Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions
for
Renal Dialysis
Provider Type – 39

Version 5.4

May 17, 2019

Document Change Log

Document Version	Date	Name	Comments
1.0	10/25/2005	EDS	Initial creation of DRAFT Billing Instructions for Renal Dialysis PT 39
1.1	12/14/2005	EDS	Update revisions made by DMS
1.2	01/06/2006	EDS	Revised Provider Rep list
1.3	04/20/2006	Lize Deane	Updated with revisions requested by Commonwealth.
1.4	06/06/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.5	09/18/2006	Ann Murray	Replaced Provider Representative table.
1.6	10/30/2006	Ron Chandler	Insert UB-04 claim form and descriptors.
1.7	11/14/2006	Lize Deane	Revisions made according to comment log.
1.8	11/15/2006	Ann Murray	Inserted additional UB-04 information. v1.6 – 1.8 are actually the same as revisions were made back-to-back and no publication would have been made
1.9	01/03/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
2.0	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
2.1	02/15/2007	Ann Murray	Updated Appendix B, KY Medicaid card and ICN.
2.2	02/21/2007	Ann Murray	Replaced Provide Rep table.
2.3	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v1.9 – 2.3 are actually the same as revisions were made back-to-back and no publication would have been made
2.4	05/04/2007	Ann Murray	Updated and added claim forms and descriptors.
2.5	05/15/2007	Cathy Hill	Added specified field descriptions as indicated by TFAL v2.4 – 2.5 are actually the same as revisions were made back-to-back and no publication would have been made

Document Version	Date	Name	Comments
2.6	06/20/07	John McCormick	Updated Rep Listing
2.7	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive eligibility per Stayce Towles.
2.8	05/21/2008	Cathy Hill	Made revisions requested by Stayce Towles. v2.7 – 2.8 are actually the same as revisions were made back-to-back and no publication would have been made
2.9	07/23/2008	Ann Murray	Updated with changes for Medicare.
3.0	02/19/2009	Cathy Hill	Inserted revised NDC form and directions per Stayce Towles.
3.1	02/20/2009	Cathy Hill	Revised UB-04 and NDC forms and directions per Stayce Towles.
3.2	03/09/2009	Cathy Hill	Made changes from KY Health Choices to KY Medicaid per Stayce Towles
3.3	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept. for Medicaid Services per Stayce Towles
3.4	03/24/2009	Ron Chandler	Revised page 32, field 43 & 44. Also page 37, field 43 & 44.
3.5	03/30/2009	Ann Murray	Made global changes per DMS request. v3.0 – 3.5 are actually the same as revisions were made back-to-back and no publication would have been made
3.6	09/08/2009	Ann Murray	Replaced Provider Rep list.
3.7	10/21/2009	Ron Chandler	Replace all instances of "EDS" with "HP Enterprise Services".
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3.9	3/9/2010	Ron Chandler	Insert new provider rep list.
4.0	9/28/2010	Patti George Ron Chandler	Insert note into Rev code list for rev codes 634 & 635.

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4.1	01/18/2011	Ann Murray	Updated global sections.
4.2	11/29/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
4.3	02/08/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman
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4.6	06/04/2012	Stayce Towles Ann Murray	Updated sections 6.2.1, 6.4.1, 7.1 and added section 6.5 Duplicate or Inappropriate Payments based upon HP recommendation with DMS approval from Alisha Clark. DMS Approved 06/28/2012, Alisha Clark
4.7	08/31/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012
4.8	01/30/2013	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
4.9	06/28/2013	Vicky Hicks Patti George	Updates to NET PAYMENT and NET EARNINGS descriptions in Section 9.10.1 DMS Approved 07/09/2013, John Hoffman
4.10	08/12/2013	Stayce Towles Patti George	Update to section 5.10- Provider Rep listing.
5.0	04/09/2014	Stayce Towles	Update to sections 1-5 per DMS. Approved 4/9/14, Lee Guice.
5.1	07/09/2015	Stayce Towles	Add field 66 to the detailed billing instructions for ICD indicator. Approved by John Hoffmann, OATS, 7/6/15.
5.2	06/30/2016	Vicky Hicks	Updated rep list. Approved by Charles Douglass DMS 6/16/2016
5.3	02/01/2017	Vicky Hicks	Added "Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of

Document Version	Date	Name	Comments
			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
5.4	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 Member 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

KyHealth Choices

Kentucky
UNBRIDLED SPIRIT ™

CHILD CLAYTON
1234567890

Member Name

First, Middle Initial (if available), Last

10 DIGIT Member Identification Number

DO NOT THROW AWAY! This is your permanent medical card.

Card Holder: Show this card each time you receive any medical services.

Rules: 1. Use this card only for the person listed on the front of this card.
2. Do not let anyone else use this card to get services.
3. Do not give false information or hide information to get medical coverage.

If you break the rules, you can be prosecuted for fraud and have to pay money back.

If you need to replace this card, call your local DCBS office.
If you have questions about your coverage, call (800) 635-2570.

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES!

Provider: You are responsible for verifying the identity, eligibility, and co-pay status of the cardholder.
Eligibility information may be obtained at http://www.chfs.ky.gov/DMS or by calling (800) 807-1301.
Pharmacy information may be obtained by calling (800) 432-7005.

To report fraud call (800) 372-2970.

If found, please drop this card in any U.S. mailbox.
Return postage is guaranteed.

Commonwealth of Kentucky
Department for Community Based Services
275 East Main Street, 3W-A
Frankfort, KY 40621-0001

Magnetic Strip

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   Member 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 40602-2100
> 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 Commercial Insurance Coverage (this does NOT include Medicare)

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 ☐ CLAIM ☐ ADJUSTMENT 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;

- Member Identification number;

- Member 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 Instruction for Completion of UB-04 Claim Form With NPI

Following are billing instructions for billing Renal Dialysis Services on the UB-04 Billing Form. Only the instructions for fields required for DXC Technology processing or the KY Medicaid Program information are included. Instructions for FIELDS not used by DXC Technology or KY Medicaid processing can be found in the UB-04 Training Manual. The UB-04 Training Manual and UB-04 billing forms may be obtained from:

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

The original UB-04 billing form must be sent to:

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

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.

6.1 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. #			0721
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		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										

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 CODE	OCCURRENCE SPAN FROM THROUGH	36 CODE	OCCURRENCE SPAN FROM THROUGH	37
								09-29-2008

38		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES 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
1 821	HEMODIALYSIS			5	600 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 →		600.00		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 Medicare				10 00		57	Pay ToTaxonomy#	A
B Medicaid/KyHealth Choices						OTHER	Facility 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			A
B			B
C			C

66 DX	518.1					68

69 ADMIT DX	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
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		LAST JONES	FIRST JAMES	
				77 OPERATING NPI		QUAL
				LAST	FIRST	

80 REMARKS P/T 39	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

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

6.2.1 Detailed Instructions

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

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 four digit code 0721 to indicate the type of bill.
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 Member's date of birth.
37	**Medicare EOMB Date**
	Enter the EOMB date from Medicare, if applicable.
39 – 41	**Value Codes**
	Enter the appropriate value code(s) for Medicare/KY Medicaid crossover claims.
	A1 = Deductible Payer A Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. A2 = Coinsurance Payer A Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due. B1 = Deductible Payer B

		Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due.

B2 = Coinsurance Payer B
Enter the amount as shown on the EOMB to be applied toward Member'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
Enter the number of coinsurance days billed to the Medicaid Program during this billing period.

83 = Life Time Reserve Days |
| 42 | | **Revenue Code** |
| | | Enter the revenue code identifying specific services. A list of revenue codes covered by KY Medicaid is located in Appendix F of this manual. |
| | | **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 the standard abbreviation assigned to each revenue code.

Effective July 1, 2009, the NDC is required when billing services for revenue codes 250-259 and 636. The N4 qualifier precedes the NDC. Do not use dashes or spaces. Example N4XXXXXXXXXXX

Only one NDC per detail line. |
44		**CPT/ Rates**
		Enter the appropriate five digit CPT-4 procedure code when billing revenue codes 300-319 for laboratory services.
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."
	NOTE: Total charge amount must be entered in field 47, line 23.
50	**Payer Identification**
	Enter the names of payer organizations from which the provider expects payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.*
	* KY Medicaid is payer of last resort.
	Note: If you are billing for a replacement policy to Medicare, Medicare needs to be indicated instead of the name of replacement policy.
54	**Medicare Paid Amount**
	Enter the paid amount from Medicare, if applicable.
56	**NPI**
	Enter the PAY TO NPI number.
57	**Taxonomy**
	Enter the PAY TO Taxonomy number.
57B	**Other**
	Enter the facilities zip code.
58	**Insured's Name**
	Enter the Member's name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the Member's name exactly as it appears on the Member Identification card in last name, first name, and middle initial format.
60	**Identification Number**
	Enter the Member Identification number in Form Locators 60 A, B, and C that relates to the Member's name in Form Locators 58 A, B, and C. Enter the 10 digit Member Identification number exactly as it appears on the Member 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
	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.)

6.3   Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KY Medicaid Program, whether due to erroneous billing or payment system faults, shall be refunded to the KY Medicaid Program. Refund checks shall be made payable to "KY State Treasurer" and sent immediately to:

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

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse and prosecuted.

7 Medicare Deductibles and Coinsurance

7.1 Resubmission of Medicare/KY Medicaid Part B Claims

On claims which have Medicare allowed procedures as well as non-allowed procedures, KY Medicaid must be billed on separate claims with copies of Medicare remit attached to each claim.

A health insurance claim form, the UB-04 or the CMS-1500 (08/06), should be submitted to KY Medicaid when an original Medicare/KY Medicaid automatic crossover claim has been denied deductible or coinsurance payment by KY Medicaid or when the provider has received no response from KY Medicaid within six weeks of the Medicare adjudication date.

In both of these situations, a new CMS-1500 (08/06) claim should be completed and submitted to KY Medicaid according to KY Medicaid guidelines. To this claim, the provider must attach the corresponding Explanation of Medicare Benefits (EOMB). A copy of the EOMB (including adjudication date and member identification information) is accepted only in its entirety.

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:

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

1. 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

2. Year of Receipt

3. 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.

4. 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.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by DXC Technology.
ATTENDING PROVIDER	The member'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 member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The allowed amount for Medicaid
SPENDDOWN COPAY AMOUNT	The amount collected from the member.
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.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by DXC Technology.
ATTENDING PROVIDER	The member'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 member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.
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.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member'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 member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.

```
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.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member'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 Member.
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 member.
SPENDDOWN AMOUNT	The amount to be collected from the member.
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.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member 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.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member 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	27	Recoupment – Billing Error
02	Prov Refund – Member/Rel Paid	28	Recoupment – Cost Settlement
03	Prov Refund – Casualty Insu Paid	29	Recoupment – Duplicate Payment
04	Prov Refund – Paid Wrong Vender	30	Recoupment – Paid Wrong Vendor
05	Prov Refund – Apply to Acct Recv	31	Recoupment – SURS
06	Prov Refund – Processing Error	32	Payout – Advance to be Recouped
07	Prov Refund-Billing Error	33	Payout – Error on Refund
08	Prov Refund – Fraud	34	Payout – RTP
09	Prov Refund – Abuse	35	Payout – Cost Settlement
10	Prov Refund – Duplicate Payment	36	Payout – Other
11	Prov Refund – Cost Settlement	37	Payout – Medicare Paid TPL
12	Prov Refund – Other/Unknown	38	Recoupment – Medicare Paid TPL
13	Acct Receivable – Fraud	39	Recoupment – DEDCO
14	Acct Receivable – Abuse	40	Provider Refund – Other TLP Rsn
15	Acct Receivable – TPL	41	Acct Recv – Patient Assessment
16	Acct Recv – Cost Settlement	42	Acct Recv – Orthodontic Fee
17	Acct Receivable – DXC Technology Request	43	Acct Receivable – KENPAC
18	Recoupment – Warrant Refund	44	Acct Recv – Other DMS Branch
19	Act Receivable-SURS Other	45	Acct Receivable – Other
20	Acct Receivable – Dup Payt	46	Acct Receivable – CDR-HOSP-Audit
21	Recoupment – Fraud	47	Act Rec – Demand Paymt Updt 1099
22	Civil Money Penalty	48	Act Rec – Demand Paymt No 1099
23	Recoupment – Health Insur TPL	49	PCG
24	Recoupment – Casualty Insur TPL	50	Recoupment – Cold Check
25	Recoupment – Member Paid TPL	51	Recoupment – Program Integrity Post Payment Review Contractor A
26	Recoupment – Processing Error	52	Recoupment – Program Integrity Post Payment Review Contractor B

53	Claim Credit Balance	86	Third Party Paid – TPL
54	Recoupment – Other St Branch	87	Claim Adjustment – TPL
55	Recoupment – Other	88	Beginning Dummy Recoupment Bal
56	Recoupment – TPL Contractor	89	Ending Dummy Recoupment Bal
57	Acct Recv – Advance Payment	90	Retro Rate Mass Adj
58	Recoupment – Advance Payment	91	Beginning Credit Balance
59	Non Claim Related Overage	92	Ending Credit Balance
60	Provider Initiated Adjustment	93	Beginning Dummy Credit Balance
61	Provider Initiated CLM Credit	94	Ending Dummy Credit Balance
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 Member 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 Member IPV	OR	On Demand Recoupment Refund
78	CAP Adjustment-Other	RP	Recoupment Payout
79	Member Not Eligible for DOS	RR	Recoupment Refund
80	Adhoc Adjustment Request	SS	State Share Only
81	Adj Due to System Corrections	SC	SURS Contract
82	Converted Adjustment	UA	DXC Technology Medicare Part A Recoup
83	Mass Adj Warr Refund		
84	DMS Mass Adj Request	UB	DXC Technology Medicare Part B Reoup
85	Mass Adj SURS Request		

XO   Reg. Psych. Crossover Refund

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

13 Appendix F

13.1 Renal Dialysis Revenue Codes

Following is a list of revenue codes that are accepted by the KY Medicaid Program when billing for Renal Dialysis on the UB-04billing form.

Revenue Codes	Description
250	Non-Routine Drugs, Administered in the Facility
270	Medical Supplies/Devices
300	Laboratory – General
301	Chemistry
302	Immunology
303	Renal
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology/Microbiology
307	Urology
310	Lab Pathology
311	Cytology
312	Histology
314	Biopsy
320	Radiology/Diagnostic
636	Drug requiring Detained Coding
730	EKG/ECG, Electrocardiogram
821	Hemodialysis/Outpatient or Home (Composite or Other Rates)
831	Peritoneal Dialysis
841	CAPD/Outpatient/Home (Composite or Other Rates)

845	CAPD Support Services
851	CCPD (Composite or Other Rates
855	CCPD Support Services
920	Electromyelogram (EMG)