

379 Recipient's Age is incompatible with the Third Diagnosis Code.

380 First Diagnosis Code is invalid.

381 Second Diagnosis Code is invalid.

382 Third Diagnosis Code is invalid.

383 First Diagnosis Code is invalid.

384 Second Diagnosis Code is invalid.

386 First Diagnosis Code is incompatible with the procedure code.

387 Second Diagnosis Code is incompatible with the procedure code.

388 Recipient's Sex is incompatible with the Second Diagnosis Code.

389 Recipient's Sex is incompatible with the Third Diagnosis Code.

390 First Diagnosis Code is invalid.

391 Second Diagnosis Code is invalid.

392 Third Diagnosis Code is invalid.

3[illegible] Technical processing problem – provider may ignore this code.

3[illegible] Invalid combination of MRVI modifiers in the Type Box.

398 Recipient Sex is incompatible with Procedure Codes or Service Code.

399 Recipient Sex is incompatible with ICDA code.

400 Sex association with Procedure Code is incompatible with sex associated with the ICDA code.

401 Procedure is not covered on the Service Date.

402 This type of provider ID# cannot be used on a Pharmacy/Supply invoice.

403 Technical processing problem – provider may ignore this code.

404 Provider is not eligible for first or only Service Date.

405 Provider is not eligible for last Date of Service.

406 Quantity is not within the allowable range.

407 Drug is not covered on this Service Date.

408 Supply is not covered on this Service Date.

409 Provider is not eligible for first or only Service Date.

410 Provider is not eligible for last Service Date.

411 Provider is suspended and not eligible for first or only Service Date.

412 Provider is suspended and not eligible for last Service Date.

413 Technical processing problem – provider may ignore this code.

414 Provider ID# is not on active file.

415 Provider is terminated and not eligible for first or only Service Date.

416 Provider is terminated and not eligible for last Service Date.

418 Inpatient Hospital miscellaneous charges exceed $50.

419 Outpatient hospital miscellaneous charges which exceed $50 must be itemized.

429 Technical processing problem – provider may ignore this code.

430 Medicare Crossover procedure billed on the wrong invoice. Please rebill on the proper invoice.

431 This service denied by Medicare is not covered by Medical Assistance.

432 This Podiatry service denied by Medicare should be billed on a Practitioner Invoice (DPW 1497) indicating "8" in the Type of Bill box.

433 This supply denied by Medicare should be billed on a Supplier Invoice (DPW 1858) with a note typed at the bottom stating "Rejected 433 from" the date of the Remittance Advice.

434 Medicare Crossover Service was not filed within the specified time limit.

435 This service denied by Medicare should be billed on a Medical Transportation Invoice (DPW 1857) indicating "8" in the Type of Bill box.

436 Medicare crossover professional component should be billed on the appropriate invoice.

437 Duplicate claim submitted to Medicare.

438 Duplicate cataract eye glasses must be prior authorized.

439 Technical processing problem – provider may ignore this code.

440 Deductible and coinsurance cannot both be equal to zero on a Medicare Crossover billing.

441 Deductible plus coinsurance cannot be greater than the total claim charge for a Medicare Crossover billing.

442 Total claim charges minus the Amount Received from Other Sources minus Amount Received from Medicare does not equal the Net Claim Charge.

443 EPSDT Line-Item is blank, or Abnormal and Normal have been checked.

444 This Medical Transportation provider cannot use Type of Bill equal to 4.

445-447 Technical processing problems – provider may ignore these codes.

448 This product was removed from the market by the F.D.A.

449 Recipient must be less than 22 years old for EPSDT.

450 Claim billed on the wrong invoice.

451 Provider is not enrolled to provide services in this category.

452 Medicare Crossover Calculation not equal to the Final Net Bill.

453 Invalid Item Code.

454 This service not covered by Medicare is also not covered by Medical Assistance.

455 This supply denied by Medicare should be billed on a Supplier Invoice (DPW 1858) with a note typed at the bottom stating "Rejected 455 from" the date of the Remittance Advice.

456-459 Technical processing problems – provider may ignore these codes.

461 Provider type is invalid.

462 Technical processing problem -- provider may ignore this code.

463 Service Date precedes the first date for which the provider is allowed to bill.

464-466 Technical processing problems - provider may ignore these codes.

467 DPW does not pay claims over 1 year old.

468-504 Technical processing problems – provider may ignore these codes.

505 This service is billed on the wrong invoice.

506 The Catastrophic Health Expense Protection Program (CHEPP) does not cover over-the-counter drugs.

507 The Catastrophic Health Expense Protection Program (CHEPP) does not cover this service.

508 The Catastrophic Health Expense Protection Program (CHEPP) does not cover non-durable supplies.

509 Technical processing problem – provider may ignore this code.

510 The Catastrophic Health Expense Protection Program (CHEPP) does not cover EPSDT screenings.

511 The Catastrophic Health Expense Protection Program (CHEPP) does not cover these services.

512 Provider has indicated that he does not want to participate in the Catastrophic Health Expense Protection Program (CHEPP).

513 Provider has indicated that he does not want to participate in the General Assistance Medical Care Program (GAMC).

514 This General Assistance Medical Care (GAMC) invoice should be billed to the county.

or

Dates of service are prior to the effective date for the Catastrophic Health Expense Protection Program (CHEPP).

515 Invalid recipient ID number.

516 Home Health Care must bill each date of service on a separate line for the Catastrophic Health Expense Protection Program (CHEPP).

517 Technical processing problem – provider may ignore this code.

518 Provider has indicated that he does not want to participate in the Medical Assistance Program (MA).

519 The General Assistance Medical Care Program (GAMC) does not cover EPSDT screenings.

520-522 Technical processing problems – provider may ignore these codes.

567 DPW cannot pay a claim which is over 2 years old.

571 Reimbursement Amount equals zero.

572-602 Technical processing problems – provider may ignore these codes.

603 Vision Care procedure code 80802 cannot be billed with procedure codes 80810 or 80820. Complete eyeglass replacement should be billed using 80103, 80104 or 80113, 80114 with the appropriate material codes.

605 Unable to identify the original claim to which the late charges should relate. Late charges must match Recipient's Medical Assistance Number and Dates of Service.

606 Item Code on the late charge invoice is the same as an Item Code on the original claim. Item codes may not be repeated.

608-609 Technical processing problems – provider may ignore these codes.

610 Claim Reference Number of Original Invoice to be Adjusted cannot be found in file of paid claims.

611 Provider ID# on Claim Reference Number of Original Invoice to be Adjusted does not match Provider ID# on the Adjustment Request.

612 Technical processing problem – provider may ignore this code.

618 Original Line Number could not be located on Original Invoice to be Adjusted.

619 Original Line Number to be adjusted was on a rejected line on the Original Invoice. (Such a rejected line should be resubmitted on a new invoice for reconsideration.)

620 Technical processing problem – provider may ignore this code.

622 Third Party Requested Increase must be less than or equal to the amount entered in Amount Received From Other Sources box on the Original Invoice.

623 Requested Decrease must be less than or equal to the amount Medical Assistance paid on the Original Invoice.

625 Third Party Requested Decrease must be equal to the amount Medical Assistance paid on the Original Invoice.

626 Line-Item Requested Decrease must be equal to the amount Medical Assistance paid on the Original Invoice.

628 Duplicate Adjustment.

630 Number of visits (Units) for Office/Hospital/Medical Services (MRVI Codes 90000-90220) exceeds the allowable limit for a calendar month.

631 Number of visits (Units) for Extended Care Services (MRVI Codes 90300-90470) exceeds the allowable limit for a calendar month.

632 Number of visits (Units) for Psychiatric Services (MRVI Code 90841) exceeds the allowable limit for a calendar year.

633 Number of visits (Units) for Psychiatric Services (MRVI Code 90848) exceeds the allowable limit for a calendar year.

634 Number of visits (Units) for Psychiatric Services (MRVI Code 90849) exceeds the allowable limit for a calendar year.

635 Number of visits (Units) for Psychiatric Services (MRVI Code 90853) exceeds the allowable limit for a calendar year.

636 Number of visits (Units) for Psychiatric Services (MRVI Code 90862) exceeds the allowable limit for a calendar year.

637 Only one visit (Unit) for Psychiatric Service (MRVI Code 90898) is allowed per day.

638 Number of visits (Units) for Opthamological/ Otorhinolaryngolgic services (MRVI Codes 92000 thru 92598) exceeds the number allowed in a calendar month.

639 Number of visits (Units) for Emergency Room Services (MRVI Codes 90500-90699) exceeds the number allowed for a calendar month.

641 Number of visits (Units) accumulated Antepartum and Postpartum Care (MRVI Codes 59420 and 59430) exceeds the number allowed for a calendar month.

642 Number of Units of a MRVI Code in the 90000 series exceeds the number allowed for a calendar month.

643 The same Radiology procedure (MRVI Code 70000 thru 89999) exceeds the number allowed for a calendar month.

645 Total OB Care (MRVI Code 594003) should include all antepartum and postpartum care.

647 This procedure appears to be a duplicate. The dates of service for this procedure overlap with another line on this claim.

648 This procedure appears to be a duplicate. The dates of service overlap with a previous claim.

649 Duplicate service code on the same invoice.

650 A patient must not see two practitioners on the same Service Date for medical visits unless one practitioner is a consultant.

651 A claim for a surgery procedure cannot have the same Service Date as a claim for Medical services (MRVI Codes 60000 thru 99999) unless the Medical service is a consultation service.

652 Number of Nursing Home visits (Units) exceeds the number allowed for a week.

653 Different providers cannot bill for the same surgery procedure, or the same non-physician procedures on the same date, unless modifier F & G are used along with the same surgery procedure or if Pathology & Radiology procedures appear on the same billing.

654 Cannot have procedure codes for Antepartum Care, Postpartum Care, and Normal Delivery during the same time period covered by a total OB Care package.

655 Cannot have procedure codes for Antepartum and Postpartum Care during the same time period as medical service codes.

656 Claims with Emergency Room Services should not occur within 1 day of another claim with Emergency Room Services.

657 Medicare crossover claims conflict if the Service Dates overlap, Provider ID#'s are identical, and the Deductible and Co-insurance are equal.

658 Medicare crossover claims conflict with Practitioner Invoice for the same category of service and Service Dates overlap.

659 The number (Units) of Nursing Home Medical Services is excessive for the time period covered.

660 For Place of Service of Inpatient Hospital (3) the Units exceed the allowable limits.

661 MRVI modifier S is required for multiple Inpatient visits for one Service Date.

662 The Catastrophic Health Expense Protection Program (CHEPP) covers only 180 Home Health visits.

663 Duplicate Medicare Crossover Claim.

664 Duplicate Medicare Crossover Claim.

665 Vision Care procedure codes 80101, 80102, 80103, 80104, 80113, or 80114 cannot be billed more than once a year unless they are prior authorized.

666 Vision Care procedure codes 80802, 80803, 80804, 80810 or 80820 cannot be billed with procedure codes 80103, 80104, 80113 or 80114.

667 Vision Care procedure code 80105 cannot be billed with procedure codes 80101, 80102, 80103, 80104, 80113, 80114.

669 Medicare Crossover Claim conflicts with Medical Transportation Claim.

670 Prescription refills are limited to six months from the original dispensing date.

671 The allowable number of prescriptions for the same drug has been exceeded.

672 Duplicate Compound or OTC Pharmacy Claim. A previous claim covered the same Drug/Supply and Service Date.

673 Duplicate refill number.

674 Pharmacy claim conflicts with an Inpatient Hospital Invoice for the same recipient.

675 Duplicate Pharmacy Claim. A previous claim from the same provider covered the same NDC Code and Service Date.

676 Duplicate Pharmacy Claim. A previous claim from a different provider covered the same Drug/Supply Code and Service Date.

677 Medicare Crossover claim conflicts with a claim submitted on a supply invoice.

678 Duplicate Medical Transportation Claim.

679 Outpatient Emergency Room Physician services conflict with another Physician claim.

680 Two institutional claims overlap.

681 Claim conflicts with another claim for Medical Transportation on the same date.

682 Medical Transportation claim is for service which falls within period covered by an Inpatient Hospital Invoice.

683 Service Dates for claim overlap service dates covered by an Inpatient Hospital Invoice.

684 Outpatient service for Psychiatry, Dentistry, or Therapy cannot be billed while Recipient is in Inpatient Care.

685 Inpatient Hospital service dates overlap with another claim from the same provider.

686 Prior Authorization is required when this service is performed twice on the same date of service.

687 This service exceeds the limitations of the Medical Assistance Program (MA).

688 Duplicate Claim. A previous claim covered the same Procedure Code and Dates of Service.

689 Duplicate Claim. A previous claim covered the same Procedure/Drug/Supply Code and Service Date.

690 Duplicate Claim. Two or more lines on the same invoice duplicate each other.

691 Number of visits exceeds the allowable limit per calendar year.

692 The number of Therapy visits (Units) exceeds the number allowed for a calendar year.

693 Daily average allowance for Physical Therapy has been exceeded.

694 Duplicate screening exam.

700 Recipient's Medical Assistance Number as reported on the invoice cannot be found in the Case Information File.

701 Birthdate reported on the invoice does not match birthdate on the Case Information File. Most frequently this indicates that an improper Recipient's Medical Assistance Number was reported. Special attention should be given to the final two digits of the MA ID# which differentiate family members.

702 Sex reported on the invoice does not match sex on Case Information File. See comments under 701 above.

703 Recipient was ineligible for payments on first or only Service Date under MA ID number used. Special attention to current ID for period of service.

704 Recipient was ineligible for payments on last Service Date.

705 Recipient is ineligible for payments on the date of service.

706 The Case Information File indicates this recipient has Medicare coverage but there is no indication this service has been billed to Medicare.

707 Refer to 706.

708 Technical processing problem – provider may ignore this code.

709 First two digits of Recipient's Medical Assistance Number are not between 01 and 89.

710 Third digit of Recipient's Medical Assistance Number is not a valid Medical Assistance program code.

711 Fourteenth digit of Recipient's Medical Assistance Number is not valid.

712 Last two digits of Recipient's Medical Assistance Number are not numeric or do not represent the person named on the invoice.

713 The Case Information File indicates that this recipient has Medicare coverage, but there is no indication on this invoice that this service has been billed to Medicare.

714 Recipient is enrolled in an HMO. Contact the HMO for payment.

715 Recipient was ineligible for payments on the first or only Service Date under the MA ID# used.

716 Medical supply for recipient in long term care facility should be provided by the facility.

717 Recipient is enrolled in an HMO. Contact the HMO for payment.

718 Rehabilitation services for a nursing home recipient cannot be billed on an Outpatient Hospital Invoice.

719 Rehabilitation services for a nursing home recipient must be billed by the nursing home.

720 Maximum number of prior authorized billings for this service has been exceeded.

721 The provider prior authorized to deliver this service does not match the Provider ID# shown on the invoice.

723 Procedure requiring Prior Authorization was not included on the Prior Authorization indicated by the Prior Auth. # on the invoice.

724 The Prior Authorization # on this invoice does not match anything in the file of Prior Authorization.

725 This service has already been Prior Authorized (Duplicate Prior Authorization).

726 The Prior Authorized amount for this service is $0.00.

727 The Tooth Number or Letter for which this service was Prior Authorized does not match the Tooth Number or Letter on the invoice.

728 Technical processing problem – provider may ignore this code.

729 The Prior Authorization for this claim is outdated.

or

The Prior Authorization for this claim was denied.

730 Other Charges covered by MA but not by Medicare exceeds $100.00 and no explanation was attached.

731 This recipient is restricted to certain providers and the provider ID# does not match any of the specified providers.

772 Inpatient Hospital Extension/Adverse Decisions Notice and Physician Recertification (DPW 1931) does not have a matching Inpatient Hospital Admission Notice and Physician Certification (DPW 1819) on file.

773 Services billed extend more than 72 hours after the utilization review committee's denial.

774 Inpatient Hospital Extension/Adverse Decision Notice and Physician Recertification (DPW 1931) not received and hospital stay is more than 60 days.

775 Inpatient Hospital Invoice does not have a matching Inpatient Hospital Admission Notice and Physician Certification (DPW 1819) on file.

776 Physician's certification of need for private room has not been received.

777 See 775 above.

780-789 Technical processing problems – provider may ignore these codes.

800-802 Technical processing problems – provider may ignore these codes.

803 Physician's name is missing.

804 Provider should recalculate the submitted charge.

805 This claim was denied by the Medical Assistance consultants.

806 Procedure Code is vague. Please resubmit with a more definitive Procedure (Service) Code or submit a verbal description of the Service under Procedure Name or as an attachment to the invoice.

807 This service is not covered by the Minnesota Medical Assistance Program.

808 This claim exceeds the allowable number of services for this diagnosis.

809 Minnesota Medical Assistance does not cover reductions which have been made by a Medicare Intermediary.

810 With regard to the diagnosis, this service is not covered by Medical Assistance.

811 Recipient is not eligible for service under the Recipient's Medical Assistance Number shown on the invoice.

812 Allowable charge under Minnesota Medical Assistance is less than the Amount Received from Other Sources. Net payment equals $0.00.

813 Procedure Code shown is "By Report" or unlisted and requires written description of the service.

814 Description of service is insufficient to accurately determine payment amount.

815 The service description and procedure code are inconsistent.

816 This service must be billed on the proper invoice type (i.e., Supplies must be on Medical Supplier Invoice, Transportation on Medical Transportation Invoice, Dental on Dental Invoice, etc.).

817 Primary Diagnosis is required.

818 Please resubmit this claim with complete data on any insurance claims or amounts received from Insurance Companies.

819 Recipient is an HMO participant. Provider should contact HMO for payment.

820 Recipient's Name cannot be found on Central Case Information File.

821 Services rendered must be itemized on the invoice for payment.

822 This line item has been combined with another line item on this invoice.

823 No Benefit is payable for Co-insurance if the provider does not submit an assigned claim to the appropriate Medicare Carrier.

824 Medicare Professional Component should be billed on an Inpatient or Outpatient Invoice.

825 This service denied by Medicare should be billed on a Medical Transportation Invoice (DPW 1857) indicating "8" in the Type of Bill box.

826 Supply denied by Medicare should be billed on a Supply Invoice (DPW-1858) with a note typed at the bottom stating "Service not covered by Medicare."

827 This service denied by Medicare is also not covered by Medical Assistance (same as EC 431).

828 This podiatry service denied by Medicare should be billed on a Practitioner Invoice (DPW 1497) indicating "8" in the Type of Bill box.

829 Authorizing physician's prescription not attached to invoice.

830 Medicare calculation is incorrect.

831 Additional payment is not warranted.

832 Supply rejected by county of responsibility.

833 Inpatient and Outpatient 42 day Automatic Reject.

834 Prior Authorization omitted for supply requiring a Prior Authorization.

835 Claim covered only when submitted by authorized provider.

836 This service denied by Medicare should be rebilled on a Practitioner Invoice indicating "8" in the Type of Bill box.

837 Point of origin and/or destination is missing.

900 Technical processing problem – provider may ignore this code.

MEDICAL ELIGIBILITY VERIFICATION REQUEST

DPW-1960
(5-76)

(See instructions on reverse)

Provider name	Number	Address

(1) The provider will use the unshaded area to supply as much information as possible; please type.
(2) The county welfare agency will use the shaded area below to verify the information provided and supply missing information.

NAME	MEDICAL ID NUMBER	BIRTHDATE	THIRD PARTY LIABILITY	DATE OF SERVICE/ ELIGIBLE DATES	BILLED TO/BILL	REJ. CODE/ STATUS

THE MEDICAL ELIGIBILITY VERIFICATION REQUEST

The Medical Eligibility Verification Request (DPW-1960) is the form which providers may use to verify patient eligibility. Completed forms are sent to the county agency and will be returned to the provider. The form will be particularly useful when incorrect identification information causes a claim to reject from the processing system. The correct information can be obtained with the completion of this form. The rejected claim can then be rebilled using correct patient identification data. These forms are available from the M.A. Program by requisition.

INSTRUCTIONS

1. The Medical Identification Card is the major source of current information available to the provider. Individuals making appointments for medical services or seeking medical supplies should be required to furnish a Medical Identification Card. Individuals claiming to be eligible, but not possessing an ID card, should be referred to the county welfare agency to obtain an ID card.

2. The Medical ID Card is issued monthly for each month of eligibility. The period of eligibility and eligible family members are indicated on the ID card. It is the responsibility of the provider to confirm from the ID card that the person is eligible for the month in which he/she is seeking service. Verification must be made each month. Providers may not assume, if they successfully used an ID number one month, that the same number may be used the following month.

3. There are two medical payment programs:

   a. Medical Assistance -- Individuals eligible for this program have a Medical ID card titled "State of Minnesota Medical Identification". Claims for these individuals should be billed directly to the State of Minnesota, Department of Public Welfare, Centralized Payment System.

   b. General Assistance Medical Care -- Individuals eligible for this program may or may not have an ID card issued by the county. Claims for these individuals should be billed directly to the appropriate county welfare agency.

4. When it is impossible to obtain a Medical ID Card from the individual, or for assistance in resolving the "700 type" reject messages appearing on the DPW Remittance Advice, providers may request information by using the "Medical Eligibility Verification Request" form. Multiple requests may be made on one form. The completed form should be sent to the county welfare agency which is responsible for servicing the provider's area.

   The request form will be processed and returned to the provider indicating the status of the individual. To complete the request form, the provider will use the unshaded area to supply as much of the requested information as possible to assist in identifying the individual and/or determining the reason for the claim being rejected for payment. The county welfare agency will use the shaded area below to verify the information and supply missing information. If the information furnished by the provider is correct, verification will consist of a check ( ) in the corresponding shaded block below. If the information is incorrect or missing, the correct information will be entered in the corresponding shaded block. If the individual is not eligible or is in a pending status, this information will be indicated in the "Eligible Dates" block.

A listing of addresses and telephone numbers for the various county agencies follows the form.

MEDICAL ELIGIBILITY INFORMATION

County	Address	Phone
1. Aitkin	Court House Annex, Aitkin 56431	218-927-2141
2. Anoka	Court House, Anoka 55303 (Box 290)	612-421-4760
3. Becker	Court House, Detroit Lakes 56501	218-847-5628
4. Beltrami	Court House, Bemidji 56601 (Box 688)	218-751-4310
5. Benton	Court House, Foley 56329	612-968-6256
6. Big Stone	340 Northwest 2nd St., Ortonville 56278	612-839-2555
7. Blue Earth	420 Cherry St., Mankato 56001	507-625-3031
8. Brown	114 North State St., New Ulm 56073	507-354-8246
9. Carlton	Court House, Carlton 55718	218-879-4583
10. Carver	Court House, Chaska 55318	612-448-3661
11. Cass	Welfare Building, Walker 56484	218-547-1340
12. Chippewa	Court House, Montevideo 56265	612-269-6581
13. Chisago	Court House Annex, Center City 55012	612-257-1300
14. Clay	Court House, Moorhead 56560	218-236-0900
15. Clearwater	Court House, Bagley 56621 (Box X)	218-694-6512
16. Cook	Court House, Grand Marais 55604	218-387-2900
17. Cottonwood	Court House, Windom 56101 (Box 31)	507-831-1891
18. Crow Wing	1112 Willow St., Brainerd 56401	218-829-3556
19. Dakota	820 Southview Blvd., So. St. Paul 55075	612-451-1741
20. Dodge	Court House, Mantorville 55955	507-635-2211
21. Douglas	Court House, Alexandria 56308	612-762-2302
22. Faribault	Box 436, Faribault County Office Bldg., Blue Earth 56013	507-526-3265
23. Fillmore	Court House, Preston 55965	507-765-3821
24. Freeborn	410 South Broadway, Albert Lea 56007	507-373-6482
25. Goodhue	Court House, Red Wing 55066	612-388-2891
26. Grant	Court House, Elbow Lake 56531	218-685-4417
27. Hennepin	A-1005 Government Center 300 So. 6th St., Minneapolis 55487	612-348-8125
28. Houston	Court House, Caledonia 55921	507-724-3344
29. Hubbard	Court House, Park Rapids 56470	218-732-3339
30. Isanti	221 Southwest 2nd St., Cambridge 55008	612-689-4900
31. Itasca	Court House, Grand Rapids 55744	218-326-9441
32. Jackson	Court House, Jackson 56143	507-847-4000
33. Kanabec	18 North Vine, Mora 55051	612-679-3465
34. Kandiyohi	Court House, Willmar 56201	612-235-3014
35. Kittson	Court House, Hallock 56728	218-843-6741
36. Koochiching	Court House Annex, International Falls 55649	218-283-8405
37. Lac qui Parle	Court House, Madison 56256	612-598-7594
38. Lake	161 3rd Ave., Two Harbors 55615	218-834-2134

County	Address	Phone
39. Lake of the Woods	Court House, Baudette 56623	218-634-2642
40. LeSueur	Court House, LeCenter 56057	612-445-7543
41. Lincoln	Court House, Ivanhoe 56142	507-694-1452
42. Lyon	Court House, Marshall 56258	507-532-2201
43. McLeod	Court House, Glencoe 55336	612-864-5551
44. Mahnomen	County Office Building, Mahomen 56557	218-935-2568
45. Marshall	Court House, Warren 56762	218-748-5481
46. Martin	Court House, Fairmont 56031	507-238-4447
47. Meeker	Court House, Litchfield 55355	612-693-2418
48. Mille Lacs	Court House, Milaca 56353	612-983-6161
49. Morrison	Court House, Little Falls 56345	612-632-9201
50. Mower	Court House, Austin 55912 (Box 189)	507-433-3416
51. Murray	2711 Broadway Ave., Slayton 56172	507-836-6144
52. Nicollet	Court House, St. Peter 56082	507-931-1170
53. Nobles	Court House, Worthington 56187	507-372-2157
54. Norman	County Office Bldg., Ada 56510	218-784-7136
55. Olmsted	915-3rd Ave. S.E., Rochester 55901	507-288-2471
56. Otter Tail	Court House, Fergus Falls 56537	218-739-2271
57. Pennington	Court House, Thief River Falls 56701 (Box 340)	218-681-2880
58. Pine	Court House, Pine City 55063	612-629-2544
59. Pipestone	Court House, Pipestone 56154	507-825-3357
60. Polk	Court House, Crookston 56716	218-281-3127
61. Pope	Court House, Glenwood 56334	612-634-4591
62. Ramsey	160 E. Kellogg Blvd., St. Paul 55102	612-298-5351
63. Red Lake	Court House, Red Lake Falls 56750	218-253-4131
64. Redwood	P.O. Box 27, Redwood Falls 56283	507-637-2926
65. Renville	300 So. 7th St., Olivia 56277	612-523-2202
66. Rice	2855 N. Hwy. #3 (P.O. Box 718) Faribault 55021	507-334-4357
67. Rock	107 East Main, Luverne 56156	507-283-4481
68. Roseau	307 3rd Street, Roseau 56751	218-463-2411
69. St. Louis	422 West 3rd St., Duluth 55806	218-727-8231
70. Scott	310 West 4th Ave., Shakopee 55379	612-445-7750
71. Sherburne	County Admin. Bldg., Elk River 55330	612-441-1711
72. Sibley	Court House, Gaylord 55334	612-237-5266
73. Stearns	700 St. Germaine, St. Cloud 56301	612-251-3272
74. Steele	Steele County Admin. Annex (West Hills) Owatonna 55060	507-451-6740
75. Stevens	Court House, Morris 56267 (Box 111)	612-589-1481
76. Swift	103 12th St. South, Benson 56215	612-843-3160
77. Todd	Court House Annex, Long Prairie 56347	612-732-6181

County	Address	Phone
78. Traverse	15 10th St. South, Wheaton 56296	612-563-8255
79. Wabasha	Court House, Wabasha 55981	612-565-4544
80. Wadena	Court House Annex, 22 S.E. Dayton, Wadena 56482	218-631-2832
81. Waseca	Security Building, Waseca 56093	507-835-3240
82. Washington	939 W. Anderson St., Stillwater 55082	612-439-6901
83. Watonwan	715 3rd Ave. So., St. James 56081	507-375-3329
84. Wilkin	Court House, Breckenridge 56520	218-643-8561
85. Winona	Court House, Winona 55987	507-452-8200
86. Wright	Court House, Buffalo 55313	612-682-3900
87. Yellow Medicine	Court House, Granite Falls 56241	612-564-2211

Medical Assistance Identification Card

OTHER PERSONS COVERED

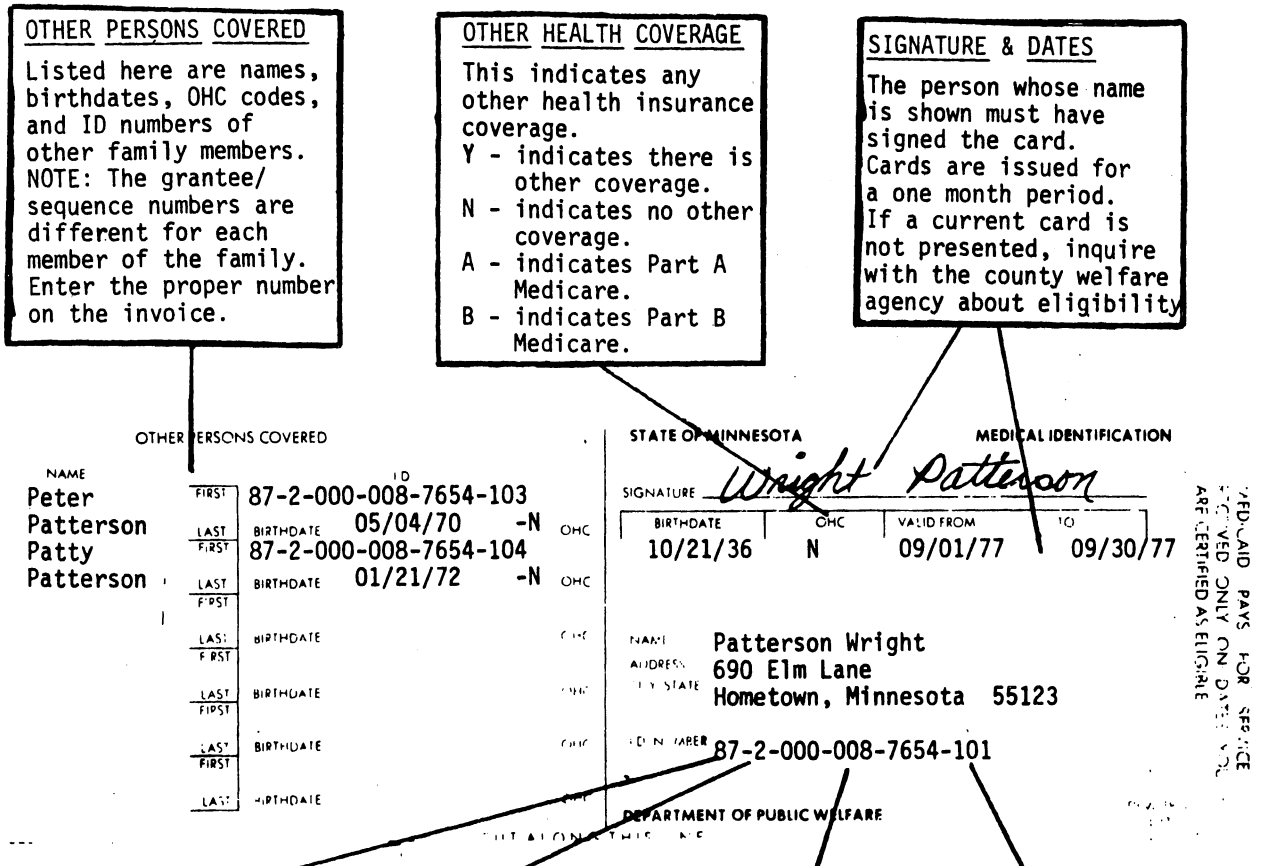
Listed here are names, birthdates, OHC codes, and ID numbers of other family members. NOTE: The grantee/ sequence numbers are different for each member of the family. Enter the proper number on the invoice.

OTHER HEALTH COVERAGE

This indicates any other health insurance coverage.
- Y - indicates there is other coverage.
- N - indicates no other coverage.
- A - indicates Part A Medicare.
- B - indicates Part B Medicare.

SIGNATURE & DATES

The person whose name is shown must have signed the card. Cards are issued for a one month period. If a current card is not presented, inquire with the county welfare agency about eligibility



RESPONSIBLE COUNTY

These two digits refer to the county responsible for the recipient's financial payments.

PROGRAM CODE

This code identifies the program under which the recipient becomes eligible for medical services

CASE NUMBER

This ten digit number is assigned by the county welfare agency to each case as the person becomes eligible for assistance.

GRANTEE/SEQUENCE NUMBER

This number uniquely identifies each member of the family. Person 101 is usually the head of the household. Services rendered must be identified with that person's own number.

RECIPIENT IDENTIFICATION NUMBER

This is the number which the 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.

REQUISITION FOR DPW FORMS

Mail this requisition to

FORMS MANAGEMENT
DEPARTMENT OF PUBLIC WELFARE
B-20 CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

FOR DPW APPROVAL

SEND FORMS ORDERED TO:

AGENCY OR NAME		
MEDICAL CENTER, P.A.		
ADDRESS		
690 N. ROBERT		
CITY	STATE	ZIP CODE
ANYTOWN	MN	55164

PLEASE SIGN REQUISITION HERE:

11/9/77 Signature

DATE

Form Number	Form Title	Quantity	DPW or Centennial Stores use only ACTION TAKEN (see reverse)
DPW- 1497	Practitioner Invoice		
DPW- 1854	Adjustment Request		
DPW- 1855	Prior Authorization		
DPW- 1863	Practitioner Envelope		
DPW- 1877	Adjustment Request Envelope		
DPW- 1876	Prior Authorization Envelope		
DPW- 121	Forms Requisition		
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			

Example

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

DPW-121
(8-77)

JULIAN DATE CALENDAR

DAY MO.	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
1.	1	32	60	91	121	152	182	213	244	274	305	335
2.	2	33	61	92	122	153	183	214	245	275	306	336
3.	3	34	62	93	123	154	184	215	246	276	307	337
4.	4	35	63	94	124	155	185	216	247	277	308	338
5.	5	36	64	95	125	156	186	217	248	278	309	339
6.	6	37	65	96	126	157	187	218	249	279	310	340
7.	7	38	66	97	127	158	188	219	250	280	311	341
8.	8	39	67	98	128	159	189	220	251	281	312	342
9.	9	40	68	99	129	160	190	221	252	282	313	343
10.	10	41	69	100	130	161	191	222	253	283	314	344
11.	11	42	70	101	131	162	192	223	254	284	315	345
12.	12	43	71	102	132	163	193	224	255	285	316	346
13.	13	44	72	103	133	164	194	225	256	286	317	347
14.	14	45	73	104	134	165	195	226	257	287	318	348
15.	15	46	74	105	135	166	196	227	258	288	319	349
16.	16	47	75	106	136	167	197	228	259	289	320	350
17.	17	48	76	107	137	168	198	229	260	290	321	351
18.	18	49	77	108	138	169	199	230	261	291	322	352
19.	19	50	78	109	139	170	200	231	262	292	323	353
20.	20	51	79	110	140	171	201	232	263	293	324	354
21.	21	52	80	111	141	172	202	233	264	294	325	355
22.	22	53	81	112	142	173	203	234	265	295	326	356
23.	23	54	82	113	143	174	204	235	266	296	327	357
24.	24	55	83	114	144	175	205	236	267	297	328	358
25.	25	56	84	115	145	176	206	237	268	298	329	359
26.	26	57	85	116	146	177	207	238	269	299	330	360
27.	27	58	86	117	147	178	208	239	270	300	331	361
28.	28	59	87	118	148	179	209	240	271	301	332	362
29.	29	--	88	119	149	180	210	241	272	302	333	363
30.	30	--	89	120	150	181	211	242	273	303	334	364
31.	31	--	90	---	151	---	212	243	---	304	---	365

FOR LEAP YEAR, ONE DAY MUST BE ADDED TO NUMBER OF DAYS AFTER FEBRUARY 28.

EXAMPLE: CLAIM REFERENCE # 770730800033300
77 = YEAR
073 = JULIAN DATE
08000333 = CONSECUTIVE # OF INVOICE
00 = INTERNAL PROCESSING

STATE OF MINNESOTA

Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM

BULLETIN

TO: Physicians and Clinics
Psychologists

November 1977

SUBJECT: Revised Prior Authorization Form

*** December 1, 1977 Effective Date ***

Effective December 1, 1977 you must use the revised Prior Authorization form (DPW-1855) for all Prior Authorization requests. Prior authorization requests submitted on the old forms will not be processed after November 30, 1977. Please note the new instructions for prior authorization of psychiatric services. These instructions will replace those in the handbook.

For questions regarding this bulletin please contact:

Outstate: 1-800-652-9055
Metro Twin Cities - 612/296-7471
Outstate: Call Metro Number Collect.

COMPLETION OF THE PRIOR AUTHORIZATION FORM DPW-1855

Submitting a Prior Authorization is a request for approval of a procedure, service or material. Approval is not a guarantee of payment. Payment can only be made if recipient is eligible on the DATE(S) OF SERVICE.

The Prior Authorization Form, DPW-1855, has information items grouped together.

PRIOR AUTHORIZATION FORM HEADING

The heading contains the address to which all Prior Authorization Request must be sent and the typewriter alignment tabs. It also contains:

1. Claims Processing Document Control Number.

   Do Not complete this item.

PROVIDER INFORMATION

2. Provider's Name

   Enter the physician's or clinic's name as enrolled.

3. Provider ID#

   Enter the physician's individual or group 7 digit identification number.

4. Own Reference #

   The provider may enter his own account reference number, which may include as many as 9 letters and/or numbers to accommodate individual filing system. Numbers are preferred for accuracy of scanning. This information is not mandatory but, if furnished, will appear on the Remittance Advice.

5. Date Submitted

   Enter the date the request is submitted using two digits for the month, day and year. Use a six digit format for this and any other date on this form. Do NOT use slashes, dashes or spaces to separate month, day and year. The printed vertical bars serve as separations.

6. Street Address

   Enter the street address of the provider.

7. City/State/Zip Code

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

8. Name and City of Hospital or LTC Facility

   If the service is rendered in a hospital or long term facility, enter the facility's name and address.

PROVIDER INFORMATION (Continued)

9. Prior Authorization #

This number will appear preprinted on the form and should be used by the provider when making inquiries regarding the authorization request. If the requested authorization is approved, this prior authorization # must be entered in block 6 on the Practitioner Invoice, DPW-1497. Do NOT alter this number.

RECIPIENT INFORMATION

10. Patient's Name

Enter the patient's full name, exactly as it appears on the M.A. identification card; last name, first name, middle initial. Use all capital letters.

11. Patient's Medical Assistance Number

Enter the 16 digit number as shown on the recipient's Medical Assistance identification card. Do NOT type in the dashes; they are provided on the form.

12. Sex

Enter the recipient's sex: M = Male
F = Female

13. Birthdate

Enter the six digits of the recipient's birth as it appears on the MA/ID card. Do NOT use dashes, slashes or spaces. The printed vertical bars separate month, day and year.

REQUESTED AUTHORIZATION

There are five lines provided in the Requested Authorization Section. This enables the provider to request authorization for up to five procedures for one patient on the same request form.

14. Service Name

Enter the name of procedure requested.

15. Service Code

Enter the appropriate procedure code.

16. Transaction

Leave blank.

17. Proposed Charge

Enter the usual and customary charge for procedure. Do not use the dollar sign.

REQUESTED AUTHORIZATION (Continued)

18. Requested # of Billings

Enter the number of clinical units requested for psychological service. Enter number one (1) for surgical procedures.

19. Delete

To delete a claim line containing errors use an X.

20. Allowed # of Billings

Leave blank. When the request is returned the allowed number of billings will be indicated.

21. Approved

Leave blank. When approved request is returned the approval will be indicated with an X in this space.

22. Denied

Leave blank. When a denied request is returned the denial will be indicated with an X in this space.

23. Authorized Charge

Leave blank. Payment will be based on "maximum allowable charge" for services

24-63.

Follow the same format as Items 14-23.

64. Total Number of Lines Used

Enter the total lines used. Do not include deleted lines.

65. Office Use Only - Billing Cycles

Leave blank.

66. Total Proposed Charges

Enter the sum of all proposed charges.

67. Total Authorized Charges

Leave blank. See box 23.

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

For each procedure listed under Requested Authorization section, give supporting evidence why this procedure is medically necessary.

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW (Continued)

If more space is needed, attach reports with a paper clip to the Prior Authorization Form before submitting.

Insufficient information will cause delay in evaluating the request.

P.A. FOR PSYCHIATRIC CARE

The revised Prior Authorization form must be submitted in addition to a letter for extended Psychiatric care. Follow the instructions for completing the form. The letter must include information pertaining to recipient's diagnosis, prognosis, expected behavioral changes, medications, present condition, and follow-up plans.

Provider's Signature

The Prior Authorization must be signed by the requesting physician before the form can be reviewed by the department.

Reviewed By

Leave blank.

SUBMISSION OF PRIOR AUTHORIZATION REQUEST

The completed Prior Authorization request must be sent intact (both copies and carbon) to the Medical Assistance Program at the address indicated at the top of the form. When the request has been reviewed, one copy will be returned to the provider. If the request is approved, the Practitioner Invoice must be completed to bill for the service. Enter the pre-printed Prior Authorization number (box 9) on the Practitioner Invoice (box 6).

5

SEND AUTHORIZATION REQUESTS TO: Minnesota Medical Assistance Program, Department of Public Welfare, Box 30199, St. Paul 55175

PRIOR AUTHORIZATION

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER 1

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

PROVIDER INFORMATION

2 PROVIDER'S NAME: DOCTORS MEDICAL CLINIC
3 PROVIDER ID #: 2112345
4 OWN REFERENCE #:
5 DATE SUBMITTED: 103077
6 STREET ADDRESS: 202 MAIN STREET
7 CITY/STATE/ZIP: HOMETOWN, MN 55123
8 NAME AND CITY OF HOSPITAL OR LTC FACILITY:
9 PRIOR AUTHORIZATION #: 0900497

RECIPIENT INFORMATION

10 PATIENT'S NAME: SMYTHE, JOHN
11 PATIENT'S MEDICAL ASSISTANCE NUMBER: 27-8-000-246-8642-101
12 SEX: M
13 BIRTHDATE: 062152

REQUESTED AUTHORIZATION

	SERVICE NAME	SERVICE CODE	TRANSACTION	PROPOSED CHARGE	REQUESTED # OF BILLINGS	DELETE	ALLOWED # BILLINGS	APPROVED	DENIED	AUTHORIZED CHARGE
1	14 INDIVIDUAL PSYCHOTHERAPY	15 90841	16	17	18 10	19	20	21	22	23
2	24 CHEMICAL DEPENDENCY	25 90899	26	27	28 30	29	30	31	32	33
3	34 DAILY HOSPITAL CARE	35 90898	36	37	38 30	39	40	41		43
4	44	45		47	48	49	50			53
5	54		56	57	58	59		61	62	63

EXAMPLE OF PRIOR AUTHORIZATION FORM

64 TOT. USED | 65 OFFICE USE ONLY BILLING CYCLES | 66 TOTAL PROPOSED CHARGES | 67 TOTAL AUTHORIZED CHARGES

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

When asking for extension of psychological services, attach a letter with information pertaining to recipient's diagnosis, prognosis, expected behavioral changes, medications, present condition, and follow-up plan.

X _____ Reviewed By (For Department Use Only)

X Your Signature Provider's Signature

SERVICES AUTHORIZED (AS INDICATED ABOVE). HOWEVER, PAYMENT DEPENDS UPON RECIPIENT BEING ELIGIBLE AT THE TIME SERVICE IS PROVIDED.

SUBMIT ALL COPIES TO ABOVE ADDRESS

DPW1855 (4-77)

SEND AUTHORIZATION REQUESTS TO: Minnesota Medical Assistance Program, Department of Public Welfare, Box 30199, St. Paul 55175

PRIOR AUTHORIZATION

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER

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

PROVIDER INFORMATION

PROVIDER'S NAME	PROVIDER ID #	OWN REFERENCE #	DATE SUBMITTED
DOCTORS MEDICAL CLINIC	2121345		103077

STREET ADDRESS: 202 MAIN STREET

CITY/STATE/ZIP: HOMETOWN, MN 55123

NAME AND CITY OF HOSPITAL OR LTC FACILITY:

PRIOR AUTHORIZATION #: 0900497

RECIPIENT INFORMATION

PATIENT'S NAME	PATIENT'S MEDICAL ASSISTANCE NUMBER	SEX	BIRTHDATE
GUNDERSON, OLIVE	62-4-000-002-4099-101	F	071548

REQUESTED AUTHORIZATION

	SERVICE NAME	SERVICE CODE			UNITS	DATE
1	GASTRIC BYPASS	43635		900.00	1	
2	PANNICULECTOMY	17499		500.00	1	
3						
4						
5						

EXAMPLE OF PRIOR AUTHORIZATION FORM

APPROVED 61 DENIED 62 — AUTHORIZED CHARGE 63

NUMBER OF TIMES PROPOSED: 2 — NUMBER OF TIMES USED — OFFICE USE ONLY BILLING CYCLES — TOTAL PROPOSED CHARGES: 1300.00 — TOTAL AUTHORIZED CHARGES

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

Give supporting evidence that requested procedure is medically necessary.

X _____
Reviewed By (For Department Use Only)

X Your Signature
Provider's Signature

SERVICES AUTHORIZED (AS INDICATED ABOVE). HOWEVER, PAYMENT DEPENDS UPON RECIPIENT BEING ELIGIBLE AT THE TIME SERVICE IS PROVIDED.

SUBMIT ALL COPIES TO ABOVE ADDRESS

DPW1855 (4-77)

State of Minnesota
Department of Public Welfare
690 North Robert Street
St. Paul, Minnesota 55164

M.A.
BULLETIN

STATE OF MINNESOTA

Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM

BULLETIN

TO: Physicians
Psychologists

January 1978

SUBJECT: Medical Assistance Program Coverage of Psychiatric and Psychological Services

The provider handbooks issued to all enrolled physicians and psychologists explain the limitations on reimbursable psychiatric and psychological services. On September 13, 1977 the Department's Medical Assistance Rule (DPW—47) was adopted. Rule 47 changes some of these limitations. This bulletin is issued in order to update the information contained in your handbook and to clarify MA coverage of Psychiatric and psychological services.

This bulletin is effective upon receipt.

Procedure Code (CPT—3)	Description of Service	Limitations
90801	Psychiatric diagnostic interview examination including history, mental status, or disposition	Once per month — not more than three (3) times per calendar year
90825	Psychological testing, psychometric and/or projective tests including interpretation, psychiatric evaluation of hospital records, psychiatric or psychological reports, and other accumulated data for diagnostic purposes without other informants or patient interview	Once per month — not more than three (3) times per calendar year
90831	Telephone consultation with or about patient for psychiatric or psychological therapeutic or diagnostic purposes.	Not covered

Procedure Code (CPT—3)	Description of Service	Limitations
90841	Individual psychotherapy with continuing diagnostic evaluation and drug management as indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy	Ten (10) clinical units per calendar year
90847	Family psychotherapy of two family members (conjoint psychotherapy) with continuing diagnostic evaluation and drug management as needed	Not more than two (2) clinical units per week
90848	Family psychotherapy of three or more members of one family with continuing diagnostic evaluation and drug management as needed	Twenty-six (26) clinical units per calendar year
90849	Multiple-family group psychotherapy with continuing diagnostic evaluation and drug management as indicated	Not more than two (2) clinical units per week
90853	Group psychotherapy (other than of a multiple-family group) with continuing diagnostic evaulation and drug management as indicated	Not more than two (2) clinical units per week
90862	Chemotherapy management, including prescription, use, and review of medication with no more than minimal medical psychotherapy — provided the medication required is antipsychotic or antidepressive	Fifty-two (52) clinical units per calendar year — not more than one (1) unit per week
90880	Hypnotherapy	Ten (10) clinical units per calendar year
90882	Environmental intervention on a psychiatric patient's behalf with agencies, employers or institutions	One (1)clinical unit per calendar year
90887	Interpretation or explanation of results of psychiatric, psychological, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	One (1) clinical unit per calendar year
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies or insurance companies	Not covered as a separate procedure

Procedure Code (CPT—3)	Description of Service	Limitations
90898	Daily hospital care by attending physician or psychologist in treating a psychiatric inpatient (including psychiatric diagnostic examination, individual or group psychotherapy, with continuing diagnostic evaluation, exchanges with nursing and other ancillary personnel and conferences with family members). This category may be used in lieu of itemizing all specific inpatient procedures performed by the physician or psychologist.	Thirty (30) days per calendar year
90899	Unlisted psychiatric service or procedure. This is a by-report code designed for all unlisted psychiatric procedures. You must attach an explanation of service provided to the invoice. This code is also used to bill for **outpatient chemical dependency** programs. Reimbursement for outpatient CD services is limited to three (3) clinical units per day not to exceed (30) days. **ALL outpatient CD Services must receive prior authorization from the state agency in order to be reimbursable.**	

REMINDERS:

1. A "clinical unit" is defined as fifty (50) plus minutes.
2. Physicians and psychologists may request prior authorization by the Department in order to be reimbursed for services in excess of any of the above-listed limitations. For instructions in submitting prior authorization requests, see Physician Bulletin # 25 and Psychologist Bulletin # 1 (November 1977) and Physician # 19 and Psychologist # 3 (April 1977).
3. The MA program covers thirty (30) days of inpatient care per calendar year if the recipient is hospitalized for psychiatric **or** chemical dependency treatment. For purposes of the MA program, inpatient chemical dependency treatment is considered equivalent to inpatient psychiatric treatment. The attending physician is responsible for requesting prior authorization for inpatient services in excess of this limitation. Without an approved prior authorization on file, neither the hospital nor the attending physician will be paid beyond the thirty day limit.
4. Providers must request prior authorization within 72 hours after admitting an emergency psychiatric patient who has used his/her thirty days per calendar year of inpatient care.
5. When a patient is hospitalized for psychiatric or CD care, the attending physican or psychologist may use code 90898 **or** 90841 when billing the MA program. Code 90898 is used in lieu of itemizing services. Code 90841 is used in accordance with the ten (10) clinical units per calendar year limitation (see explanation of code 90841, above).
6. All outpatient chemical dependency clinics and programs must be approved by the MA program as providers of outpatient CD care. Contact the Medical Advisory Unit, 296-8822, for instructions on submitting your CD program for approval. In addition, an approved provider must submit a prior authorization request for each MA recipient for whom services will be provided.
7. Code 90825, psychological testing, includes interpretation and preparation of reports. Providers should identify each test given by name and indicate total time spent in testing and evaluation, interpretation and preparation of reports. Do not bill separately for preparation of reports.
8. Providers should bill the MA program according to the actual length of the clinical unit. For example, if you spend 25 minutes in a therapy session, you must put a "B" modifier in the type box and indicate "25 minutes" on the line. The MA program will reimburse according to reported length of the clinical unit. Clinical units that are less than 50 minutes long will nevertheless be fully counted toward the service limitation for that category of service.
9. The MA program does not pay for missed appointments.
10. The MA program does not pay billing or mileage charges.
11. The MA program does not pay for aversion therapy (including cash payments from recipients) unless provided in accordance with Rule DPW 39.

If you have any questions about this bulletin, contact:

Medical Advisory Unit: 296-8822
Claims Processing:
Physicians — 296-7471
Psychologists — 296-7668
Toll Free 1-800-652-9055