Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions
for
Physician's Services
Provider Type – 64, 65

Version 7.8

March 23, 2020

Document Change Log

Document Version	Date	Name	Comments
1.5	04/05/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.6	08/24/2006	Ann Murray	Updated with revisions requested by Brenda Orberson.
1.7	08/31/2006	Ann Murray	Updated with revisions submitted by Stayce Towles.
1.8	09/06/2006	Ann Murray	Updated with revisions submitted by Vicky Hicks.
1.9	09/15/2006	Cathy Hill	Updated with revisions submitted by Vicky Hicks.
2.0	09/18/2006	Ann Murray	Replaced Provider Representative table.
2.1	09/21/2006	Ann Murray	Updated with revisions submitted by Vicky Hicks. v1.6 – 2.1 are actually the same as revisions were made back-to-back and no publication would have been made
2.2	12/28/2006	Ron Chandler	Updated with revisions submitted by Stayce Towles
2.3	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
2.4	02/15/2007	Ann Murray	Updated Appendix C, KY Medicaid card and ICN.
2.5	02/21/2007	Ann Murray	Replaced Provider Rep table.
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2.7	04/30/2007	Ann Murray	Updated and added CMS claim forms and descriptors.
2.8	06/20/07	John McCormick	Updated IAW BI Comment Log / Updated Rep List
2.9	12/11/2007	Ann Murray	Inserted new rep list and NDC Billing Instructions, form and Appendix
3.0	03/17/2008	Ann Murray	Updated forms and form locators
3.1	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive

Document Version	Date	Name	Comments
			eligibility per Stayce Towles.
3.2	06/12/2008	Ann Murray	Deleted without NPI and NPI and KY Medicaid claims and instructions and updated field locators for NPI and Taxonomy claim.
3.3	08/12/2008	Ann Murray	Added Medicare Coding section.
3.4	02/19/2009	Cathy Hill	Inserted revised NDC form per Stayce Towles
3.5	03/10/2009	Cathy Hill	Replaced KYHealth Choices with KY Medicaid per Stayce Towles
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3.7	03/30/2009	Ann Murray	Made global changes per DMS request. v3.5 – 3.7 are actually the same as revisions were made back-to-back and no publication would have been made
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4.2	4/3/2010	Ron Chandler	Revise "note" in field 24D and first paragraph in Appendix B, per Patti George.
4.3	4/23/2010	Ron Chandler	Revise pg. 36, FL 24D and page 51 NDC Detail Sheet per Stayce Towles.
4.4	4/28/2010	Ron Chandler	Revise section 1.1, "General MCD eligibility" section per Stayce Towles. v4.2 – 4.4 are actually the same as revisions were made back-to-back and no publication would have been made
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4.7	01/18/2011	Ann Murray	Updated global sections.
4.8	09/13/2011	Ann Murray	Added Modifiers
4.9	11/27/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
5.0	01/19/2012	Brenda Orberson Ann Murray	Removed "Each 15 minute increment equals one time unit; time units shall be expressed in whole numbers, rounded up." from section 7.2.1, field 24G.
5.1	01/25/2012	Brenda Orberson Ann Murray	Updated section 7.2.1, field G to read "Beginning with dates of services January 1, 2012, anesthesia services should be submitted in actual minutes spent providing anesthesia services as the number of units. (The number of minutes will be converted into units during claims processing (15 minutes = 1 unit).) Do NOT add anesthesia base units to the actual time you submit. The base units are already included in the reimbursement." DMS approved 01/25/2012, John Hoffman
5.2	02/08/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman
5.3	02/21/2012	Brenda Orberson Ann Murray	Updated due to typing error.
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5.5	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
5.6	08/16/2012	Stayce Towles Patti George	Section 7- Changed Taxonomy Qualifier from PXC to ZZ in form locators 24I and 33B per CO18459. (Update of Provider Inquiry form approved by John Hoffman on 08/30/12)
5.7	10/25/2012	Stayce Towles Sandy Berryman	Appendix A – Updated CMS 1500 Crossover EOMB Form and Instructions DMS Approved 10/29/2012, Jennifer L. Smith

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5.9	01/04/2013	Vicky Hicks Patti George	Revise section 7.2.1- field locator 24G-Days or Units Non Shaded Area- Change “Beginning with dates of services January 1, 2012…” to read “Beginning with claims received January 1, 2012…” DMS Approved, Gayle Nickels 1/7/2013
6.0	01/31/2013	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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6.3	12/05/2013	Vicky Hicks Stayce Towles	Updates to section 6- add new CMS form and instructions. DMS approved 12/12/2013, John Hoffmann
6.4	04/14/2014	Stayce Towles	Updates sections 1-5, removed CMS 1500 (08/05) claim form, and revised vaccines requirements in section. Approved 4/14/2014, Charles Douglass.
6.5	12/16/14	Stayce Towles	Updated section 7.5.5 regarding vaccines. Add SL modifier.
6.6	01/08/2015	Stayce Towles	Added Wellness Incentive modifiers per change order 23769 per Erin Hoben, DMS. Added 81 place of service per change order 18212. Erin Hoben and Charles Douglass, DMS approved on 1/13/15.
6.7	07/10/2015	Stayce Towles	Updated detailed instructions for field 21 – diagnosis indicator. Approved by John Hoffmann, OATS, 7/6/15.
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6.9	01/12/2016	Vicky Hicks	Added Sterilization Consent form per request by Charles Douglass, DMS 1/12/2016

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7.0	02/16/2016	Vicky Hicks	Updated Section 8 with U1 Modifier update per CO25051.
7.1	06/16/2016	Vicky Hicks	Updated field 19 verbiage on CMS 1500 form. Added Place of Service code 19 per CO26401. Approved by Charles Douglass DMS 6/16/2016
7.2	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, 2/1/17 Added information for form locators 17 and 17B regarding Referring and Ordering Providers. Removed "Note: For Any claim prior to 11/01/2011, KenPAC or Lockin may be required." Approved by Charles Douglass, DMS, 2/8/2017
7.3	08/22/2017	Vicky Hicks	Removed CMS 1500 Form Locator 24D Modifiers Shaded Area information. Approved by Catherann Terry, DMS. 8/3/17 Removed CMS 1500 Form Locator 19 per Charles Douglass DMS Approved 7/27/2017
7.4	12/28/2018	Vicky Hicks	Updated MAP 250, Provider Inquiry Form, replaced all instances of HP with DXC Technology, updated Rep List. Approved by Charles Douglass, DMS
7.5	02/11/2019	Vicky Hicks	Placed Disclaimer on MAP 250 form stating "The most current version of the MAP 250 can be found at www.kymmis.com under Provider Relations, Forms, then click on Provider Relations."
7.6	05/17/2019	Vicky Hicks Mary Larson	Updated: 1) Provider Rep Table, 2) all forms, 3) DMS URLs in Introduction, 4) ICD-9/ICD-9-CM to ICD-10, 5) added Place of Service code 02 – Telehealth per CO29475
7.7	01/27/2020	Vicky Hicks	Added Place of Service Code 81 as covered for all physicians effective 1/1/2020 per CO31069
7.8	03/23/2020	Vicky Hicks	Added Modifiers 27, 58, 78, 79, 91, LM, RI, XE, XP, XS, XU to Billing Instructions per DMS

Document Version	Date	Name	Comments
			request. Approved by Tom Young.

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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

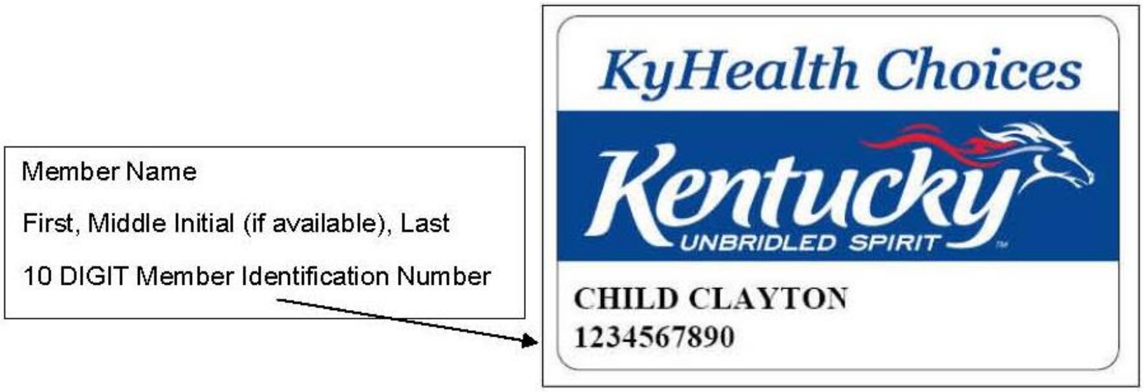
1.2 Member Eligibility

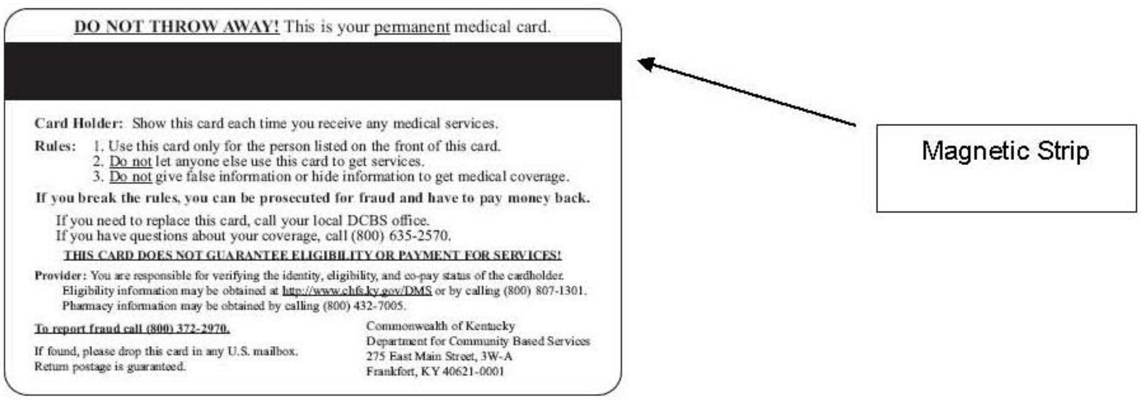
Members should apply for Medicaid eligibility through kynect (kyenroll.ky.gov), by phone at 1-855-4kynect (1-855-459-6328), or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through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





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 40602-2016
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 provide 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 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;
- 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 numbers: 1-800-807-1232**

6 Forms Requirements

The Health Insurance Claim Form CMS-1500 is used to bill for physician services provided to eligible KY Medicaid Program members. A CMS-1500 claim with information submitted in black typewritten form is recommended, although neat, printed, legible handwriting is acceptable. CMS-1500 claims can be obtained from:

U.S. Government Printing Office
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
1-202-512-1800

The following MAP forms may be obtained on the DXC Technology website: www.kymmis.com

Additional forms required for specific services include, but may not be limited to, the following:

- Drug Prior Authorization Form (MAP-82001, MAP-82101 and MAP 012802);
- Hysterectomy Consent Form (MAP-251);
- Sterilization Consent Form (MAP-250);
- Certification Form for Induced Abortion or Induced Miscarriage (MAP-235); and,
- Certification Form for Induced Premature Birth (MAP-236).

Required claims and forms completed incorrectly and submitted to KY Medicaid results in denial of payment. All forms should be completed according to KY Medicaid guidelines as outlined and detailed in these instructions. In certain situations involving the "automatic crossover" of claims, it may be necessary to follow the guidelines of two insurers concurrently (Medicare/Medicaid), as in this document, or to follow the guidelines designed for special billing situations, as related in this document. Example of Certification for Induced Abortion or Induced Miscarriage Form (MAP-235).

CERTIFICATION FORM FOR INDUCED ABORTION OR INDUCED MISCARRIAGE

I, ____, certify that on the basis of
(Physician's Name)

my professional judgment, the life of ____________________________________
(Patient's Name)

______________________________ of ______________________________
(MAID #) (Patient's Address)

(Please check appropriate box)

Suffered from a ____physical disorder, ____physical injury, and/or ____physical illness that placed her in danger of death if the fetus were carried to term. I further certify that the following procedure(s) were medically necessary to induce an abortion or miscarriage.

(Please indicate date and the procedure that was performed)

____

____

____

____
Physician's Signature

____
Name of Physician

____
License Number

____
Date

MAP-235 (2/00)

6.1.1 Completion of Induced Abortion or Induced Miscarriage Form (MAP-235)

Field	Description
Physician's Name	Enter the physician's name.
Patient's Name	Enter the Member's name.
Member Identification #	Enter the Member's 10 digit Member Identification number.
Patient's Address	Enter the Member's address.
(Please indicate date and the procedure that was performed.)	Enter the date the procedure was performed and include any other pertinent information.
Physician Signature	The physician's actual signature is required. Stamped signatures are not acceptable.
License Number	Enter the physician's six digit Unique Physician Identification Number (UPIN) or other license number.
Date	Enter the date the form was signed by the physician.

Certification for Induced Premature Birth Form (MAP-236)

MAP-236 (8/78)

CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH

I, ____, certify that on the basis of
(Physician's Name)

my professioanl judgement, it was necessary to perform the following procedure on ______________
(Date)

to induce premature birth intended to produce a live viable child. ____________________________
(Procedure)

This Procedure was necessary for the health of ____
(Name of Mother)

_________________________________ of ____
(MAID #) (Address)

and/or her unborn child.

____
Physician's Signature

____
Name of Physician

____
License Number

____
Date

6.1.2 Completion of Certification for Induced Premature Birth Form (MAP-236)

Field	**Description**
Physician’s Name	Enter the physician’s name.
Date	Enter the date the procedure was performed.
Procedure	Enter the procedure.
Name of Mother	Enter the name of the mother.
Member Identification #	Enter the mother’s Member Identification number.
Address	Enter the mother’s address.
Physician’s Signature	The physician’s actual signature is required. Stamped signatures are not acceptable.
Name of Physician	Enter the name of the performing physician.
License Number	Enter the physician’s six digit Unique Physician Identification Number (UPIN) or other license number.
Date	Enter the date the form was signed by the physician.

6.2 Diagnosis Coding

Physicians report member diagnoses on CMS-1500 claim forms using codes contained in the Internal Classification of Diseases Ninth Revision, Clinical Modification ICD-10. KY Medicaid recognizes and accepts all codes from this reference, with the exclusion of the morphology of neoplasm codes, M800 through M997. The ICD-10 book of codes (order # OP-065-196) can be ordered from:

American Medical Association
ATTN: Order Department
P.O. Box 7046
Dover, DE 19903-7046
1-800-621-8335

6.3 Procedure Coding

Services and procedures performed for members by physicians are billed on the CMS-1500 claim form using levels 1 and 2 of the Centers for Medicare and Medicaid Services (CMS) Common Procedural Coding System (HCPCS).

Level 1 numeric five digit codes are those contained in the American Medical Association's Current Physicians' Procedural Terminology (CPT) book and should be entered on the CMS-1500 to report the majority of services and procedures performed by physicians. CPT books can be purchased from:

American Medical Association
ATTN: Order Department
P.O. Box 7046
Dover, DE 19903-7046
1-800-621-8335

NOTE: The KY Medicaid Program provides reimbursement for covered services provided for Medicaid members according to the CPT/HCPCS codes (both levels) reported on the claim form and only as the descriptors of the codes in the CPT code book

According to the information in the CPT code book, the American Medical Association (AMA) welcomes correspondence, inquiries and suggestions concerning CPT codes from physician members. Physician members may request assistance with coding for services that are universal or where there are no listed codes by written or telephone communication to:

Department for Coding and Nomenclature
American Medical Association
515 North State Street
Chicago, IL 60610
1-312-464-4737

7 Completion of Sterilization Consent Form

7.1 Purpose

Federal regulations (42 CFR 441.250-441.258) require that any individual being sterilized must read and sign a federally approved consent form. The consent form contains information about the procedure being performed and the results of the procedure. The MAP-250 Sterilization Consent Form (or another form approved by the Secretary of Health and Human Services) requires the form be signed by the Member, the person obtaining the consent, and the physician according to Program policy.

7.2 General Instructions

The Sterilization Consent Form (MAP-250) is a five part self-carbonized form.

All applicable fields must be completed.

The following individuals or offices must receive a copy of the completed MAP-250 form:

- The surgeon;

Attach the signed and dated MAP-250 to the corresponding claim form and submit for processing.

NOTE: The most current version of the MAP 250 can be found at www.kymmis.com under Provider Relations, Forms, then click on Provider Relations.

Obtain MAP-250 forms from:

www.kymmis.com

7.2.1 MAP-250 – Sterilization Consent Form

Form Approved: OMB No. 0937-0166
Expiration date: 1/31/2019

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from ______________ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ______________ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: ______________ (*Date*)

I, ______________, hereby consent of my own free will to be sterilized by ______________ (*Doctor or Clinic*) by a method called ______________ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

______________ *Signature* ______________ *Date*

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ______________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

______________ *Interpreter's Signature* ______________ *Date*

HHS-687 (10/12)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before ______________ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation ______________ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

______________ *Signature of Person Obtaining Consent* ______________ *Date*

______________ *Facility*

______________ *Address*

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon ______________ (*Name of Individual*) on ______________ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation ______________ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: ______________
- ☐ Emergency abdominal surgery *(describe circumstances)*: ______________

______________ *Physician's Signature* ______________ *Date*

7.2.2 Detailed Instructions for Completion of the Consent Form

7.2.2.1 Consent to Sterilization

The MAP-250 Form must be completed at least 30 days prior to the sterilization procedure, except in cases of premature delivery and emergency abdominal surgery in which case a 72 hour waiting period is required. No more than 180 days should elapse between the date the form is signed and the procedure is performed.

- Enter the name of the physician, clinic or the name of the physician and the phrase “and/or associates” who expects to perform the procedure.
- Enter the name of the procedure to be performed.
- Enter the birth date of the Member. *The Member must be 21 years of age or older.
- Enter the name of the Member.
- Enter the name of the physician expected to perform the procedure.
- Enter the method of sterilization.
- An original Member signature is required.
- An original handwritten date is required for the date of signature. No typed dates are accepted.

NOTE: The Member’s signature and/or date of signature cannot be altered. If alterations in either of these two areas occur, the claim is denied. Race and ethnicity information may be designated by checking the appropriate block but is not mandatory.

7.2.2.2 Interpreter’s Statement

If appropriate, complete this section at the same time the above section is completed.

- Enter the language used to read and explain the form.
- The interpreter must sign the form.
- The interpreter must date the form.

7.2.2.3 Statement of Person Obtaining Consent

This section should be completed at the same time or after the above two sections are completed.

- Enter the Member’s name.
- Enter the procedure name.
- The person obtaining the consent must read and sign the form.
- The person obtaining the consent must date the form. The date must be on or after the date the Member signed.
- Enter the name of the facility or office of the person obtaining consent.
- Enter the address of the facility or office of the person obtaining consent.

7.2.2.4 Physician Statement

This section must be completed at the same time or after the procedure is performed.

- Enter the name of the Member.
- Enter the date of the sterilization.
- Enter the procedure performed.
- Enter the specific type of operation.
- Follow instructions on the form. Cross out the paragraphs not used.

If the sterilization was performed less than 30 days but more than 72 hours after date of the individual's signature and date on the consent form, check the applicable block and provide the information requested.

In the case of premature delivery, enter the expected date of delivery. The expected date of delivery should be at least 30 days after the individual's signature and date.

If the procedure was performed as result of emergency abdominal surgery, enter a brief description in the designated area of the consent form, or attach an operative report to describe the circumstances.

The physician(s) who performed the procedure must sign the form in this section.

Enter the date the physician signed the form. This date must be on or after the date of the surgery.

NOTE: Federal regulations require that MAP-250 forms be completed without error or corrections. If an error is made or correction is required during the completion of the form, destroy the form and complete another form correctly according to these instructions.

To ensure payment for all claims related to this procedure, close adherence to these instructions for completion of the form is recommended.

8 Completion of the New CMS-1500 Paper Claim Form

The new CMS-1500 claim form is used to bill Medicaid physician services. A copy of a completed claim is shown on the following page.

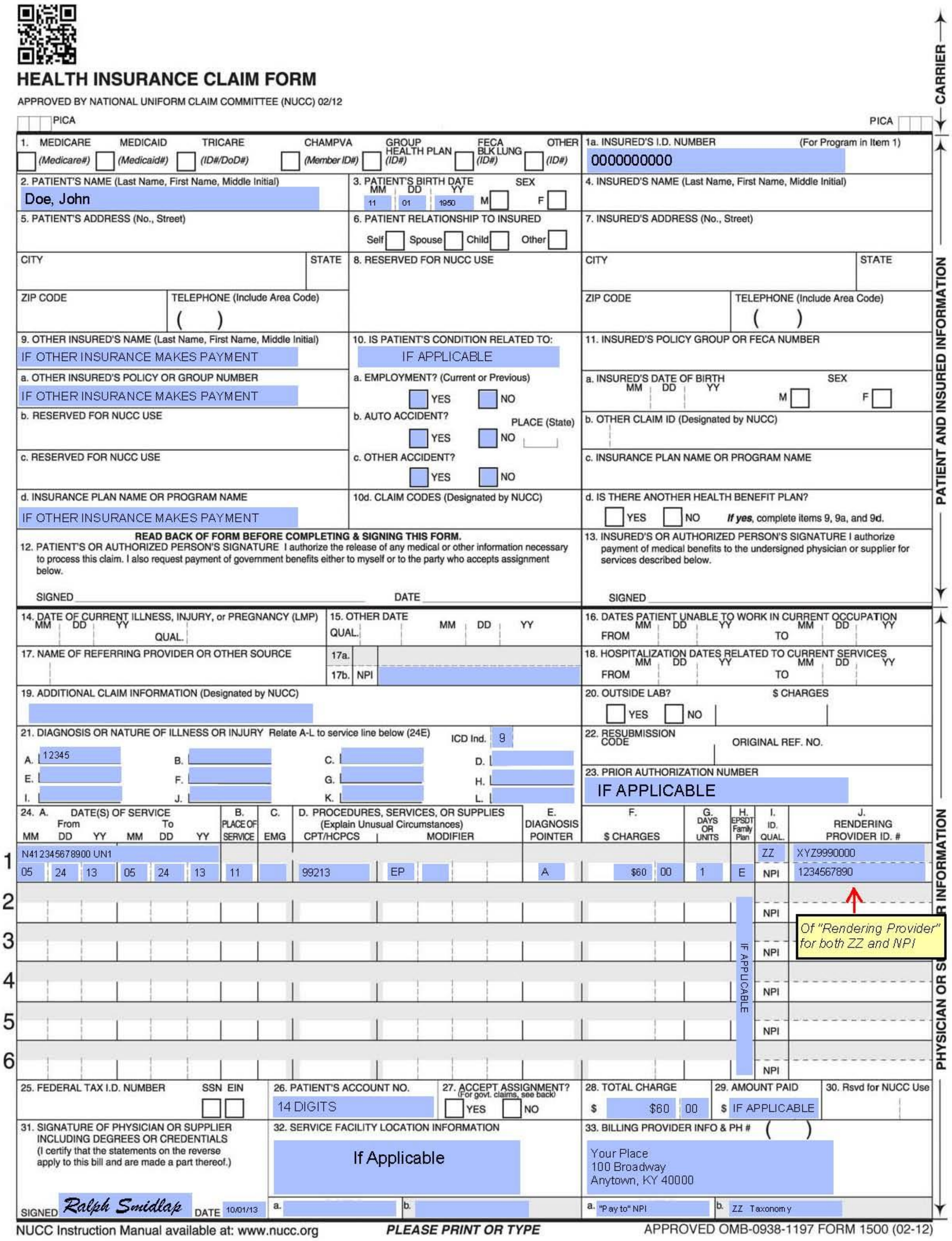
Providers may order CMS-1500 claims from the:

U. S. Government Printing Office
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
1-202-512-1800

DXC Technology does not require an original CMS 1500 for processing.

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.**

8.1 New CMS-1500 (02/12) Claim Form with NPI and Taxonomy



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA — CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0000000000

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE MM DD YY: 11 01 1950 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): IF OTHER INSURANCE MAKES PAYMENT

10. IS PATIENT'S CONDITION RELATED TO: IF APPLICABLE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: IF OTHER INSURANCE MAKES PAYMENT

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: IF OTHER INSURANCE MAKES PAYMENT

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 12345 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: IF APPLICABLE

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 N412345678900 UN1								ZZ	XYZ9990000
05 24 13 05 24 13	11		99213 EP	A	$60 00	1	E	NPI	1234567890
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

IF APPLICABLE

Of "Rendering Provider" for both ZZ and NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 14 DIGITS

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ $60 00

29. AMOUNT PAID $ IF APPLICABLE

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Ralph Smidlap DATE 10/01/13

32. SERVICE FACILITY LOCATION INFORMATION: If Applicable

a. b.

33. BILLING PROVIDER INFO & PH # ( )

Your Place
100 Broadway
Anytown, KY 40000

a. "Pay to" NPI b. ZZ Taxonomy

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

8.2 Completion of New CMS 1500 (02/12) Paper Claim Form with NPI and Taxonomy

8.2.1 Detailed Instructions

Claims are returned or rejected if required information is incorrect or omitted. Handwritten claims must be completed in black ink ONLY. Black typewriter ribbon must be used for typed claims.

The following fields are required and must be completed. The top, right, blank portion of the claim is reserved for DXC Technology use only.

FIELD NUMBER	FIELD NAME AND DESCRIPTION
1	Check the “Medicare” and “Medicaid” blocks when billing a claim to **Medicare** to request Medicare to send the claim to Medicaid for processing coinsurance and deductible amounts. Check the “Medicaid” block if the claim is to be processed by “Medicaid” **only**.
1A	**Insured’s I.D. Number**
	Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card.
2	**Patient’s Name**
	Enter the member’s last name and first name exactly as it appears on the Member Identification card.
3	**Date of Birth**
	Enter the date of birth for the member.
9	**Other Insured’s Name**
	Enter the Insured's Name. Required only if member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim.
9A	**Other Insured’s Policy Group Number**
	Required only if member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. If this field is completed, also complete Fields 9D and 29. NOTE: If other insurance denies the submitted claim, leave Fields 9, 9A, 9D and 29 blank and attach denial statement from other insurance carrier to the CMS-1500 (02/12) claim.

9D	**Insurance Plan or Program Name**
	Enter the Member’s insurance carrier name. Complete only if entry in 9.
10	**Patient’s Condition**
	Check the appropriate block if applicable.
14	**Date of Current**
	Enter the appropriate date, if you marked “Yes” in the fields 10A-10C.
17	**Name of Referring Provider or Other Source**
	Enter the applicable qualifier and the name of the Referring Provider or Ordering Provider. **Qualifiers:** DN – Denotes Referring Provider DK – Denotes Ordering Provider
17B	**Name of Referring Provider or Other Source**
	Enter the Referring or Ordering Provider NPI, if applicable.
21	**Diagnosis or Nature of Illness or Injury**
	Enter an ICD indicator in the upper right corner to indicate the type of diagnosis being used. 9= ICD-9 0= ICD-10 **Twelve diagnosis codes may be entered.**
23	**Prior Authorization Number**
	Enter the PA number assigned for these procedures. **NOTE: See Physician fee schedule located at www.chfs.ky.gov/dms for procedure codes marked “R” indicating prior authorization required, or procedures listed on KY HealthNet.**
24A	**Date(s) of Service (Non-Shaded Area)**
	Enter the date or dates of service(s) in month, day, year numeric format (MMDDYY). **NOTE: Span-dating is only allowed for identical services provided on consecutive dates of service. For providers who span-date, enter the corresponding number of consecutive days in Field 24G.**
24A	**NDC (Shaded Area)**
	Enter in the following order: NDC qualifier (N4) 11-digit NDC code, one space, unit/basis of

	measurement qualifier (see list below), quantity The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (99999999.999). If entering a whole number, do not use a decimal. Do not use commas. F2= International Unit ME= Milligram UN= Unit GR= Gram ML= Milliliter
24B	**Place of Service**
	Enter the appropriate two digit place of service code which identifies the location where services were rendered. See Appendix C for a list of values.
24D	**Procedures, Services or Supplies CPT/ HCPCS (Non-Shaded Area)**
	Enter the appropriate HIPAA compliant procedure code identifying the service or supply provided for the member. Local codes are no longer valid for dates of service October 16, 2003 and after. **NOTE: Effective July 1, 2007, providers are required to bill the actual NDC administered when billing a "J" HCPCS code on the CMS 1500. NDC is entered in 24A Shaded area. See instructions above.** You may only bill one NDC per claim line detail.
24D	**Modifier (Non-Shaded Area)**
	Enter the appropriate HIPAA compliant two digit modifier, if applicable, that further describes the procedure code. Modifiers accepted by Medicaid are:

24	Unrelated evaluation and management (E&M) service by the same physician during a postoperative period.
25	Used only with an evaluation and management (E&M) service code and only when a significant, separately identifiable evaluation and management service is provided by the same provider to the same patient on the same day of the procedure or service. Documentation is not required to be submitted with the claim but appropriate documentation for the procedure and evaluation and management service must be maintained.
26	Professional Component
27	Multiple outpatient hospital E/M encounters on the same date
33	Preventive Services – effective dates of service 1/1/14

	50	Bilateral Procedure
	51	Multiple Procedures
	57	Decision for surgery. An evaluation and management (E&M) service that resulted in the initial decision to perform the surgery may be identified by adding the modifier 57 to the appropriate level of E&M service.
	58	Staged or related procedure or service by the same physician during the postoperative period
	59	Distinct Procedural Service
	76	Repeat Procedure by Same MD
	77	Repeat Procedure by Another MD
	78	Return to the operating room for a related procedure during the postoperative period
	79	Unrelated procedure or service by the same physician during the postoperative period
	80	Assistant Surgeon
	91	Repeat clinical diagnostic laboratory test
	TC	Technical Component
	GT	Telehealth Consultation
	Q6	Locum Tenens
	U1	Physician Assistant- (valid for dates of service prior to 10/1/15)
	XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
	XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner
	XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
	XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service
	Effective January 1, 2009, only Physicians who have a specialty of	

	teleradiology may use the following modifiers:	
	Modifier	**Description**
	U2	Teleradiology In-State
	U3	Teleradiology Out-of-State
	LEVEL II HCPCS Modifiers Only to be used with appropriate CPT codes.	
	Modifier	**Description**
	LM	Left main coronary artery
	LT	Left side
	RI	Ramus Intermedius coronary artery
	RT	Right side
	E1	Upper left, eyelid
	E2	Lower left, eyelid
	E3	Upper right, eyelid
	E4	Lower right, eyelid
	FA	Left hand, thumb
	F1	Left hand, second digit
	F2	Left hand, third digit
	F3	Left hand, fourth digit
	F4	Left hand, fifth digit
	F5	Right hand, thumb
	F6	Right hand, second digit
	F7	Right hand, third digit
	F8	Right hand, fourth digit
	F9	Right hand, fifth digit
	LC	Left circumflex, coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)

	LD	Left anterior descending coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
	RC	Right coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
	TA	Left foot, great toe
	T1	Left foot, second digit
	T2	Left foot, third digit
	T3	Left foot, fourth digit
	T4	Left foot, fifth digit
	T5	Right foot, great toe
	T6	Right foot, second digit
	T7	Right foot, third digit
	T8	Right foot, fourth digit
	T9	Right foot, fifth digit
24D	**Modifier (Non-Shaded Area)**	
	Wellness Incentive Modifiers will be used from January 1, 2015 to June 30, 2016, on elected procedures. You may review a copy of the fee schedule and elected procedures at **www.chfs.ky.gov/dms/fee.htm** There will be two modifiers to describe the service	
	Modifier	**Description**
	33 and U7	Blood Lead Screening/Cancer Screenings/Spirometry Testing
	33 and UA	EPSDT/Well Child Visit – 15 months and younger
	33 and U5	Childhood Immunizations/Flu Vaccine/DXC TECHNOLOGYV Vaccine
	33 and UB	BMI/Weight Assessment and Counseling for Nutrition and Physical Activity
	33 and UD	Controlling High Blood Pressure
	33 and U8	After Hours Care

24E	**Diagnosis Code Indicator**
	Enter the diagnosis pointers A-L to refer to a diagnosis code in field 21. Do not enter the actual diagnosis code.
24F	**Charges (Non-Shaded Area)**
	Enter the total usual and customary charge(s) for the service(s) provided for the member.
24G	**Days or Units (Non-Shaded Area)**
	Enter the number of times per line the procedure was performed for the member on this date.
	Anesthesia Billing
	Beginning with claims received January 1, 2012, anesthesia services should be submitted in actual minutes spent providing anesthesia services as the number of units. (The number of minutes will be converted into units during claims processing (15 minutes = 1 unit).) Do NOT add anesthesia base units to the actual time you submit. The base units are already included in the reimbursement.
24G	**Documenting Time for Anesthesia Services (Shaded Area)**
	For anesthesia services, enter the total number of minutes from the Anesthesia and Operative record based on the anesthesia start time and the anesthesia stop time.
24I	**ID Qualifier (Shaded Area)**
	Enter a ZZ to indicate Taxonomy. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.**
24J	**Rendering Provider ID # (Shaded Area)**
	Enter the Rendering Provider's Taxonomy Number. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.**
	(Non-Shaded Area)
	Enter the Rendering Provider's NPI Number. **Note: For services prior to 10/1/15, if you are supervising a physician assistant, the supervising provider's NPI is listed in this field. The physician assistants NPI number is located in 19. If this is a physician assistant providing the service, remember to append the modifier U1 to the procedure code (for services provided**

	prior to dates of service 10/1/15.) **Effective with dates of service 10/1/15, Physician Assistant services will no longer be billed using the U1 modifier or utilizing the Supervising Physician as the rendering provider. Please reference the Physician Assistant Billing Instructions for more information.**
26	**Patient's Account No.**
	Enter the office account number you have assigned to this member, if desired. Up to 14 alpha/numeric characters are typed. The account number appears on the remittance statement you receive from KY Medicaid as the invoice number.
28	**Total Charge**
	Enter the total of all individual charges entered in column 24F. Total each claim separately.
29	**Amount Paid**
	Enter the amount paid, if any, by a private insurance. Do not enter a Medicare or Medicaid amount that may have been previously paid. Also, complete Fields 9, 9A and 9D.
31	**Date**
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
32	**Service Facility Location Information**
	If the address in Form Locator 33 is not the address where the service was rendered, Form Locator 32 must be completed.
33	**Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number**
	Enter the provider's name, address, zip code and phone number (including area code).
33A	**NPI**
	Enter the appropriate Pay to NPI Number.
33B	**(Shaded Area)**
	Enter ZZ and the Pay to Taxonomy Number. **NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.**

8.3 Helpful Hints for Successful CMS-1500 (02/12) Filing

- Be sure to include the “AS OF” date and “EOB” code when copying a remittance advice as proof of timely filing or for inquiries concerning claim status.
- Please follow up on a claim that appears to be outstanding after six weeks from your submission date.
- Field 24B (Place of Service) requires a two digit code.
- Field 24E (Diagnosis Code Indicator) is a one digit only field.
- If any insurance other than Medicare/KY Medicaid makes a payment on services you are billing, complete Fields 9, 9A, 9D, and 29 on the CMS-1500 (02/12) claim form.
- If insurance does not make a payment on services you are billing, attach the private insurance denial to the CMS-1500 claim form. Do not complete Fields 9, 9A, 9D, and 29 on the CMS-1500 (02/12) claim form.
- An adjustment is a change made to a PAID claim or a PAID detail line of a claim.
- Do not submit an adjustment and refund for the same claim at the same time.
- Healthcare organizations have traditionally conducted business by trading information on preprinted paper forms. The variety and volume of paper-based exchanges has grown. This has forced healthcare organizations to seek more efficient ways of communicating. Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

8.4 Mailing Information

Send the completed claims to DXC Technology for processing as soon as possible after the service is provided. Retain a copy in the office file.

Mail completed claims to:

DXC Technology
P.O. Box 2101
Frankfort, KY 40602-2101

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.**

8.5 Special Billing instructions

8.5.1 Assistant Surgeon Services

Assistant surgeon services may be billed by entering the appropriate CPT code corresponding to the primary surgical procedure and modifier 80 in field 24D of the claim form.

NOTE: Assistant surgeon and primary surgeon services must be billed on separate claims. Physician Assistants may not bill with modifier 80.

8.5.2 Multiple Medical/Surgical Procedures

Multiple medical or surgical procedures performed for a member during a single operative session must be listed separately on the same CMS-1500 claim by entering the corresponding CPT procedure codes in Field 24D. The submission of a physician claim for more than six Medical/Surgical procedures during one operative event necessitates the completion of more than one paper claim. With electronic claim format there is the ability to bill 50 details.

When additional procedures are billed on a second claim form with the same dates of service as the procedures billed on the first claim, the second claim automatically denies. To obtain payment for the additional procedures (those listed on the second or a third claim), the provider must:

- Submit another CMS-1500 listing the denied procedures;
- Attach the Remittance Advice showing denial of payment; and,
- Complete and mail to DXC Technology an Adjustment and Claim Credit Request Form for the originally filed partial-paid claim for multiple medical/surgical procedures to the following address:

  DXC Technology
  P.O. Box 2108
  Frankfort, KY 40602-2108.

NOTE: KY Medicaid does not make separate payment for procedures that are part of a more comprehensive service. Payment for the major procedure includes payment for any separately identified component parts of the procedure (that is, incidental or intrinsic procedures such as analysis of adhesions, appendectomy and so on).

8.5.3 Newborn Care

Routine newborn care services may be reported by entering the mother’s name and number on the claim form.

If using the CMS-1500 (02/12):
Enter the mother’s name in Field 2 and the mother’s Member Identification number in Field 1A.

The CPT code corresponding to the service must be entered in Field 24D.

To report routine newborn care services provided after multiple birth events (that is, for twins, triplets, quadruplets and so on), enter the mother’s name in Field 2 of the claim form and the mother’s Member Identification number in Field 1A. The CPT code corresponding to the service provided must be entered in Field 24D with a notation “multiple birth” (that is, Twin A and Twin B) in the adjacent Unusual Circumstance field. Enter the number of units in Field 24G that corresponds to the number of times the procedure is performed (for example, on line one of the

CMS form, 1 unit of service for one routine hospital visit on day one for Twin A. Line two of the CMS form, 1 unit of service for one routine visit on day one for Twin B).

Physician claims for routine newborn care services include:

- Initial normal newborn care (procedures 99460);
- Subsequent hospital normal newborn care (procedures 99462);
- Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn (procedure code 99464); and,
- Circumcision when performed during the time period the mother and newborn are hospitalized in the same hospital (procedures 54150, 54160).

NOTE: Routine newborn care can be billed using the mother's Member Identification number and name only once per nine month period. When a newborn requires other than routine newborn care (for example, newborn resuscitation), the services must be billed under the baby's own name and Member Identification number.

8.5.4 Chemotherapy (Antineoplastic)

Claims for chemotherapy and the administration thereof may be submitted for payment for members who have malignancy diagnoses. The malignancy diagnosis should be entered as the first diagnosis in Field 21 of the CMS-1500.

The administration of anti-neoplastic drugs may be reported on the CMS-1500 (02/12) claim by entering the appropriate CPT procedure code in Field 24D.

8.5.5 VFC Vaccine Administration

For dates of service prior to January 1, 2014, Medicaid did not reimburse vaccines provided by the Department for Health Services Vaccines for Children (VFC) program. Only the administration of vaccines was reimbursed for children under age 21 billed with the CPT code applicable to the vaccine used and a "26" modifier (in field 24D of the CMS claim).

As of dates of service January 1, 2014, vaccines will be paid by the following:

- For patients under age 19, bill KY Medicaid using the administration CPT and the vaccine CPT. If the vaccine was procured from the Vaccines for Children (VFC) program bill modifier SL with the vaccine CPT code. If not, bill the vaccine CPT without modifier SL.
- For patients 19 and older, bill KY Medicaid using the administration CPT and the vaccine CPT. Do not use modifier SL.

The 26 modifier is no longer used.

9 Appendix A

9.1 Resubmission of Medicare/Medicaid Part B Claims

On claims which have Medicare allowed procedures as well as non-allowed procedures, Medicaid must be billed on separate claims.

1. For services denied by Medicare, attach a copy of Medicare's denial to the claim.
2. If a service was allowed by Medicare, submit a CMS-1500, which should be submitted to KY Medicaid according to Medicaid guidelines. To this claim, the provider must attach the corresponding Medicare Coding Sheet.

For claims automatically crossed over from Medicare to KY Medicaid, allow six weeks for processing. If no response is received within six week of the Medicare EOMB date, resubmit per item two.

9.1.1 Medicare Coding

As of September 29, 2008, the Medicare EOMB is no longer needed to be attached to a claim if Medicare pays on the service. Instead of the Medicare EOMB, providers will utilize the coding sheet on the next page.

In the event that Medicare denies your service, the Medicare EOMB will be required to be attached to the claim.

The Medicare Coding Sheet may be accessed at www.kymmis.com. You may type in the Medicare information into the PDF and print the coding sheet so you don't have to hand-write the required information. The PDF will not save your changes in the coding sheet.

Please follow the guidelines below so the Medicare Coding Sheet may process accurately.

- Black ink only. No colored ink, pencils or highlighters;
- No white out. Correction tape is allowed;
- If a service is paid in full by Medicare, those services do not need to be billed to Kentucky Medicaid. The allowed amount and paid amount from Medicare would be the same.
- When writing zeros do not put a line through the zero.
- When billing a claim with multiple detail lines, be sure that Medicare has allowed a payment on those services. If Medicare has denied a detail line, that detail must be on a separate claim with the Medicare EOMB attached.
- The documents must be listed in the following order:
  - Claim form;
  - Coding sheet;
  - NDC Detail Attachment, and;
  - Any other attachments that may be needed.

9.1.2 Medicare Coding Sheet

CMS1500 CROSSOVER EOMB FORM

Member Name: 1 Member ID: 2

EOMB Date: 3

Line 4

Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4

Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4

Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4

Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4

Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

Line 4

Deduct/Pat Resp Amt		Coinsurance and/or Co-pay Amt		Provider Pay Amt	
5		6		7	
8					

9.1.3 Medicare Coding Sheet Instructions

FIELD NUMBER	FIELD NAME AND DESCRIPTION
1	**Member’ s Name**
	Enter the Member’s last name and first name exactly as it appears on the Member Identification card.
2	**Member’ s ID**
	Enter the Member’s ID as it appears on the claim form.
3	**EOMB Date**
	Enter Medicare’s EOMB date.
4	**Line Number**
	Enter the line number. The line numbers must be in sequential order.
5	**Deductible Amount**
	Enter deductible amount from Medicare, if applicable.
6	**Co-insurance and/or Co-pay Amount**
	Enter the total amount of co-insurance and/or co-pay from Medicare if applicable.
7	**Provider Pay Amount**
	Enter the amount paid from Medicare
8	**Patient Responsibility**
	Enter the patient responsibility amount from Medicare

10 Appendix B

10.1 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 2 3 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

11 Appendix C

11.1 Place of Service Codes

The following is a two character place of service code indicating the location where services were rendered.

02	Telehealth (effective date of service 1/1/18)
03	School (effective date of service 7/1/15)
04	Homeless Shelter (effective date of service 7/1/15)
11	Office
12	Home
13	Assisted Living Facility (effective date of service 7/1/15)
14	Group Home (effective date of service 7/1/15)
15	Mobile Unit (effective date of service 7/1/15)
16	Temporary Lodging (effective date of service 7/1/15)
17	Walk-in Retail Health Clinic (effective date of service 7/1/15)
19	Off Campus Outpatient Hospital (effective 1/1/2016)
20	Urgent Care Facility (effective date of service 7/1/15)
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility (effective date of service 7/1/15)
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
49	Independent Clinic (effective date of service 7/1/15)

50 Federally Qualified Health Center (effective date of service 7/1/15)

51 Inpatient Psychiatric Facility

52 Psychiatric Facility-Partial Hospitalization

54 Intermediate Care Facility/Mentally Retarded

55 Residential Substance Abuse Treatment Center

56 Psychiatric Residential Treatment Center

57 Non-residential Substance Abuse Treatment Facility (effective date of service 7/1/15)

60 Mass Immunization Center (effective date of service 7/1/15)

61 Comprehensive Inpatient Rehabilitation Facility

62 Comprehensive Outpatient Rehabilitation Facility

65 End Stage Renal Disease Treatment Facility

71 State or Local Public Health Clinic

72 Rural Health Clinic

81 Independent Laboratory (with Pathologist specialty-effective date of service 7/11/2015-12/31/2019) Covered for all physicians effective 1/1/2020.

99 Other Unlisted Facility (end dated 6/30/15)

12 Appendix D

12.1 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.

12.1.1 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.

12.2 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.

12.3 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-BANN-R	COMMONWEALTH OF KENTUCKY (M1)	DATE: 01/23/2007
RA#: 9999999	MEDICAID MANAGEMENT INFORMATION SYSTEM	PAGE: 1
	PROVIDER REMITTANCE ADVICE	
	CMS 1500 CLAIMS PAID	

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID	99999999
NPI ID	
CHECK/EFT NUMBER	999999999
ISSUE DATE	01/26/2007

--ICN-- / --PATIENT NUMBER--	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	PAID AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.: 9999999999						
9999999999999	060606	060606	200.00		0.00			0.00
9999999XXX				18.05		0.00	2.00	16.05

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
22	88304	TC	1.00	060606	060606	MCD 64000000	200.00	18.05	5001 0018 9918 00A2

	BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID
TOTAL CMS 1500 CLAIMS PAID:	200.00		0.00		0.00	
		18.05		0.00		16.05

12.4 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.
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 allowed amount for Medicaid
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount collected from the member.
COPAY AMOUNT	The amount 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.
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-BANN-R                          COMMONWEALTH OF KENTUCKY (M1)                        DATE:  01/23/2007
      RA#:      9999999                   MEDICAID MANAGEMENT INFORMATION SYSTEM                  PAGE:             1
                                                PROVIDER REMITTANCE ADVICE
                                                  CMS 1500 CLAIMS DENIED

PROVIDER                                                                                    PAYEE ID             99999999
555 ANY STREET                                                                              NPI ID
CITY, KY 55555-0000                                                                         CHECK/EFT NUMBER     000999999
                                                                                            ISSUE DATE           01/26/2007
    --ICN--              SERVICE DATES           BILLED                  TPL                SPENDDOWN
 --PATIENT NUMBER--      FROM      THRU          AMOUNT                 AMOUNT                 AMOUNT

MEMBER NAME: JANE DOE                      MEMBER NO.: 9999999999
  2007017999999          060606 060606           200.00                   0.00                   0.00
      9999999XXX

HEADER EOBS:   3015  0011

                                                SERVICE DATES    RENDERING                  BILLED
PL SERV      PROC CD     MODIFIERS      UNITS   FROM    THRU     PROVIDER                   AMOUNT       DETAIL EOBS
   22         88304          TC          1.00   060606 060606      MCD 64000000             200.00         0145  0011

              TOTAL  CMS 1500 CLAIMS DENIED:         200.00                   0.00                  0.00
```

12.5 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.
CLAIM SERVICE DATE 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.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.
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).

```
REPORT:   CRA-BANN-R                    COMMONWEALTH OF KENTUCKY (M1)                    DATE:  01/23/2007
      RA#:      9999999              MEDICAID MANAGEMENT INFORMATION SYSTEM           PAGE:              1
                                          PROVIDER REMITTANCE ADVICE
                                          CMS 1500 CLAIMS IN PROCESS

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

      --ICN--              SERVICE DATES          BILLED                      TPL
  --PATIENT NUMBER--       FROM        THRU       AMOUNT                     AMOUNT

MEMBER NAME: JANE DOE                MEMBER NO.: 9999999999
  9999999999999            060606 060606          200.00                      0.00
      9999999XXX

                                              SERVICE DATES        RENDERING                BILLED
PL SERV       PROC CD     MODIFIERS     UNITS    FROM   THRU          PROVIDER                 AMOUNT       DETAIL EOBS
  22            88304        TC           1.00    060606 060606          MCD 64000000              200.00


              TOTAL  CMS 1500 CLAIMS IN PROCESS:       200.00                      0.00
```

12.6 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.
CLAIM SERVICE DATE 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.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.

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

12.7 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-PRAD-R                         COMMONWEALTH OF KENTUCKY (M1)                          DATE:  12/14/2006
   RA#:        9999999                     MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:            2
                                               PROVIDER REMITTANCE ADVICE
                                                 CMS CLAIM ADJUSTMENTS

HEALTH SERVICES                                                                               PAYEE ID        99999999
ATTN: JANE DOE                                                                                NPI ID
555 ANY STREET
CITY, KY 55555-0000

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

MEMBER NAME: JANE DOE            MEMBER NO.: 9999999999
  9999999999999            031103 031103         (20.00)                  (0.00)                 (0.00)
      99999                                                  (20.00)               (0.00)                   (20.00)
  9999999999999            031103 031103          20.00                    0.00                   0.00
      99999                                                   20.00                 0.00                     20.00

                                    SERVICE DATES RENDERING                  BILLED       ALLOWED
PL SERV  PROC CD  MODIFIERS   UNITS    FROM    THRU  PROVIDER                 AMOUNT       AMOUNT  DETAIL EOBS
  99     WP101                  1.00  031103 031103 MCD 40097065              20.00         20.00 0102 0029

         TOTAL NO. OF ADJ:        1
         TOTAL  CMS 1500 ADJUSTMENT CLAIMS:           0.00                      0.00                    0.00
                                                                  0.00                  0.00                     0.00
```

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.

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

A/R NUMBER/ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL AMOUNT	TOTAL -RECOUPED-	--BALANCE--	REASON CODE
1106	011306	0.00	22.41	0.00	22.41	92
	TOTAL BALANCE				22.41	

12.9 Financial Transaction Page

12.9.1 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.

12.9.2 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.

12.9.3 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
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
SUMMARY

DATE: 02/01/2007
PAGE: 13

PROVIDER

P O BOX 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 999999999
ISSUE DATE 02/02/2007

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

	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TD NUMBER	MONTH-TD AMOUNT	YEAR-TD NUMBER	YEAR-TD 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
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

DATE: 02/01/2007
PAGE: 14

PROVIDER

P O BOX 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 999999999
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.

12.10 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.

12.10.1 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.

13 Appendix E

13.1 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

14 Appendix F

14.1 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
02	Prov Refund – Member/Rel Paid
03	Prov Refund – Casualty Insu Paid
04	Prov Refund – Paid Wrong Vender
05	Prov Refund – Apply to Acct Recv
06	Prov Refund – Processing Error
07	Prov Refund-Billing Error
08	Prov Refund – Fraud
09	Prov Refund – Abuse
10	Prov Refund – Duplicate Payment
11	Prov Refund – Cost Settlement
12	Prov Refund – Other/Unknown
13	Acct Receivable – Fraud
14	Acct Receivable – Abuse
15	Acct Receivable – TPL
16	Acct Recv – Cost Settlement
17	Acct Receivable – DXC Technology Request
18	Recoupment – Warrant Refund
19	Act Receivable-SURS Other
20	Acct Receivable – Dup Payt
21	Recoupment – Fraud
22	Civil Money Penalty
23	Recoupment – Health Insur TPL
24	Recoupment – Casualty Insur TPL
25	Recoupment – Member Paid TPL
26	Recoupment – Processing Error
27	Recoupment – Billing Error
28	Recoupment – Cost Settlement
29	Recoupment – Duplicate Payment
30	Recoupment – Paid Wrong Vendor
31	Recoupment – SURS
32	Payout – Advance to be Recouped
33	Payout – Error on Refund
34	Payout – RTP
35	Payout – Cost Settlement
36	Payout – Other
37	Payout – Medicare Paid TPL
38	Recoupment – Medicare Paid TPL
39	Recoupment – DEDCO
40	Provider Refund – Other TLP Rsn
41	Acct Recv – Patient Assessment
42	Acct Recv – Orthodontic Fee
43	Acct Receivable – KENPAC
44	Acct Recv – Other DMS Branch
45	Acct Receivable – Other
46	Acct Receivable – CDR-HOSP-Audit
47	Act Rec – Demand Paymt Updt 1099
48	Act Rec – Demand Paymt No 1099
49	PCG
50	Recoupment – Cold Check
51	Recoupment – Program Integrity Post Payment Review Contractor A
52	Recoupment – Program Integrity Post Payment Review Contractor B
53	Claim Credit Balance
54	Recoupment – Other St Branch
55	Recoupment – Other

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	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		

15 Appendix G

15.1 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