Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions
for
Home Health Services
Provider Type – 34

Version 4.9

May 17, 2019

Document Change Log

Document Version	Date	Name	Comments
1.0	10/14/2005	EDS	Initial creation of DRAFT Home Health Services Provider Type – 34
1.1	01/19/2006	EDS	Updated Provider Rep list
1.2	02/16/2006	Carolyn Stearman	Updated with revisions requested by Commonwealth.
1.3	03/28/2006	Lize Deane	Updated with revisions requested by Commonwealth.
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1.6	09/18/2006	Ann Murray	Replaced Provider Representative table.
1.7	11/14/2006	Ron Chandler	Insert UB-04 and descriptors.
1.8	01/03/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
1.9	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
2.0	02/15/2007	Ann Murray	Updated Appendix B, KY Medicaid card and ICN.
2.1	02/21/2007	Ann Murray	Replaced Provider Rep table.
2.2	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v1.7 – 2.2 are actually the same as revisions were made back-to-back and no publication would have been made
2.3	05/04/2007	Ann Murray	Updated and added claim forms and descriptors.
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2.5	01/31/2008	Ann Murray	Updated

Document Version	Date	Name	Comments
2.6	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive eligibility per Stayce Towles.
2.7	03/09/2009	Cathy Hill	Made changes from KY Health Choices to KY Medicaid per Stayce Towles
2.8	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept. for Medicaid Services per Stayce Towles
2.9	03/30/2009	Ann Murray	Made global changes per DMS request. v2.7 – 2.9 are actually the same as revisions were made back-to-back and no publication would have been made
3.0	09/08/2009	Ann Murray	Replaced Provider Rep list.
3.1	10/21/2009	Ron Chandler	Replace all instances of "EDS" with "HP Enterprise Services".
3.2	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @hp.com. Removed the HIPAA section. v3.1 – 3.2 are actually the same as revisions were made back-to-back and no publication would have been made
3.3	03/09/2010	Ron Chandler	Insert new provider rep list.
3.4	01/18/2011	Ann Murray	Updated global sections.
3.5	11/29/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
3.6	02/08/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman
3.7	02/22/2012	Brenda Orberson Ann Murray	Global updates made to remove all references to KenPAC and Lockin.
3.8	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
3.9	06/22/2012	Stayce Towles Ann Murray	Updated sections 7.4.1, 7.6.1 and deleted sections 7.1 UB 04 claim form without NPI and instructions per HP recommendation and DMS review by Ellenore Callan. DMS Approved 07/10/2012, Ellenore Callan

Document Version	Date	Name	Comments
4.0	08/31/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012
4.1	01/25/2013	Vicky Hicks Patti George	Update section 1.2.2.2 to reflect former Passport Members having a choice of MCOs as of 1/1/2013. DMS Approved 02/27/2013, John Hoffman
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4.3	08/12/2013	Stayce Towles Patti George	Update to section 5.10- Provider Rep listing.
4.4	04/07/2014	Stayce Towles	Update sections 1-5 per DMS. Approved 4/7/14 by Lee Guice.
4.5	05/19/2015	Stayce Towles	Update TOB 331 to 321. Approved, 5/20/15, Sheila Davis DMS.
4.6	07/08/2015	Stayce Towles	Add field 66 to the detailed billing instructions for ICD indicator. Approved by John Hoffmann, OATS, 7/6/15.
4.7	06/24/2016	Vicky Hicks	Updated rep list
4.8	02/01/2017	Vicky Hicks	Added "Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com under Companion Guides and EDI Guides." Approved by Charles Douglass, DMS 2/1/2017 Added form locators 78 and 80 regarding Referring and Attending provider information. Approved by Charles Douglass, DMS 2/8/2017
4.9	05/17/2019	Vicky Hicks Mary Larson	Updated: 1) HP/HPE to DXC, hpe.com to dxc.com, 2) Provider Rep Table, 3) all forms, 4) DMS URLs in Introduction, 5) ICD-9/ICD-9-CM to ICD-10

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1   General

1.1   Introduction

Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com under Companion Guides and EDI Guides.

These instructions are intended to assist persons filing claims for services provided to Kentucky Medicaid Members. Guidelines outlined pertain to the correct filing of claims and do not constitute a declaration of coverage or guarantee of payment.

Policy questions should be directed to the Department for Medicaid Services (DMS). Policies and regulations are outlined on the DMS website at:

https://chfs.ky.gov/agencies/dms/Pages/default.aspx

Fee and rate schedules are available on the DMS website at:

https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx

1.2   Recipient Eligibility

Members should apply for Medicaid eligibility through kynect (kyenroll.ky.gov), by phone at 1-855-4kynect (1-855-459-6328), or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through Friday. This office is closed on holidays.

The primary identification for Medicaid-eligible members is the Kentucky Medicaid card. This is a permanent plastic card issued when the Member becomes eligible for Medicaid coverage. The name of the member and the member's Medicaid identification (ID) number are displayed on the card. The provider is responsible for checking identification and verifying eligibility before providing services.

NOTE: Payment cannot be made for services provided to ineligible members. Possession of a Member Identification card does not guarantee payment for all medical services.

1.2.1 Plastic Swipe KY Medicaid Card
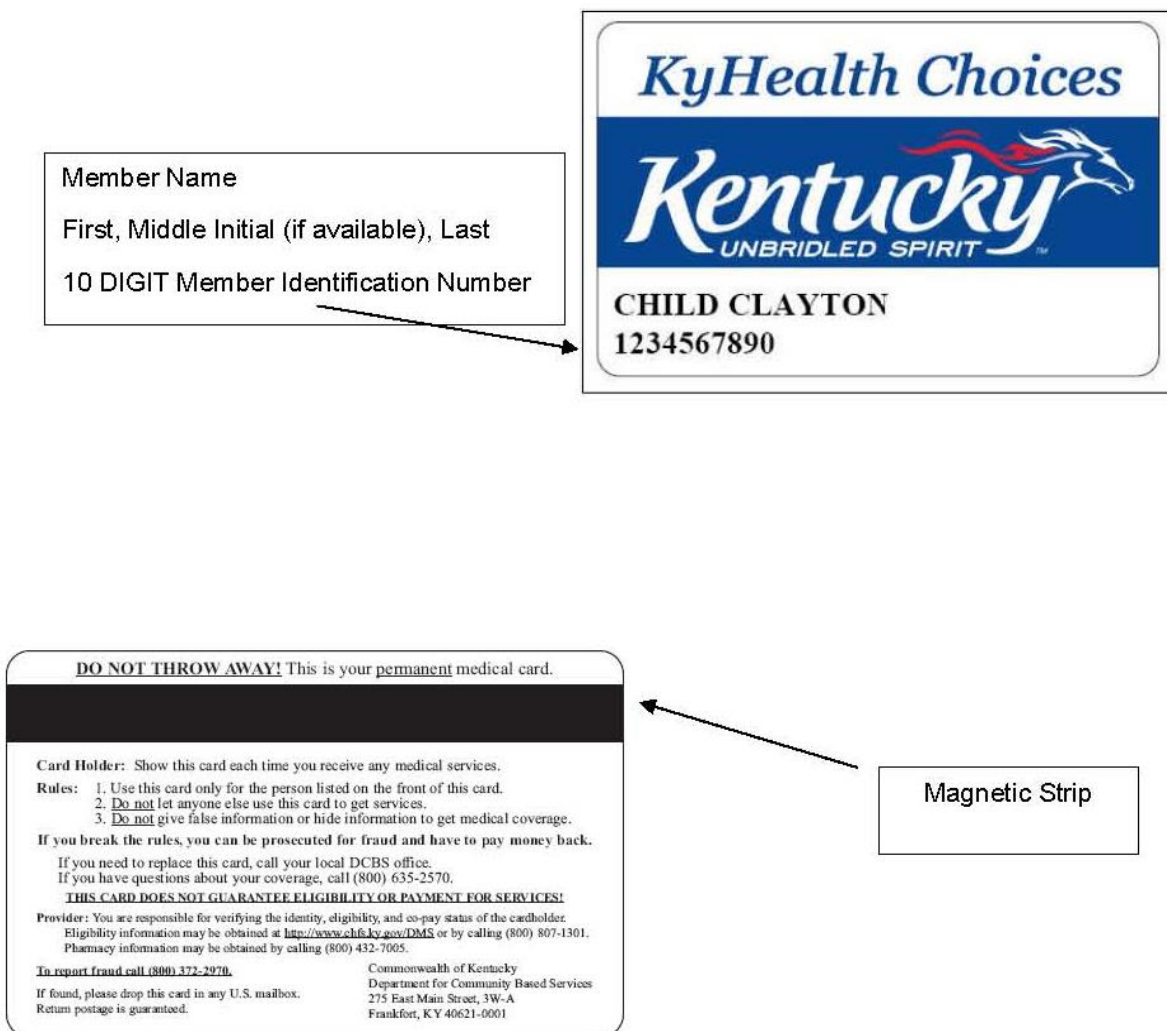
Through a vendor of your choice, the magnetic strip can be swiped to obtain eligibility information.

Providers who wish to use the card's magnetic strip to access eligibility information may do so by contracting with one of several vendors.

1.2.2   Recipient Eligibility Categories

1.2.2.1   QMB and SLMB

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are Members who qualify for both Medicare and Medicaid. In some cases, Medicaid may be limited. QMB Members have Medicare and full Medicaid coverage, as well. QMB-only Members have Medicare, and Medicaid serves as a Medicare supplement only. A Member with SLMB does not have Medicaid coverage; Kentucky Medicaid pays a "buy-in" premium for SLMB Members to have Medicare, but offers no claims coverage.

1.2.2.2   Managed Care Partnership

Medical benefits for persons whose care is overseen by a Managed Care Organization (MCO) are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ. Providers with MCO questions should contact the respective MCO provider services: Passport Health Plan at 1-800-578-0775, WellCare of Kentucky at 1-877-389-9457, Humana Caresource at 1-855-852-7005, Anthem Blue Cross Blue Shield at 1-800-880-2583, or Aetna Better Health of KY at 1-855-300-5528.

1.2.2.3   KCHIP

The Kentucky Children's Health Insurance Program (KCHIP) provides coverage to children through age 18 who have no insurance and whose household income meets program guidelines. Children with KCHIP III are eligible for all Medicaid-covered services except Non-Emergency Transportation and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Special Services. Regular KCHIP children are eligible for all Medicaid-covered services.

For more information, access the KCHIP website at http://kidshealth.ky.gov/en/kchip.

1.2.2.4   Presumptive Eligibility

Presumptive Eligibility (PE) is a program that offers certain individuals and pregnant women temporary medical coverage. A treating physician or hospital may issue an Identification Notice to an individual if it is determined that the individual meets the criteria as described below. PE benefits are in effect up to 60 days from the date the Identification Notice is issued, or upon denial or issuance of Medicaid. The 60 days includes current month through end of the next month. This short-term program is intended to allow financially needy individuals to have access to medical services while they are completing the application process for full Medicaid benefits.

Reimbursement for services is different for presumptively eligible individuals depending on the method by which eligibility is granted. The two types of PE are as follows:

- PE for pregnant women

- PE for hospitals

1.2.2.4.1 PE for Pregnant Women

1.2.2.4.1.1 Eligibility

A determination of presumptive eligibility for a pregnant woman shall be made by a qualified provider who is enrolled as a Kentucky Medicaid provider in one of the following categories:

1. A family or general practitioner;

2. A pediatrician;

3. An internist;

4. An obstetrician or gynecologist;

5. A physician assistant;

6. A certified nurse midwife;

7. An advanced practice registered nurse;

8. A federally-qualified health care center;

9. A primary care center;

10. A rural health clinic

11. A local health department

Presumptive eligibility shall be granted to a woman if she:

1. Is pregnant;

2. Is a Kentucky resident;

3. Does not have income exceeding 195 percent of the federal poverty level established annually by the United States Department of Health and Human Services;

4. Does not currently have a pending Medicaid application on file with the DCBS;

5. Is not currently enrolled in Medicaid;

6. Has not been previously granted presumptive eligibility for the current pregnancy; and

7. Is not an inmate of a public institution

1.2.2.4.1.2 Covered Services

Covered services for a presumptively eligible pregnant woman shall be limited to ambulatory prenatal services delivered in an outpatient setting and shall include:

1. Services furnished by a primary care provider, including:

    a. A family or general practitioner;

    b. A pediatrician;

    c. An internist;

    d. An obstetrician or gynecologist;

  e. A physician assistant;

  f. A certified nurse midwife; or

  g. An advanced practice registered nurse;

2. Laboratory services;

3. Radiological services;

4. Dental services;

5. Emergency room services;

6. Emergency and nonemergency transportation;

7. Pharmacy services;

8. Services delivered by rural health clinics;

9. Services delivered by primary care centers, federally-qualified health centers, and federally-qualified health center look-alikes; or

10. Primary care services delivered by local health departments.

1.2.2.4.2 PE for Hospitals

1.2.2.4.2.1 Eligibility

A determination of presumptive eligibility can be made by an inpatient hospital participating in the Medicaid program using modified adjusted gross income for an individual who:

1. Does not have income exceeding:

  a. 138 percent of the federal poverty level established annually by the United States Department of Health and Human Services; or

  b. 200 percent of the federal poverty level for children under age one and 147 percent of the federal poverty level for children ages 1-5 as established annually by the United States Department of Health and Human Services, if the individual is a targeted low-income child;

2. Does not currently have a pending Medicaid application on file with the DCBS;

3. Is not currently enrolled in Medicaid; and

4. Is not an inmate of a public institution

1.2.2.4.2.2 Covered Services

Covered services for a presumptively eligible individual who meet the income guidelines above shall include:

1. Services furnished by a primary care provider, including:

  a. A family or general practitioner;

b. A pediatrician;

c. An internist;

d. An obstetrician or gynecologist;

e. A physician assistant;

f. A certified nurse midwife; or

g. An advanced practice registered nurse;

2. Laboratory services;

3. Radiological services;

4. Dental services;

5. Emergency room services;

6. Emergency and nonemergency transportation;

7. Pharmacy services;

8. Services delivered by rural health clinics;

9. Services delivered by primary care centers, federally-qualified health centers and federally-qualified health center look-alikes;

10. Primary care services delivered by local health departments; or

11. Inpatient or outpatient hospital services provided by a hospital.

1.2.2.5 Breast & Cervical Cancer Treatment Program

The Breast & Cervical Cancer Treatment Program (BCCTP) offers Medicaid coverage to women who have a confirmed cancerous or pre-cancerous condition of the breast or cervix. In order to qualify, women must be screened and diagnosed with cancer by the Kentucky Women's Cancer Screening Program, be between the ages of 21 and 65, have no other insurance coverage, and not reside in a public institution. The length of coverage extends through active treatment for the breast or cervical cancer condition. Those members receiving Medicaid through BCCTP are entitled to full Medicaid services. Women who are eligible through BCCTP do not receive a Medicaid card for services. The enrolling provider will provide a printed document that is to be used in place of a card.

1.2.3 Verification of Member Eligibility

This section covers:

- Methods for verifying eligibility;

- How to verify eligibility through an automated 800 number function;

- How to use other proofs to determine eligibility; and

- What to do when a method of eligibility is not available.

1.2.3.1 Obtaining Eligibility and Benefit Information

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;

- KY HealthNet at https://home.kymmis.com;

- The Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except holidays.

1.2.3.1.1 Voice Response Eligibility Verification (VREV)

DXC Technology maintains a VREV system that provides member eligibility verification, as well as information regarding third party liability (TPL), Managed Care, PRO review, Card Issuance, Co-pay, provider check write, and claim status.

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.

2. Prompt the caller to select the type of inquiry desired (eligibility, TPL, Managed Care, PRO reviews, Card Issuance, Co-pay, provider check write, claim status, etc.).

3. Prompt the caller for the dates of service (enter four digit year, for example, MMDDCCYY).

4. Respond by providing the appropriate information for the requested inquiry.

5. Prompt for another inquiry.

6. Conclude the call.

This system allows providers to take a shortcut to information. Users may key the appropriate responses (such as provider ID or Member ID) as soon as each prompt begins. The number of inquiries is limited to five per call. The VREV spells the member name and announces the dates of service. Check amount data is accessed through the VREV voice menu. The Provider's last three check amounts are available.

1.2.3.1.2 KY HealthNet Online Member Verification

KY HealthNet online access can be obtained at https://home.kymmis.com. The KY HealthNet website is designed to provide real-time access to member information. Providers can download a User Manual to assist providers in system navigation. Providers with suggestions, comments, or questions, should contact the DXC Technology Electronic Claims Department at KY_EDI_Helpdesk@dxc.com or 1-800-205-4696.

All Member information is subject to HIPAA privacy and security provisions, and it is the responsibility of the provider and the provider's system administrator to ensure all persons with access understand the appropriate use of this data. It is suggested that providers establish office guidelines defining appropriate and inappropriate uses of this data.

2   Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

2.1   How to Get Started

All Providers are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner or to obtain a list of Trading Partner vendors, contact the DXC Technology Electronic Data Interchange Technical Support Help Desk at:

> DXC Technology
> P.O. Box 2100
> Frankfort, KY 40602-2016
> 1-800-205-4696

Help Desk hours are between 7:00 a.m. and 6:00 p.m. Monday through Friday, except holidays.

2.2   Format and Testing

All EDI Trading Partners must test successfully with DXC Technology and have Department for Medicaid Services (DMS) approved agreements to bill electronically before submitting production transactions. Contact the EDI Technical Support Help Desk at the phone number listed above for specific testing instructions and requirements.

2.3   ECS Help

Providers with questions regarding electronic claims submission may contact the EDI Help desk.

3   KY HealthNet

The KY HealthNet website allows providers to submit claims online via a secure, direct data entry function. Providers with internet access may utilize the user-friendly claims wizard to submit claims, in addition to checking eligibility and other helpful functions.

3.1   How to Get Started

All Providers are encouraged to utilize KY HealthNet rather than paper claims submission. To become a KY HealthNet user, contact our EDI helpdesk at 1-800-205-4696, or click the link below.

http://www.chfs.ky.gov/dms/kyhealth.htm

3.2   KY HealthNet Companion Guides

Field-by-field instructions for KY HealthNet claims submission are available at:

http://www.kymmis.com/kymmis/Provider%20Relations/KyHealthNetManuals.aspx

4 General Billing Instructions for Paper Claim Forms

4.1 General Instructions

The Department for Medicaid Services is mandated by the Centers for Medicare and Medicaid Services (CMS) to use the appropriate form for the reimbursement of services. Claims may be submitted on paper or electronically.

4.2 Imaging

All paper claims are imaged, which means a digital photograph of the claim form is used during claims processing. This streamlines claims processing and provides efficient tools for claim resolution, inquiries, and attendant claim related matters.

By following the guidelines below, providers can ensure claims are processed as they intend:

- USE BLACK INK ONLY;

- Do not use glue;

- Do not use more than one staple per claim;

- Press hard to guarantee strong print density if claim is not typed or computer generated;

- Do not use white-out or shiny correction tape; and,

- Do not send attachments smaller than the accompanying claim form.

4.3 Optical Character Recognition

Optical Character Recognition (OCR) eliminates human intervention by sending the information on the claim directly to the processing system, bypassing data entry. OCR is used for computer generated or typed claims only. Information obtained mechanically during the imaging stage does not have to be manually typed, thus reducing claim processing time. Information on the claim must be contained within the fields using font 10 as the recommended font size in order for the text to be properly read by the scanner.

5   Additional Information and Forms

5.1   Claims with Dates of Service More than One Year Old

In accordance with federal regulations, claims must be received by Medicaid no more than 12 months from the date of service, or six months from the Medicare or other insurance payment date, whichever is later. "Received" is defined in 42 CFR 447.45 (d) (5) as "The date the agency received the claim as indicated by its date stamp on the claim."

Kentucky Medicaid includes the date received in the Internal Control Number (ICN). The ICN is a unique number assigned to each incoming claim and the claim's related documents during the data preparation process. Refer to Appendix A for more information about the ICN.

For claims more than 12 months old to be considered for processing, the provider must attach documentation showing timely receipt by DMS or DXC Technology and documentation showing subsequent billing efforts, if any.

To process claims beyond the 12 month limit, you must attach to each claim form involved, a copy of a Claims in Process, Paid Claims, or Denied Claims section from the appropriate Remittance Statement no more than 12 months old, which verifies that the original claim was received within 12 months of the service date.

Additional documentation that may be attached to claims for processing for possible payment is:

- A screen print from KY HealthNet verifying eligibility issuance date and eligibility dates must be attached behind the claim;

- A screen print from KY HealthNet verifying filing within 12 months from date of service, such as the appropriate section of the Remittance Advice or from the Claims Inquiry Summary Page (accessed via the Main Menu's Claims Inquiry selection);

- A copy of the Medicare Explanation of Medicare Benefits received 12 months after service date but less than six months after the Medicare adjudication date; and,

- A copy of the commercial insurance carrier's Explanation of Benefits received 12 months after service date but less than six months after the commercial insurance carrier's adjudication date.

5.2   Retroactive Eligibility (Back-Dated) Card

Aged claims for Members whose eligibility for Medicaid is determined retroactively may be considered for payment if filed within one year from the eligibility issuance date. Claim submission must be within 12 months of the issuance date. A copy of the KY HealthNet card issuance screen must be attached behind the paper claim.

5.3   Unacceptable Documentation

Copies of previously submitted claim forms, providers' in-house records of claims submitted, or letters detailing filing dates are not acceptable documentation of timely billing. Attachments must prove the claim was received in a timely manner by DXC Technology.

5.4 Third Party Coverage Information

5.4.1 Third Party Liability

When a claim is received for a Member whose eligibility file indicates other health insurance is active and applicable for the dates of services, and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied unless documentation is attached.

5.4.2 Documentation That May Prevent a Claim from Being Denied for Other Coverage

The following forms of documentation prevent claims from being denied for other health insurance when attached to the claim.

1. Remittance statement from the insurance carrier that includes:

   - Member name;

   - Date(s) of service;

   - Billed information that matches the billed information on the claim submitted to Medicaid; and,

   - An indication of denial or that the billed amount was applied to the deductible.

NOTE: Rejections from insurance carriers stating "additional information necessary to process claim" is not acceptable.

2. Letter from the insurance carrier that includes:

   - Member name;

   - Date(s) of service(s);

   - Termination or effective date of coverage (if applicable);

   - Statement of benefits available (if applicable); and,

   - The letter must have the signature of an insurance representative, or be on the insurance company's letterhead.

3. Letter from a provider that states they have contacted the insurance company via telephone. The letter must include the following information:

   - Member name;

   - Date(s) of service;

   - Name of insurance carrier;

   - Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached;

   - Termination or effective date of coverage; and,

   - Statement of benefits available (if applicable).

4. A copy of a prior remittance statement from an insurance company may be considered an acceptable form of documentation if it is:

- For the same Member;

- For the same or related service being billed on the claim; and,

- The date of service specified on the remittance advice is no more than six months prior to the claim's date of service.

NOTE: If the remittance statement does not provide a date of service, the denial may only be acceptable by DXC Technology if the date of the remittance statement is no more than six months from the claim's date of service.

5. Letter from an employer that includes:

- Member name;

- Date of insurance or employee termination or effective date (if applicable); and,

- Employer letterhead or signature of company representative.

5.4.3   When there is no response within 120 days from the insurance carrier

When the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim, a provider may complete a TPL Lead Form. Write "no response in 120 days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to DXC Technology. DXC Technology overrides the other health insurance edits and forwards a copy of the TPL Lead form to the TPL Unit. A member of the TPL staff contacts the insurance carrier to see why they have not paid their portion of liability.

5.4.4   For Accident and Work Related Claims

For claims related to an accident or work related incident, the provider should pursue information relating to the event. If an employer, individual, or an insurance carrier is a liable party but the liability has not been determined, claims may be submitted to DXC Technology with an attached letter containing any relevant information, such as, names of attorneys, other involved parties and/or the Member's employer to:

DXC Technology
ATTN: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

5.4.4.1   TPL Lead Form

DXC Technology

DXC Technology
Attention: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

Third Party Liability Lead Form

Provider Name: _____   Provider #: _____

Member Name: _____   Member #: _____

Address: _____   Date of Birth: _____

From Date of Service: _____   To Date of Service: _____

Date of Admission: _____   Date of Discharge: _____

Insurance Carrier Name: _____

Address: _____

Policy Number: _____   Start Date: _____   End Date: _____

Date Claim was Filed with Insurance Carrier: _____

Please check the one that applies:

_____   No Response in over 120 Days

_____   Policy Termination Date: _____

_____   Other: Please explain in the space provided below

_____
_____
_____
_____

Contact Name: _____   Contact Telephone #: _____

Signature: _____   Date: _____

DMS Approved: January 10, 2011

5.5   Provider Inquiry Form

Provider Inquiry Forms may be used for any unique questions concerning claim status; paid or denied claims; and billing concerns. The mailing address for the Provider Inquiry Form is:

>DXC Technology
>Provider Services
>P.O. Box 2100
>Frankfort, KY 40602-2100

Please keep the following points in mind when using this form:

- Send the completed form to DXC Technology. A copy is returned with a response;

- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;

- A toll free DXC Technology number **1-800-807-1232** is available in lieu of using this form; and,

- To check claim status, call the DXC Technology Voice Response on **1-800-807-1301** or you may use the KY HealthNet by logging into https://home.kymmis.com.

Provider Inquiry Form

DXC Technology
P.O. Box 2100
Frankfort, KY 40602

Please check claim status, verify eligibility, and download Remittance statements using KY HealthNet. Please contact the EDI Helpdesk at (800) 205-4696 for access information.

Provider Number	Member Name
Provider Name/Address	Member ID Number
Billed Amount	Claim Service Date/(ICN if applicable)

Providers Message

_____
Signature/Date

DXC TECHNOLOGY RESPONSE:

	This claim was previously processed according to KY Medicaid guidelines. Claim will be sent for denial.
	This claim has been sent to processing.
	AGED CLAIM, claim will be sent for denial. See reverse side for timely filing guidelines.

Other: _____

_____

_____
Signature/Date

▪**HIPAA Privacy Notification:** This message and accompanying documents are covered by the Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information for the specified individual only. This information is confidential. If you are not the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error please notify us immediately and delete the original message.

5.6 Prior Authorization Information

- The prior authorization process does NOT verify anything except medical necessity. It does not verify eligibility or age.

- The prior authorization letter does not guarantee payment. It only indicates that the service is approved based on medical necessity.

- If the individual does not become eligible for Kentucky Medicaid, loses Kentucky Medicaid eligibility, or ages out of the program eligibility, services will not be reimbursed despite having been deemed medically necessary.

- Prior Authorization should be requested prior to the provision of services except in cases of:

    - Retro-active Member eligibility

    - Retro-active provider number

- Providers should always completely review the Prior Authorization Letter prior to providing services or billing.

Access the kymmis website to obtain blank Prior Authorization forms.

http://www.kymmis.com/kymmis/Provider%20Relations/PriorAuthorizationForms.aspx

Access to Electronic Prior Authorization request (EPA).

https://home.kymmis.com

5.7   Adjustments and Claim Credit Requests

An adjustment is a change to be made to a "PAID" claim. The mailing address for the Adjustment Request form is:

> DXC Technology
> P.O. Box 2108
> Frankfort, KY 40602-2108
> Attn: Financial Services

Please keep the following points in mind when filing an adjustment request:

- Attach a copy of the corrected claim and the paid remittance advice page to the adjustment form. For a Medicaid/Medicare crossover, attach an EOMB (Explanation of Medicare Benefits) to the claim;

- Do not send refunds on claims for which an adjustment has been filed;

- Be specific. Explain exactly what is to be changed on the claim;

- Claims showing paid zero dollar amounts are considered paid claims by Medicaid. If the paid amount of zero is incorrect, the claim requires an adjustment; and,

- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely.

DXC Technology

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

MAIL TO: DXC Technology
P.O. BOX 2108
FRANKFORT, KY 40602-2108
1-800-807-1232
ATTN: FINANCIAL SERVICES

NOTE: **A CLAIM CREDIT VOIDS THE CLAIM ICN FORM THE SYSTEM – A "NEW DAY" CLAIM MAY BE SUBMITTED, IF NECESSARY. THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A CORRECTED CLAIM AND REMITTANCE ADVICE TO ADJUST A CLAIM.**

CHECK APPROPRIATE BOX: CLAIM ADJUSTMENT ☐ CLAIM CREDIT ☐		1. Original Internal Control Number (ICN)	
2. Member Name		3. Member Medicaid Number	
4. Provider Name and Address	5. Provider	6. From Date of Service	7. To Date of Service
	8. Original Billed Amount	9. Original Paid Amount	10. Remittance Advice Date

11. Please specify WHAT is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.

_____

_____

12. Please specify the REASON for the adjustment or claim credit request.

_____

_____

_____

13. Signature _____   14. Date _____

DMS Approved: January 10, 2011

5.8   Cash Refund Documentation Form

The Cash Refund Documentation Form is used when refunding money to Medicaid. The mailing address for the Cash Refund Form is:

> DXC Technology
> P.O. Box 2108
> Frankfort, KY 40602-2108
> Attn: Financial Services

Please keep the following points in mind when refunding:

- Attach the Cash Refund Documentation Form to a check made payable to the KY State Treasurer.

- Attach applicable documentation, such as a copy of the remittance advice showing the claim for which a refund is being issued.

- If refunding all claims on an RA, the check amount must match the total payment amount on the RA. If refunding multiple RAs, a separate check must be issued for each RA.

DXC Technology

Mail To: DXC Technology
               P.O. Box 2108
               Frankfort, KY 40602-2108
               ATTN: Financial Services

CASH REFUND DOCUMENTATION

1 Check Number	2. Check Amount

3. Provider Name/ID/Address

4. Member Name

5. Member Number

6. From Date of Service	7. To Date of Service	8. RA Date

9. Internal Control Number (If server ICNs, attach RAs)

⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢

Research for Refund: (Check appropriate blank)

_____   a.   Payment from other source – Check the category and list name *(attach copy of EOB)*
              _____ Health Insurance
              _____ Auto Insurance
              _____ Medicare Paid
              _____ Other

_____   b.   Billed in error

_____   c.   Duplicate payment (attach a copy of both RAs)
              If RAs are paid to two different providers, specify to which provider ID the check is to be applied.
              __ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ ⎢ __

_____   d.   Processing error OR overpayment (explain why)
              _____
              _____

_____   e.   Paid to wrong provider

_____   f.   Money has been requested – date of the letter   ⎢ ⎢
              (attach a copy of letter requesting money)

_____   g.   Other _____
              _____
              _____
              _____

Contact Name _____   Phone _____

DMS Approved: January 10, 2011

5.9   Return to Provider Letter

Claims and attached documentation received by DXC Technology are screened for required information (listed below). If the required information is not complete, the claim is returned to the provider with a "Return to Provider Letter" attached explaining why the claim is being returned.

A claim is returned before processing if the following information is missing:

- Provider ID;

- Recipient Identification number;

- Recipient first and last names; and,

- EOMB for Medicare/Medicaid crossover claims.

Other reasons for return may include:

- Illegible claim date of service or other pertinent data;

- Claim lines completed exceed the limit; and,

- Unable to image.

DXC

RETURN TO PROVIDER LETTER

Date: _____ - _____ - _____

Dear Provider,

The attached claim is being returned for the following reason(s). These items require correction before the claim can be processed.

01) ___ PROVIDER NUMBER – A valid NPI or provider number must be on the claim form in the appropriate field.
___ Missing ___ Not a valid provider number

02) ___ PROVIDER SIGNATURE – All claims require an original signature in the provider signature block. The Provider signature cannot be stamped or typed on the claim.
___ Missing
___ Typed signature not valid
___ Stamped signature not valid

03) ___ Detail lines exceed the limit for claim type.

04) ___ UNABLE TO IMAGE OR KEY – Claim form/EOMB must be legible. Highlighted forms cannot be accepted. Please resubmit on a new form.
___ Print too light ___ Print too dark ___ Highlighted data fields ___ Not legible ___ Dark copy

05) Medicaid **does not** make payment when Medicare has paid the amount in full.

06) ___ The Recipient's Medicaid (MAID) number is missing.

07) ___ Medicare Coding Sheet does not match the claim
___ Dates of Service ___ Member Number ___ Charges ___ Balance due in Block 30

08) Other Reason

_____

_____

_____ **Claims are being returned to you for correction for the reasons noted above.**

Helpful Hints When Billing for Services Provided to a Medicaid Member

- The Member's Medicaid number on the CMS 1500 (08/05) must be entered Field 9A
- The Member's Medicaid number on the CMS 1500 (02/12) must be entered Field 1A
- The Member's Medicaid number on the UB04 must be entered Block 60
- Medicare numbers **are not** valid Medicaid numbers
- Please refer to your billing manual if you have any concerns about billing the Medicaid program correctly.

Please make the necessary corrections and resubmit for processing. If you have any questions, please feel free to contact our Provider Relations Group, open Monday through Friday, 8:00 a.m. until 6:00 p.m. eastern standard/daylight savings time, at 1-800-807-1232.

If you are interested in billing Medicaid electronically, please contact DXC Technology at 1-800-205-4696 7:30 a.m. to 6 p.m. Monday through Friday except holidays.

Initials of Clerk _____

Provider Name _____

Provider Number _____

Reason Code _____

5.10 Provider Representative List

5.10.1 Phone Numbers and Assigned Counties

Martha Edwards 502-209-3100 Extension 2111045 Martha.senn@dxc.com			Vicky Hicks 502-209-3100 Extension 2111016 vicky.hicks@dxc.com		
Assigned Counties			**Assigned Counties**		
ADAIR	GREEN	MCCREARY	ANDERSON	GARRARD	MENIFEE
ALLEN	HART	MCLEAN	BATH	GRANT	MERCER
BALLARD	HARLAN	METCALFE	BOONE	GRAYSON	MONTGOMERY
BARREN	HENDERSON	MONROE	BOURBON	GREENUP	MORGAN
BELL	HICKMAN	MUHLENBERG	BOYD	HANCOCK	NELSON
BOYLE	HOPKINS	OWSLEY	BRACKEN	HARDIN	NICHOLAS
BREATHITT	JACKSON	PERRY	BRECKINRIDGE	HARRISON	OHIO
CALDWELL	KNOX	PIKE	BULLITT	HENRY	OLDHAM
CALLOWAY	KNOTT	PULASKI	BUTLER	JEFFERSON	OWEN
CARLISLE	LARUE	ROCKCASTLE	CAMPBELL	JESSAMINE	PENDLETON
CASEY	LAUREL	RUSSELL	CARROLL	JOHNSON	POWELL
CHRISTIAN	LESLIE	SIMPSON	CARTER	KENTON	ROBERTSON
CLAY	LETCHER	TAYLOR	CLARK	LAWRENCE	ROWAN
CLINTON	LINCOLN	TODD	DAVIESS	LEE	SCOTT
CRITTENDEN	LIVINGSTON	TRIGG	ELLIOTT	LEWIS	SHELBY
CUMBERLAND	LOGAN	UNION	ESTILL	MADISON	SPENCER
EDMONSON	LYON	WARREN	FAYETTE	MAGOFFIN	TRIMBLE
FLOYD	MARION	WAYNE	FLEMING	MARTIN	WASHINGTON
FULTON	MARSHALL	WEBSTER	FRANKLIN	MASON	WOLFE
GRAVES	MCCRACKEN	WHITLEY	GALLATIN	MEADE	WOODFORD

- **NOTE – Out-of-state providers contact the Representative who has the county closest bordering their state, unless noted above.**

- **Provider Relations contact number: 1-800-807-1232**

6 Department for Medicaid Services (DMS) Forms and Requirements

6.1 Completion of The Home Health Agency Map-34 Form

This form is only completed when the Recipient has Medicare and the service is not covered by Medicare but is covered by KY Health Choices.

This form is not submitted with the claim. It is maintained in the Recipient's record. The form is to be updated whenever the information changes, or at least annually.

FIELD	DESCRIPTION
Name of Agency	Enter the name of the Home Health Agency.
Name of Patient	Enter the name of the Recipient as it appears on the Recipient Identification card.
Vendor #	Enter the vendor number.
County	Enter the name of county.
Month	Enter the month.
Year	Enter the year.
City	Enter the city.
State	Enter the state.
Explanation	Enter the explanation of rejection by Title XVIII.
Explanation	Enter the explanation of rejection by utilization review.
Authorized Home Health Agency Representative	Enter a hand written signature of the authorized home health agency representative.

MAP-34 (Rev. 10/96)
COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

HOME HEALTH AGENCY CERTIFICATION

_____   _____
(Name of Agency)   (Name of Patient)

Date of Service:_____
_____   _____   (Month)   (Year)
(Vendor #)   (County)

_____   _____
(City)   (State)

      This document serves to certify that benefits for Home Health Agency services has been utilized to the full extent of Title XVIII benefits under Part A and Part B and that the request for Program payment represents the Home Health Agency Services provided after exhaustion of benefits available under Title XVIII for the above-referenced program Member.

      I certify the above information is true, complete and correct to the best of my knowledge and belief.

Rejected by Title XVIII   ☐   **Explanation:**_____
  (Provide explanation in   _____
    space to the right of   _____
    the box)   _____

Rejected by Utilization   ☐   **Explanation:**_____
  Review Mechanism   _____
  (Provide explanation in   _____
    space to the right of   _____
    the box)

_____
Authorized Home Health Agency Representative

6.2   Completion Of The Home Health Services Map-248

This form is only completed when the Recipient is receiving covered disposable medical supplies and is not receiving home health visits (Medicare or Medicaid).

This form is not submitted with the claims. It is maintained in the Recipient's record. The form is to be updated whenever the information changes or at least every six months.

FIELD	DESCRIPTION
Agency Name	Enter the name of the Home Health Agency.
Vendor Number	Enter the Vendor Number.
Agency Address	Enter the address of the Home Health Agency.
Patient's Name	Enter the recipient's name as it appears on the Recipient Identification card.
Recipient Identification Number	Enter the Recipient Identification number as it appears on the card.
Address	Enter the recipient's address.
Medicare Number	Enter the Medicare number.
Birth Date	Enter the recipient's birth date.
Other Insurance	Enter other insurance information, if any.
Diagnosis	Enter diagnosis explanation.
Indicate Directions for Use of the Supplies	Enter the directions for use of the supplies.
Anticipated Duration of Need	Enter the anticipated duration of need.
0-30 Days	Indicate 0-30 day's duration of used.
1-6 Months	Indicate one - six months duration of used.
Lifetime	Indicate lifetime duration of use.
Indefinite	Indicate indefinite duration of use.
Physician's signature	Enter a physician's handwritten signature.
Address	Enter the physician's address.
License Number	Enter the physician's license number.

MAP-248
(Rev. 12/01)

**COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Home Health Program

Agency Name _____   Provider # _____

Agency Address _____

CERTIFICATION FOR DISPOSABLE MEDICAL SUPPLIES

Patient's Name _____   MAID # _____

Address _____   Medicare # _____

_____   Birthdate _____

Other Insurance _____

Diagnosis _____

_____

This is to certify that the following medical supplies are essential to meet the medical needs of this recipient.
(Indicate Directions for Use of the Supplies) _____

_____

_____

_____

_____

Anticipated Duration of Need: ____ 0-30 days ____ 1-6 months ____ Lifetime ____ Indefinite

I, _____ certify this patient requires the supplies listed above.
      Physician's Signature

Address _____   License # _____ Date _____

_____

Must be signed and dated by the physician every 6 months.

7   Completion of UB-04 Claim Form

The Uniform Billing form (UB-04) is used to bill Home Health services rendered to eligible KY Medicaid Program Recipients. In the case of electronic billing, the information should be in an 837 Institutional format. A completed UB-04 paper copy is located on the next page.

UB-04 billing forms may be obtained from the address or telephone number listed below:

> KY Hospital Association
> P.O. Box 24163
> Louisville, KY 40224
> Telephone: 1-502-426-6220

Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com under Companion Guides and EDI Guides.

7.1 UB-04 Claim Form with NPI and Taxonomy

1 Provider Name	2		3a PAT. CNTL #	Patient Control Number		4 TYPE OF BILL
Street Address			b. MED. REC. #			0331
City or Town ST ZIP			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7	
AC+Phone Number				010107 013107		

8 PATIENT NAME	a		9 PATIENT ADDRESS	a				
b						c	d	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18 19 20 21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
01021900		010107	01 1		30				

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a	80 30		
	b			
	c			
	d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	120	ROOM CHARGES			31	10,000 00			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	0001	*PAGE____ OF____*	*CREATION DATE* 013107	**TOTALS** ➡	10,000.00				23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	Pay To NPI #	
A KyHealth Choices						57	Pay ToTaxonomy#	A
B						OTHER	Zip Code	B
C						PRV ID		C

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A JANE DOE		4000000000			A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A 1234567890			A
B			B
C			C

66 DX	234.5				G H I		68

69 ADMIT DX	234.5	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI		73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING	NPI NPI Number	QUAL
				LAST		FIRST
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING	NPI	QUAL
				LAST		FIRST

80 REMARKS P/T 34	81CC a	78 OTHER	NPI	QUAL
	b	LAST		FIRST
	c	79 OTHER	NPI	QUAL
	d	LAST		FIRST

UB-04 CMS-1450   APPROVED OMB NO.   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

NUBC National Uniform Billing Committee
LIC9213257

7.2 Completion of UB-04 Claim Form with NPI and Taxonomy

7.2.1 Detailed Instructions

The following is a representative sample of codes and/or services that may be covered by KY Health Choices.

FIELD NUMBER	FIELD NAME AND DESCRIPTION	
1	**Provider Name, Address and Telephone**	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	**Patient Control Number**	
	Enter the patient control number. The first 14 digits (alpha/numeric) will appear on the remittance advice as the invoice number.	
4	**Type of Bill**	
	Enter the appropriate code to indicate the type of bill.	
	The type of bill for 0331 will become obsolete for dates of service after July 31, 2015.	
	Type of bill 0321 has an effective date of October 1, 2013.	
6	**Statement Covers Period**	
	FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).	
10	**Date of Birth**	
	Enter the Recipient's date of birth.	
12	**Admission Date**	
	Enter the date on which the Recipient was admitted to the Home Health program in numeric format (MMDDYY).	
17	**Patient Status Code**	
	Enter the appropriate two-digit patient status code indicating the disposition of the patient as of the "through" date in Form Locator 6.	
	Status Codes Accepted by KY Health Choices	
	01	Discharged to Home or Self Care (Routine Discharge)

	02	Discharged or Transferred to Acute Hospital
	03	Discharged or Transferred to Skilled Nursing Facility (SNF) or NF
	30	Still a Patient
18 – 28	**Condition Codes**	
	A1 Enter an A1 if the services were provided as a direct consequence of the Recipient being referred to you as an EPSDT examination.	
	12 Enter a 12 for home health service(s) provided to a Medicare recipient that has Medicaid eligibility which has been determined that Medicare will not cover. A map-34 has been completed for the service(s) billed on the UB04 and is available in the recipient's record.	
31 – 34	**Occurrence Codes and Dates**	
	Enter the appropriate code(s) and date(s) defining a significant event relating to this bill. Reference the UB-04 Training Manual for additional codes.	
	Accident Related Codes: 01 = Auto Accident 02 = No Fault Insurance Involved - Including Accident or Other 03 = Accident - Tort Liability 04 = Accident - Employment Related 05 = Other Accident - Not described by the other codes	
35 – 36	**Occurrence Span Code and Dates**	
	Enter occurrence span code "MO" and the first and last days approved by the PRO/UR when condition code C3 (partial approval) has been entered in Form Locators 18-28.	
39 – 41	**Value Codes**	
	A1 = Deductible Payer A Enter the amount as shown on the EOMB to be applied to the Recipient's deductible amount due. A2 = Coinsurance Payer A Enter the amount as shown on the EOMB to be applied toward Recipient's coinsurance amount due. B1 = Deductible Payer B Enter the amount as shown on the EOMB to be applied to the Recipient's deductible amount due. B2 = Coinsurance Payer B Enter the amount as shown on the EOMB to be applied toward	

	Recipient's coinsurance amount due.	
	80 = Covered Days Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46.	
	82 = Coinsurance Days Medicaid Program during this billing period.	
	83 = Life Time Reserve Days	
42	**Revenue Codes**	
	Enter the three digit revenue code identifying specific accommodation and ancillary services.	

Service	Revenue Codes
Disposable Medical Supplies	270
Nutritional Supplement	279
Physical Therapy	420
Occupational Therapy	430
Speech Therapy	440
Nursing	550
Medical Social Services	560
Home Health Aide	570
Total	001

	NOTE: Total charge Revenue code 0001 must be the final entry in column 42, line 23. Total charge amount must be shown in column 47, line 23.	
43	**Description**	
	Enter a brief description of the service provided.	
44	**HCPC**	
	Effective September 1, 2007, enter the appropriate HCPC code for revenue codes 270 and 279.	
45	**Detail Date of Service**	
	Enter the date of service to correspond with the revenue code shown in Field 42.	

45	Creation Date
	Enter the invoice date or invoice creation date.
46	Unit
	Enter the quantitative measure of services provided per revenue code.
47	Total Charges
	Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry "total charges."
	Enter the Total Charge in column 47, line 23.
50	Payer Identification
	Enter the names of payer organizations from which the provider expects payment. For Medicaid, use KY Health Choices. All other liable payers, including Medicare, must be billed first.*
	* KY Medicaid is payer of last resort.
54	Prior Payments
	Enter the amount the facility has received toward payment of the claim. Third party payment should be entered in this area. Do not enter Medicare payment amounts in this area.
56	NPI
	Enter the NPI Number of the facility.
57	
	Enter the Taxonomy Number of the facility.
57B	Other
	Enter the facility's zip code.
58	Insured's Name
	Enter the Recipient's name in Form Locators 58 A, B, and C that relates to KY Medicaid the payer in Form Locators 50 A, B, and C. Enter the Recipient's name exactly as it appears on the Recipient Identification card in last name, first name, and middle initial format.
60	Identification Number
	Enter the Recipient Identification number in Form Locators 60 A, B, and C that relates to the Recipient's name in Form Locators 58 A, B, and C. Enter the 10 digit Recipient Identification number exactly as it appears

	on the Recipient Identification card.
66	**Diagnosis Indicator**
	Enter the appropriate ICD indicator. 9= ICD 9 0= ICD-10
67	**Principal Diagnosis Code**
	Enter the ICD-10 code describing the principal diagnosis.
67A – Q	**Other Diagnosis Code**
	Enter additional diagnosis codes that co-exist at the time the service is provided.
76	**Attending Physician ID**
	Enter the NPI Number of the attending physician.
76	**NPI**
	Enter the Attending Physician NPI number.
78	**Other (NPI)**
	Enter DN (to denote referring) and the Referring Physician NPI number, if applicable.
80	**Remarks**
	Enter the Attending Physician taxonomy, if applicable. (paper claim submission only.)

7.3   Mailing Information

The UB-04 claim should be submitted to DXC Technology at the address listed below as soon as possible after the service is provided. A copy of the claim should be retained by the provider's office for their records.

Claims should be mailed to:

> DXC Technology
> P.O. Box 2106
> Frankfort, KY 40602-2106

8 Appendix A

8.1   Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by DXC Technology to each claim. During the imaging process a unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking. The ICN consists of 13 digits and contains the following information:

$$11 - 10 - 032 - 123456$$
$$1 \quad 2 \quad 3 \quad 4$$

6. Region

10	PAPER CLAIMS WITH NO ATTACHMENTS
11	PAPER CLAIMS WITH ATTACHMENTS
20	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
21	ELECTRONIC CLAIMS WITH ATTACHMENTS
22	INTERNET CLAIMS WITH NO ATTACHMENTS
40	CLAIMS CONVERTED FROM OLD MMIS
45	ADJUSTMENTS CONVERTED FROM OLD MMIS
50	ADJUSTMENTS - NON-CHECK RELATED
51	ADJUSTMENTS - CHECK RELATED
52	MASS ADJUSTMENTS - NON-CHECK RELATED
53	MASS ADJUSTMENTS - CHECK RELATED
54	MASS ADJUSTMENTS - VOID TRANSACTION
55	MASS ADJUSTMENTS - PROVIDER RATES
56	ADJUSTMENTS - VOID NON-CHECK RELATED
57	ADJUSTMENTS - VOID CHECK RELATED

7. Year of Receipt

8. Julian Date of Receipt (The Julian calendar numbers the days of the year 1-365. For example, 001 is January 1 and 032 (shown above) is February 1.

9. Batch Sequence Used Internally

9 Appendix B

9.1 Remittance Advice

This section is a step-by-step guide to reading a Kentucky Medicaid Remittance Advice (RA). The following sections describe major categories related to processing/adjudicating claims. To enhance this document's usability, detailed descriptions of the fields on each page are included, reading the data from left to right, top to bottom.

9.1.1 Examples Of Pages In Remittance Advice

There are several types of pages in a Remittance Advice, including separate page types for each type of claim; however, if a provider does not have activity in that particular category, those pages are not included.

Following are examples of pages which may appear in a Remittance Advice:

FIELD	DESCRIPTION
Returned Claims	This section lists all claims that have been returned to the provider with an RTP letter. The RTP letter explains why the claim is being returned. These claims are returned because they are missing information required for processing.
Paid Claims	This section lists all claims paid in the cycle.
Denied Claims	This section lists all claims that denied in the cycle.
Claims In Process	This section lists all claims that have been suspended as of the current cycle. The provider should maintain this page and compare with future Remittance Advices until all the claims listed have appeared on the PAID CLAIMS page or the DENIED CLAIMS page. Until that time, the provider need not resubmit the claims listed in this section.
Adjusted Claims	This section lists all claims that have been submitted and processed for adjustment or claim credit transactions.
Mass Adjusted Claims	This section lists all claims that have been mass adjusted at the request of the Department for Medicaid Services (DMS).
Financial Transactions	This section lists financial transactions with activity during the week of the payment cycle.
	NOTE: It is imperative the provider maintains any A/R page with an outstanding balance.

Summary	This section details all categories contained in the Remittance Advice for the current cycle, month to date, and year to date. Explanation of Benefit (EOB) codes listed throughout the Remittance Advice is defined in this section.
EOB Code Descriptions	Any Explanation of Benefit Codes (EOB) which appears in the RA is defined in this section.

NOTE: For the purposes of reconciliation of claims payments and claims resubmission of denied claims, it is highly recommended that all remittance advices be kept for at least one year.

9.2 Title

The header information that follows is contained on every page of the Remittance Advice.

```
REPORT:   CRA-XBPD-R              COMMONWEALTH OF KENTUCKY (M1)              DATE:  01/25/2007
   RA#:      9999999          MEDICAID MANAGEMENT INFORMATION SYSTEM         PAGE:          2
                                  PROVIDER REMITTANCE ADVICE
```

FIELD	DESCRIPTION
DATE	The date the Remittance Advice was printed.
RA NUMBER	A system generated number for the Remittance Advice.
PAGE	The number of the page within each Remittance Advice.
CLAIM TYPE	The type of claims listed on the Remittance Advice.
PROVIDER NAME	The name of the provider that billed. (The type of provider is listed directly below the name of provider.)
PAYEE ID	The eight-digit Medicaid assigned provider ID of the billing provider.
NPI ID	The NPI number of the billing provider.

The category (type of page) begins each section and is centered (for example, *PAID CLAIMS*). All claims contained in each Remittance Advice are listed in numerical order of the prescription number.

9.3 Banner Page

All Remittance Advices have a "banner page" as the first page. The "banner page" contains provider specific information regarding upcoming meetings and workshops, "top ten" billing errors, policy updates, billing changes etc. Please pay close attention to this page.

```
REPORT:   CRA-BANN-R                  COMMONWEALTH OF KENTUCKY (M1)                        DATE:  01/23/2007
RA#:      9999999                  MEDICAID MANAGEMENT INFORMATION SYSTEM                  PAGE:        1
                                        PROVIDER REMITTANCE ADVICE
                                        PROVIDER BANNER MESSAGES


PROVIDER                                                                  PAYEE ID           99999999
555 ANY STREET                                                            NPI ID             99999999
CITY, KY 55555-0000                                                       CHECK/EFT NUMBER   999999999
                                                                          ISSUE DATE         01/26/2007



Commonwealth of Kentucky
```

```
REPORT:   CRA-IPPD-R                      COMMONWEALTH OF KENTUCKY (M1)                          DATE: 01/30/2007
RA#:      9999999                      MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:       2
                                             PROVIDER REMITTANCE ADVICE
                                                  UB CLAIMS PAID

PROVIDER                                                             PAYEE ID                      99999999
5555 ANY STREET                                                      NPI ID
CITY, KY 55555-5555                                                  CHECK/EFT NUMBER             999999999
                                                                     ISSUE DATE                   02/02/2007

  --ICN--          ATTENDING PROV.     SERVICE DATES  DAYS  ADMIT    BILLED AMT   ALLOWED AMT   SPENDDOWN       TPL AMT      PAID AMT
  PAT.ACCT NUM.                        FROM    THRU         DATE                                COPAY AMT

MEMBER NAME: JANE DOE                      MEMBER NO.: MBRID99999
ICN9999999999       NPI9999999         030806 031006  2    030806    6,307.35        0.00         0.00          0.00       3,488.25
PATACCT 99999999999                                                                              0.00

HEADER EOBS:  9932 00A2

REV CD HCPCS/RATE SRV DATE LVL CARE     UNITS      BILLED AMT  ALLOWED AMT    DETAIL EOBS
 120              030806    DEF          2.00       1,700.00         0.00      2527 0062 0883 0018
 250              030806    DEF         48.00         653.90         0.00      9932 0018
 258              030806    DEF          7.00         275.30         0.00      9932 0018
 270              030806    DEF         67.00         386.15         0.00      9932 0018
 300              030806    DEF         12.00         292.00         0.00      9932 0018
 310              030806    DEF          3.00         177.00         0.00      9932 0018
 360              030806    DEF          1.00       2,148.00         0.00      9932 0018
 370              030806    DEF          1.00         299.00         0.00      9932 0018
 710              030806    DEF          1.00         376.00         0.00      9932 0018


MEMBER NAME: JANE DOE                      MEMBER NO.: 9999999999
 9999999999999    9999999999           030806 031006  2    030806    6,307.35        0.00         0.00          0.00       3,488.25
   99999999999                                                                                   0.00

HEADER EOBS:  9932 0018

REV CD HCPCS/RATE SRV DATE LVL CARE     UNITS      BILLED AMT  ALLOWED AMT    DETAIL EOBS

 120              030806    DEF          2.00       1,700.00         0.00      9932 0018 0275 0015
 250              030806    DEF         48.00         653.90         0.00      9932 0015 0883 00
 258              030806    DEF          7.00         275.30         0.00      9932 0018
 270              030806    DEF         67.00         386.15         0.00      9932 0018
 300              030806    DEF         12.00         292.00         0.00      9932 0018
 310              030806    DEF          3.00         177.00         0.00      9932 0018
 360              030806    DEF          1.00       2,148.00         0.00      9932 0018
 370              030806    DEF          1.00         299.00         0.00      9932 0018
 710              030806    DEF          1.00         376.00         0.00      9932 0018

                      TOTAL UB CLAIMS PAID:                       12,614.70        0.00         0.00          0.00       6,976.50
```

9.4 Paid Claims Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Account Number from Form Locator 3.
RECIPIENT NAME	The Recipient's last name and first initial.
RECIPIENT NUMBER	The Recipient's ten-digit Identification number as it appears on the Recipient's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by DXC Technology.
ATTENDING PROVIDER	The recipient's attending provider.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of the recipient.
BILLED AMOUNT	The usual and customary charge for services provided for the Recipient.
ALLOWED AMOUNT	The allowed amount for Medicaid
SPENDDOWN COPAY AMOUNT	The amount collected from the recipient.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS PAID ON THIS RA	The total number of paid claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).

```
REPORT:   CRA-IPDN-R                    COMMONWEALTH OF KENTUCKY (M1)                      DATE:  01/25/2007
RA#:      9999999               MEDICAID MANAGEMENT INFORMATION SYSTEM                     PAGE:       11
                                       PROVIDER REMITTANCE ADVICE
                                          UB CLAIMS DENIED


PROVIDER                                                              PAYEE ID           99999999
5555 ANY STREET                                                       NPI ID             99999999
SUITE 555                                                             CHECK/EFT NUMBER   999999999
CITY, KY 55555-0000                                                  ISSUE DATE         01/26/2007

   --ICN--        ATTENDING PROV.    SERVICE DATES   DAYS   ADMIT         BILLED        TPL         SPENDDOWN
  PATIENT ACCT.   NUM.               FROM    THRU           DATE          AMOUNT        AMOUNT      AMOUNT

MEMBER NAME: JANE DOE                       MEMBER NO.: MBRID99999
ICN9999999999    NPI9999999          021706 022106   4    021706        10,212.66         0.00         0.00
PATACCT9999

HEADER EOBS:  2660 0092

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS    BILLED AMT  DETAIL EOBS
  174            021706    DEF         4.00    9,382.04   2527 0062
  250            021706    DEF         3.00       15.96   9953 0062 0883 001
  300            021706    DEF         5.00      355.28   9953 0018
  301            021706    DEF        11.00      361.54   9953 0018
  302            021706    DEF         3.00       81.42   9953 0018
  306            021706    DEF         1.00       16.42   9953 0018


MEMBER NAME: JANE DOE                       MEMBER NO.: 9999999999
 9999999999999   MCD 9999             021706 022106   4    021706        10,802.46         0.00         0.00
  99999999

HEADER EOBS:  2198 0016

REV CD HCPCS/RATE SRV DATE LVL CARE   UNITS     BILLED AMT  DETAIL EOBS
  111            021706    DEF         3.00     1,805.40
  112            021706    DEF         1.00       601.80
  250            021706    DEF       232.00       608.33
  258            021706    DEF        27.00       122.17
  272            021706    DEF         1.00       206.78
  300            021706    DEF         6.00       374.96
  301            021706    DEF        29.00       909.72
  307            021706    DEF         2.00        50.45
  312            021706    DEF         3.00       582.99
  370            021706    DEF         1.00       663.54
  460            021706    DEF         1.00        15.06
  720            021706    DEF         3.00     4,549.14
  732            021706    DEF         1.00       312.12


                    TOTAL UB CLAIMS DENIED:                      21,015.12       200.00         0.00
```

9.5   Denied Claims Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
RECIPIENT NAME	The Recipient's last name and first initial.
RECIPIENT NUMBER	The Recipient's ten-digit Identification number as it appears on the Recipient's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by DXC Technology.
ATTENDING PROVIDER	The recipient's attending provider.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of the recipient.
BILLED AMOUNT	The usual and customary charge for services provided for the Recipient.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the recipient.
CLAIM PMT. AMT.	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS DENIED ON THIS RA	The total number of denied claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).

```
REPORT:   CRA-IPSU-R                    COMMONWEALTH OF KENTUCKY (M1)                    DATE: 01/25/2007
RA#:      9999999                      MEDICAID MANAGEMENT INFORMATION SYSTEM           PAGE:      17
                                            PROVIDER REMITTANCE ADVICE
                                              UB CLAIMS IN PROCESS


PROVIDER                                                                   PAYEE ID           99999999
5555 ANY STREET                                                           NPI ID             99999999
SUITE 555                                                                 CHECK/EFT NUMBER   999999999
CITY, KY 55555-0000                                                       ISSUE DATE         01/26/2007


   --ICN--          ATTENDING      SERVICE DATES   DAYS   ADMIT      BILLED        TPL        SPENDDOWN
  PATIENT ACCT. NUM.    PROV.      FROM    THRU            DATE      AMOUNT        AMOUNT     AMOUNT


MEMBER NAME: JOHN DOE                    MEMBER NO.: MBRID99999
ICN9999999999    NPI9999999       062206 062406    2    062206      4,010.60       0.00        0.00
PATACCT9999


REV CD HCPCS/RATE SRV DATE LVL CARE     UNITS     BILLED AMT   DETAIL EOBS
  111            062206    DEF          2.00      1,203.60
  250            062206    DEF         42.00        587.84
  258            062206    DEF         22.00        455.82
  272            062206    DEF          1.00          9.01
  370            062206    DEF          1.00        774.12
  410            062206    DEF          6.00        387.76
  710            062206    DEF          1.00        592.45


            TOTAL UB CLAIMS IN PROCESS:              4010.60        0.00        0.00
```

9.6 Claims In Process Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
RECIPIENT NAME	The Recipient's last name and first initial.
RECIPIENT NUMBER	The Recipient's ten-digit Identification number as it appears on the Recipient's Identification card.
ICN	The 13-digit unique system-generated identification number assigned to each claim by DXC Technology.
ATTENDING PROVIDER	The attending provider's NPI.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of recipient.
BILLED AMOUNT	The usual and customary charge for services provided for the Recipient.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the recipient.

```
REPORT:   CRA-IPPD-R                    COMMONWEALTH OF KENTUCKY (M1)                      DATE:  01/30/2007
   RA#:     9999999           MEDICAID MANAGEMENT INFORMATION SYSTEM                      PAGE:         2
                                    PROVIDER REMITTANCE ADVICE
                                       UB CLAIMS RETURNED

PROVIDER                                                              PAYEE ID            99999999
5555 ANY STREET                                                       NPI ID
CITY, KY 55555-5555                                                   CHECK/EFT NUMBER    999999999
                                                                     ISSUE DATE          02/02/2007


  --ICN--            REASON CODE
9999999999999         01




  CLAIMS RETURNED:  01
```

9.7   Returned Claim

FIELD	DESCRIPTION
ICN	The 13-digit unique system generated identification number assigned to each claim by DXC Technology.
REASON CODE	A code denoting the reason for returning the claim.
CLAIMS RETURNED ON THIS RA	The total number of returned claims on the Remittance Advice.

Note: Claims appearing on the "returned claim" page are forthcoming in the mail. The actual claim is returned with a "return to provider" sheet attached, indicating the reason for the claim being returned.

```
REPORT:   CRA-HHAD-R                    COMMONWEALTH OF KENTUCKY (M1)                      DATE: 01/23/2007
   RA#:      9999999                  MEDICAID MANAGEMENT INFORMATION SYSTEM                PAGE:        33
                                           PROVIDER REMITTANCE ADVICE
                                             UB CLAIM ADJUSTMENTS


PROVIDER                                                                  PAYEE ID              99999999
55555 ANY STREET                                                          NPI ID
CITY, KY 55555-0000



   --ICN--      ATTEND PROV.        SERVICE DATES      BILLED      ALLOWED       TPL      CO-PAY    SPENDDOWN        PAID
   --PATIENT NUMBER--               FROM    THRU       AMOUNT      AMOUNT      AMOUNT     AMOUNT     AMOUNT        AMOUNT

MEMBER NAME: JOHN DOE                  MEMBER NO.: 9999999999
   9999999999999  MCD 9999       030106 033106   (3,886.47)      (0.00)      (0.00)     (0.00)     (0.00)    (3,592.90)
      99999999999999


   9999999999999  MCD 9999       030106 033106    3,886.47        0.00        0.00       0.00       0.00         0.00
      99999999999999


HEADER EOBS:  0053 00A1



REV CD HCPCS/RATE SRV DATE  MODIFIERS     UNITS    BILLED AMT  ALLOWED AMT  DETAIL EOBS
  651              030106                 31.00    3,886.47        0.00  0686 0119
                                                               NET OVERPAYMENT (AR)                          3,592.90


TOTAL NO. OF ADJ:      1
    TOTAL UB ADJUSTMENT CLAIMS:                       0.00                   0.00                  0.00
                                                                 0.00                  0.00             -3,592.90
```

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Billing Instructions).
If a cash refund is submitted, an adjustment **CANNOT** be filed.
If an adjustment is submitted, a cash refund **CANNOT** be filed.

9.8   Adjusted Claims Page

The information on this page reads left to right and does not follow the general headings.

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
RECIPIENT NAME	The Recipient's last name and first initial.
RECIPIENT NUMBER	The Recipient's ten-digit Identification number as it appears on the Recipient's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by DXC Technology.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Recipient.
ALLOWED AMOUNT	The amount allowed for this service.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
COPAY AMOUNT	Copay amount to be collected from recipient.
SPENDDOWN AMOUNT	The amount to be collected from the recipient.
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
PAID AMOUNT	Amount paid.

Note: The ORIGINAL claim information appears first, followed by the NEW (adjusted) claim information.

```
REPORT:   CRA-TRAN-R                    COMMONWEALTH OF KENTUCKY                        DATE: 12/26/2006
RA#:      9999999                  MEDICAID MANAGEMENT INFORMATION SYSTEM               PAGE:        2
                                         PROVIDER REMITTANCE ADVICE
                                          FINANCIAL TRANSACTIONS


PROVIDER              J                                                   PAYEE ID       99999999
PO BOX 5555                                                               NPI ID         99999999
CITY, KY 55555-5555



            --------------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS--------------


    TRANSACTION               PAYOUT   REASON  RENDERING           SVC DATE
     NUMBER      --CCN--      --AMOUNT--  CODE  PROVIDER        FROM   THRU    MEMBER NO.   MEMBER NAME


                     NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS


            --------------NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS------------


                REFUND      REASON
     --CCN--    --AMOUNT--   CODE    MEMBER NO.   MEMBER NAME


                     NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS


            ----------------ACCOUNTS RECEIVABLE----------------


      A/R        SETUP    RECOUPED     ORIGINAL      TOTAL               REASON
   NUMBER/ICN    DATE    THIS CYCLE    AMOUNT      -RECOUPED-   --BALANCE--  CODE

    1106        011306        0.00       22.41         0.00       22.41   92

              TOTAL BALANCE                                       22.41
```

9.9   Financial Transaction Page

9.9.1   Non-Claim Specific Payouts To Providers

FIELD	DESCRIPTION
TRANSACTION NUMBER	The tracking number assigned to each financial transaction.
CCN	The cash control number assigned to refund checks for tracking purposes.
PAYMENT AMOUNT	The amount paid to the provider when the financial reason code indicates money is owed to the provider.
REASON CODE	Payment reason code.
RENDERING PROVIDER	Rendering provider of service.
SERVICE DATES	The from and through dates of service.
RECIPIENT NUMBER	The KY Medicaid recipient identification number.
RECIPIENT NAME	The KY Medicaid recipient name.

9.9.2   Non-Claim Specific Refunds From Providers

FIELD	DESCRIPTION
CCN	The cash control tracking number assigned to refund checks for tracking purposes.
REFUND AMOUNT	The amount refunded by provider.
REASON CODE	The two byte reason code specifying the reason for the refund.
RECIPIENT NUMBER	The KY Medicaid recipient identification number.
RECIPIENT NAME	The KY Medicaid recipient name.

9.9.3   Accounts Receivable

FIELD	DESCRIPTION
A / R NUBMER / ICN	This is the 13-digit Internal Control Number used to identify records for one accounts receivable transaction.
SETUP DATE	The date entered on the accounts receivable transaction in the MM/DD/CCYY format. This date identifies the beginning of the accounts receivable event.

RECOUPED THIS CYCLE	The amount of money recouped on this financial cycle.
ORIGINAL AMOUNT	The original accounts receivable transaction amount owed by the provider.
TOTAL RECOUPED	This amount is the total of the provider's checks and recoupment amounts posted to this accounts receivable transaction.
BALANCE	The system generated balance remaining on the accounts receivable transaction.
REASON CODE	A two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a providers account.

ANY RECOUPMENT ACTIVITY OR PAYMENTS RECEIVED FROM THE PROVIDER list below the "RECOUPMENT PAYMENT SCHEDULE." All initial accounts receivable allow 60 days from the "setup date" to make payment on the accounts receivable. After 60 days, if the accounts receivable has not been satisfied nor a payment plan initiated, monies are recouped from the provider on each Remittance Advice until satisfied.

This is your only notification of an accounts receivable setup. Please keep all Accounts Receivable Summary pages until all monies have been satisfied.

```
REPORT:   CRA-SUMM-R                        COMMONWEALTH OF KENTUCKY (M1)                      DATE: 02/01/2007
  RA#:      9999999                      MEDICAID MANAGEMENT INFORMATION SYSTEM                PAGE:      13
                                              PROVIDER REMITTANCE ADVICE
                                                      SUMMARY


PROVIDER                                                                  PAYEE ID             99999999
                                                                          NPI ID
P O BOX 555                                                               CHECK/EFT NUMBER     999999999
CITY, KY 55555-0000                                                       ISSUE DATE           02/02/2007

                                    -----------------------CLAIMS DATA--------------------------

                           CURRENT      CURRENT    MONTH-TD      MONTH-TD    YEAR-TD       YEAR-TD
                           NUMBER       AMOUNT     NUMBER        AMOUNT      NUMBER        AMOUNT
         CLAIMS PAID           43     130,784.46      43      130,784.46     1,988     4,143,010.13
         CLAIM ADJUSTMENTS      0           0.00       0            0.00        18             0.00
         MASS ADJUSTMENTS       0           0.00       0            0.00         0             0.00
            TOTAL CLAIMS PAYMENTS 43    130,784.46      43      130,784.46     2,006     4,143,010.13
         CLAIMS DENIED          1                       1                      917
         CLAIMS IN PROCESS      2


                                    ----------------------EARNINGS DATA----------------------
         PAYMENTS:
            CLAIMS PAYMENTS                130,784.46           130,784.46          4,143,010.13

            SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)    0.00              0.00                  0.00
            ACCOUNTS RECEIVABLE (OFFSETS):
               CLAIM SPECIFIC:
                  CURRENT CYCLE               (0.00)             (0.00)                 (0.00)
                  OUTSTANDING FROM PREVIOUS CYCLES (0.00)        (0.00)             (44,474.35)
               NON-CLAIM SPECIFIC OFFSETS      (0.00)             (0.00)                 (0.00)

            NET PAYMENT                    130,784.46           130,784.46          4,098,535.78

         REFUNDS:
            CLAIM SPECIFIC ADJUSTMENT REFUNDS  (0.00)             (0.00)                 (0.00)
            NON-CLAIM SPECIFIC REFUNDS         (0.00)             (0.00)                 (0.00)

         OTHER FINANCIAL:
            MANUAL PAYOUTS (NON-CLAIM SPECIFIC)  0.00              0.00                  0.00
            VOIDS                             (0.00)             (0.00)                 (0.00)

         NET EARNINGS                      130,784.46           130,784.46          4,098,535.78
```

```
REPORT:   CRA-EOBM-R                    COMMONWEALTH OF KENTUCKY (M1)                     DATE: 02/01/2007
   RA#:     9999999                    MEDICAID MANAGEMENT INFORMATION SYSTEM              PAGE:        14
                                            PROVIDER REMITTANCE ADVICE
                                             EOB CODE DESCRIPTIONS


PROVIDER                                                          PAYEE ID                99999999
                                                                 NPI ID
P O BOX 555                                                      CHECK/EFT NUMBER         999999999
CITY, KY 55555-0000                                             ISSUE DATE              02/02/2007


   EOB CODE                    EOB CODE DESCRIPTION
   0022        COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.
   0271        CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE.  PLEASE
               CONTACT DMS AT 502-564-6885.
   0409        INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
   0883        CLAIM DENIED. DEPLICATE PROCEDURE HAS BEEN PAID.
   9999        PROCESSED PER MEDICAID POLICY


   HIPAA REASON CODE          HIPAA ADJ REASON CODE DESCRIPTION
   0016        Claim/service lacks information which is needed for adjudication. Additional information is supplied
               using remittance advice remarks codes whenever appropriate
   0018        Duplicate claim/service.
   0052        The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the
               service billed.
   0092        Claim Paid in full.
   00A1        Claim denied charges.
```

9.10 Summary Page

FIELD	DESCRIPTION
CLAIMS PAID	The number of paid claims processed, current month and year to date.
CLAIM ADJUSTMENTS	The number of adjusted/credited claims processed, adjusted/credited amount billed, and adjusted/credited amount paid or recouped by Medicaid. If money is recouped, the dollar amount is followed by a negative (-) sign. These figures correspond with the summary of the last page of the ADJUSTED CLAIMS section.
PAID MASS ADJ CLAIMS	The number of mass adjusted/credited claims, mass adjusted/credited amount billed, and mass adjusted/credited amount paid or recouped by Medicaid. These figures correspond with the summary line of the last page of the MASS ADJUSTED CLAIMS section. Mass Adjustments are initiated by Medicaid and DXC Technology for issues that affect a large number of claims or providers. These adjustments have their own section "MASS ADJUSTED CLAIMS" page, but are formatted the same as the ADJUSTED CLAIMS page.
CLAIMS DENIED	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
CLAIMS IN PROCESS	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

9.10.1 Payments

FIELD	DESCRIPTION
CLAIMS PAYMENT	The number of claims paid.
SYSTEM PAYOUTS	Any money owed to providers.
NET PAYMENT	Total check amount.
REFUNDS	Any money refunded to Medicaid by a provider.

OTHER FINANCIAL	
NET EARNINGS	The 1099 amount.

EXPLANATION OF BENEFITS

FIELD	DESCRIPTION
EOB	A five-digit number denoting the EXPLANATION OF BENEFITS detailed on the Remittance Advice.
EOB CODE DESCRIPTION	Description of the EOB Code. All EOB Codes detailed on the Remittance Advice are listed with a description/ definition.
COUNT	Total number of times an EOB Code is detailed on the Remittance Advice.

EXPLANATION OF REMARKS

FIELD	DESCRIPTION
REMARK	A five-digit number denoting the remark identified on the Remittance Advice.
REMARK CODE DESCRIPTION	Description of the Remark Code. All remark codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times a Remark Code is detailed on the Remittance Advice.

EXPLANATION OF ADJUSTMENT CODE

FIELD	DESCRIPTION
ADJUSTMENT CODE	A two-digit number denoting the reason for returning the claim.
ADJUSTMENT CODE DESCRIPTION	Description of the adjustment Code. All adjustment codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times an adjustment Code is detailed on the Remittance Advice.

EXPLANATION OF RTP CODES

FIELD	DESCRIPTION
RTP CODE	A two-digit number denoting the reason for returning the claim.
RETURN CODE DESCRIPTION	Description of the RTP Code. All RTP codes detailed on the Remittance Advice are listed with a description/ definition.
COUNT	Total number of times an RTP Code is detailed on the Remittance Advice.

10 Appendix C

10.1 Remittance Advice Location Codes (LOC CD)

The following is a code indicating the Department for Medicaid Services branch/division or other agency that originated the Accounts Receivable:

A   Active

B   Hold Recoup - Payment Plan Under Consideration

C   Hold Recoup - Other

D   Other-Inactive-FFP-Not Reclaimed

E   Other – Inactive - FFP

F   Paid in Full

H   Payout on Hold

I   Involves Interest – Cannot Be Recouped

J   Hold Recoup Refund

K   Inactive-Charge off – FFP Not Reclaimed

P   Payout – Complete

Q   Payout – Set Up In Error

S   Active - Prov End Dated

T   Active Provider A/R Transfer

U   DXC Technology On Hold

W   Hold Recoup - Further Review

X   Hold Recoup - Bankruptcy

Y   Hold Recoup - Appeal

Z   Hold Recoup - Resolution Hearing

11 Appendix D

11.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

The following is a two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a provider's account:

01	Prov Refund – Health Insur Paid	32	Payout – Advance to be Recouped
02	Prov Refund – Recipient/Rel Paid	33	Payout – Error on Refund
03	Prov Refund – Casualty Insu Paid	34	Payout – RTP
04	Prov Refund – Paid Wrong Vender	35	Payout – Cost Settlement
05	Prov Refund – Apply to Acct Recv	36	Payout – Other
06	Prov Refund – Processing Error	37	Payout – Medicare Paid TPL
07	Prov Refund-Billing Error	38	Recoupment – Medicare Paid TPL
08	Prov Refund – Fraud	39	Recoupment – DEDCO
09	Prov Refund – Abuse	40	Provider Refund – Other TLP Rsn
10	Prov Refund – Duplicate Payment	41	Acct Recv – Patient Assessment
11	Prov Refund – Cost Settlement	42	Acct Recv – Orthodontic Fee
12	Prov Refund – Other/Unknown	43	Acct Receivable – KENPAC
13	Acct Receivable – Fraud	44	Acct Recv – Other DMS Branch
14	Acct Receivable – Abuse	45	Acct Receivable – Other
15	Acct Receivable – TPL	46	Acct Receivable – CDR-HOSP-Audit
16	Acct Recv – Cost Settlement	47	Act Rec – Demand Paymt Updt 1099
17	Acct Receivable – DXC Technology Request	48	Act Rec – Demand Paymt No 1099
		49	PCG
18	Recoupment – Warrant Refund	50	Recoupment – Cold Check
19	Act Receivable-SURS Other	51	Recoupment – Program Integrity Post Payment Review Contractor A
20	Acct Receivable – Dup Payt	52	Recoupment – Program Integrity Post Payment Review Contractor B
21	Recoupment – Fraud		
22	Civil Money Penalty	53	Claim Credit Balance
23	Recoupment – Health Insur TPL	54	Recoupment – Other St Branch
24	Recoupment – Casualty Insur TPL	55	Recoupment – Other
25	Recoupment – Recipient Paid TPL	56	Recoupment – TPL Contractor
26	Recoupment – Processing Error	57	Acct Recv – Advance Payment
27	Recoupment – Billing Error	58	Recoupment – Advance Payment
28	Recoupment – Cost Settlement	59	Non Claim Related Overage
29	Recoupment – Duplicate Payment	60	Provider Initiated Adjustment
30	Recoupment – Paid Wrong Vendor	61	Provider Initiated CLM Credit
31	Recoupment – SURS		

62	CLM CR-Paid Medicaid VS Xover	95	Beginning Recoupment Balance
63	CLM CR-Paid Xover VS Medicaid	96	Ending Recoupment Balance
64	CLM CR-Paid Inpatient VS Outp	97	Begin Dummy Rec Bal
65	CLM CR-Paid Outpatient VS Inp	98	End Dummy Recoup Balance
66	CLS Credit-Prov Number Changed	99	Drug Unit Dose Adjustment
67	TPL CLM Not Found on History	AA	PCG 2 Part A Recoveries
68	FIN CLM Not Found on History	BB	PCG 2 Part B Recoveries
69	Payout-Withhold Release	CB	PCG 2 AR CDR Hosp
71	Withhold-Encounter Data Unacceptable	DG	DRG Retro Review
72	Overage .99 or Less	DR	Deceased Recipient Recoupment
73	No Medicaid/Partnership Enrollment	IP	Impact Plus
74	Withhold-Provider Data Unacceptable	IR	Interest Payment
75	Withhold-PCP Data Unacceptable	CC	Converted Claim Credit Balance
76	Withhold-Other	MS	Prog Intre Post Pay Rev Cont C
77	A/R Recipient IPV	OR	On Demand Recoupment Refund
78	CAP Adjustment-Other	RP	Recoupment Payout
79	Recipient Not Eligible for DOS	RR	Recoupment Refund
80	Adhoc Adjustment Request	SC	SURS Contract
81	Adj Due to System Corrections	SS	State Share Only
82	Converted Adjustment	UA	DXC Technology Medicare Part A Recoup
83	Mass Adj Warr Refund	UB	DXC Technology Medicare Part B Reoup
84	DMS Mass Adj Request	XO	Reg. Psych. Crossover Refund
85	Mass Adj SURS Request		
86	Third Party Paid – TPL		
87	Claim Adjustment – TPL		
88	Beginning Dummy Recoupment Bal		
89	Ending Dummy Recoupment Bal		
90	Retro Rate Mass Adj		
91	Beginning Credit Balance		
92	Ending Credit Balance		
93	Beginning Dummy Credit Balance		
94	Ending Dummy Credit Balance		

12 Appendix E

12.1 Remittance Advice Status Code (ST CD)

The following is a one-character code indicating the status of the accounts receivable transaction:

A   Active

B   Hold Recoup - Payment Plan Under Consideration

C   Hold Recoup - Other

D   Other-Inactive-FFP-Not Reclaimed

E   Other – Inactive - FFP

F   Paid in Full

H   Payout on Hold

I   Involves Interest – Cannot Be Recouped

J   Hold Recoup Refund

K   Inactive-Charge off – FFP Not Reclaimed

P   Payout – Complete

Q   Payout – Set Up In Error

S   Active - Prov End Dated

T   Active Provider A/R Transfer

U   DXC Technology On Hold

W   Hold Recoup - Further Review

X   Hold Recoup - Bankruptcy

Y   Hold Recoup - Appeal

Z   Hold Recoup - Resolution Hearing