Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions for Intermediate Care Facility for Individuals with Intellectual Disabilities or Developmental Disabilities Provider Type – 11

Version 6.4

February 3, 2020

Document Change Log

Document Version	Date	Name	Comments
1.0	10/14/2005	DXC Technology	Initial creation of DRAFT Provider type 11/12 Billing Instruction
1.2	01/19/2006	DXC Technology	Updated Provider Rep list.
1.3	02/16/2006	Carolyn Stearman	Updated with revisions requested by Commonwealth.
1.4	03/28/2006	Lize Deane	Updated with revisions requested by Commonwealth.
1.5	04/27/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.5	05/24/2006	Cathy Hill	Adjusted margins as needed.
1.6	05/30/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.7	09/18/2006	Ann Murray	Replaced Provider Representative table.
1.7	10/30/2006	Ron Chandler	Insert new UB-04 form and descriptors.
1.7	10/31/2006	Cathy Hill	Insert revisions requested by internal reviewers.
1.8	11/14/2006	Lize Deane	Revisions made according to comment log.
1.9	11/15/2006	Lize Deane	Insert UB-04 with NPI.
2.0	01/30/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
2.1	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
2.2	02/15/2007	Ann Murray	Updated Appendix D, KY Medicaid card and ICN.
2.3	02/21/2007	Ann Murray	Replaced Provider Rep table.
2.4	02/23/2007	Ann Murray	Revised according to comment log Walkthrough.
2.5	05/03/2007	Ann Murray	Updated and added claim forms and descriptors.
2.6	05/15/2007	Cathy Hill	Inserted text in UB04 Field Descriptions as specified by the TFAL v2.5 – 2.6 are actually the same as revisions

Document Version	Date	Name	Comments
			were made back-to-back and no publication would have been made
2.7	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive eligibility per Stayce Towles.
2.8	05/20/2008	Cathy Hill	Made revisions requested by Stayce Towles. v2.7 – 2.8 are actually the same as revisions were made back-to-back and no publication would have been made
2.9	06/12/2088	Ann Murray	Updated section 4.6 Prior Authorization Information.
3.0	07/23/2008	Ann Murray	Updated with changes for Medicare.
3.1	03/09/2009	Cathy Hill	Made changes from KYHealth Choices to KY Medicaid per Stayce Towles
3.2	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept for Medicaid Services per Stayce Towles
3.3	03/30/2009	Ann Murray	Made global revisions per DMS request. v3.1 – 3.3 are actually the same as revisions were made back-to-back and no publication would have been made
3.4	09/08/2009	Ann Murray	Replaced Provider Rep list.
3.5	10/21/2009	Ron Chandler	Replaced all instances of “EDS” with “DXC Technology”.
3.6	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @DXC Technology.com. Removed HIPAA section. v3.5 – 3.6 are actually the same as revisions were made back-to-back and no publication would have been made
3.7	03/08/2010	Ron Chandler	Inserted new provider rep list.
3.8	06/23/2010	Ann Murray	Updated Detailed Billing instructions and Appendix A
3.9	6/28/2010	Ron Chandler	Revised pages 35 and 43, field 4. v3.8 – 3.9 are actually the same as revisions were made back-to-back and no publication would have been made
4.0	11/18/2010	Patti George	Revised per Patti George paper document with

Document Version	Date	Name	Comments
		Ron Chandler	markup.
4.1	01/18/2011	Ann Murray	Updated global sections. v4.0 – 4.1 are actually the same as revisions were made back-to-back and no publication would have been made
4.2	05/04/2011	Patti George	Replace occurrences of SDXC TECHNOLOGYS with Carewise Health, Inc.
4.3	11/29/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
4.4	02/08/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman
4.5	02/22/2012	Brenda Orberson Ann Murray	Global updates made to remove all references to KenPAC and Lockin. DMS Approved 03/09/2012, John Hoffman
4.6	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
4.7	06/04/2012	Stayce Towles Ann Murray	Updated sections 7.3.1 and 7.5.1 and added section 7.6 Duplicate or Inappropriate Payments based upon DXC TECHNOLOGY recommendation with DMS approval from Alisha Clark. DMS Approved 06/04/2012, Betty Murphy
4.8	08/30/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012
4.9	01/16/2013	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 2/27/2013, John Hoffman
5.0	06/26/2013	Vicky Hicks Patti George	Updates to NET PAYMENT and NET EARNINGS descriptions in Section 12.10.1 DMS Approved 07/09/2013, John Hoffman
5.1	07/29/2013	Stayce Towles Patti George	Update to section 5.10- Provider Rep listing.
5.2	03/19/2014	Stayce Towles	Updated sections 1-5 per DMS. Approved 4-7-14 by Lee Guice.

Document Version	Date	Name	Comments
5.3	02/04/2015	Stayce Towles	Name change from Intermediate Care Facilities with Mental Retardation (ICF/MR) to Intermediate Care Facilities for Individuals with Intellectual Disabilities or Developmental Disabilities (ICF/IID/DD). Approved on 2/4/15, Charles Douglass, DMS.
5.4	04/10/2015	Stayce Towles	Updating procedure codes in appendix. Also, add field 66 to the detailed billing instructions for ICD indicator. Approved by John Hoffmann, OATS, 7/6/15. Approval received on August 19, 2015 by Charles Douglass.
5.5	04/27/2016	Vicky Hicks	Updating Type of Bills due to CO26510. Approval received on April 29, 2016 by Charles Douglass.
5.6	05/03/2016	Vicky Hicks	Additional Type of Bills added. Approval received on May 6, 2016 by Charles Douglass, DMS
5.7	07/21/2016	Vicky Hicks	Moved Type of Bill 812-814 and 821-824 to Appendix as archived information to align with the NUBC guidelines. Approved by Charles Douglass, DMS on 7/26/2016
5.8	10/10/2016	Vicky Hicks	Added “If applicable” to form locator 13, Section 7.3.1 to align with the NUBC guidelines. Approved by Charles Douglass, DMS, on 10/10/2016
5.9	02/01/2017	Vicky Hicks	Added “Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at www.kymmis.com under Companion Guides and EDI Guides.” Approved by Charles Douglass, DMS 2/1/2017 Added form locators 78 and 80 regarding Referring and Attending provider information. Approved by Charles Douglass, DMS 2/8/2017
6.0	04/03/2017	Vicky Hicks	Updated PT and OT CPT codes per CO27503

Document Version	Date	Name	Comments
6.1	12/01/2018	Vicky Hicks	Updated all instances of “HP” with DXC Technology. Updated Rep list and Provider Inquiry form
6.2	05/14/2019	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
6.3	01/17/2020	Vicky Hicks	Split Billing Instructions listed as Provider Types 11/12 into Billing Instructions for each provider type. Change approved by Charles Douglass, DMS. Updated due to CO31005 adding covered revenue codes in section 9.1.2. Updated due to CO29674 adding covered revenue codes 429 and 439 in section 9.1.5. Updated due to CO28158 adding revenue codes 470, 510, 511, 512, 730, 942, 960 in section 9.1.9 – 9.1.13.
6.4	02/03/2020	Vicky Hicks	Added revenue codes 260 and 460 per CO29671. Added statement regarding billing calendar month pure to section 7. Removed Procedure Codes from the BI.

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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

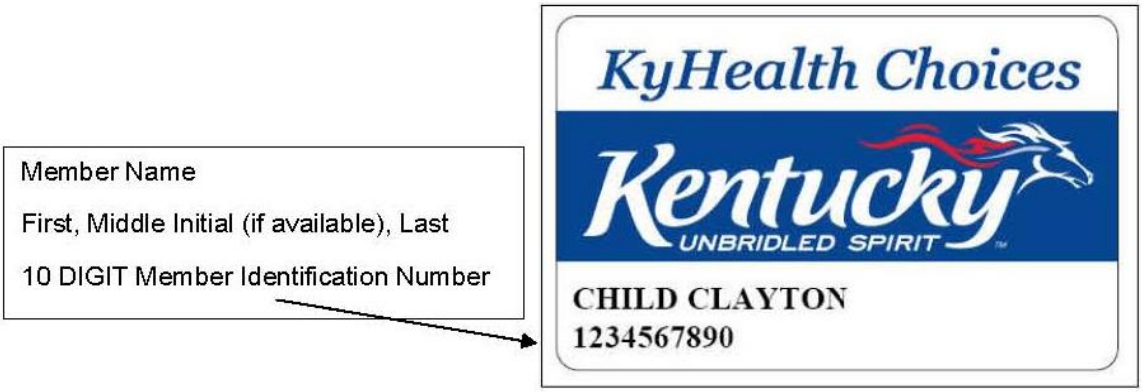
1.2 Member Eligibility

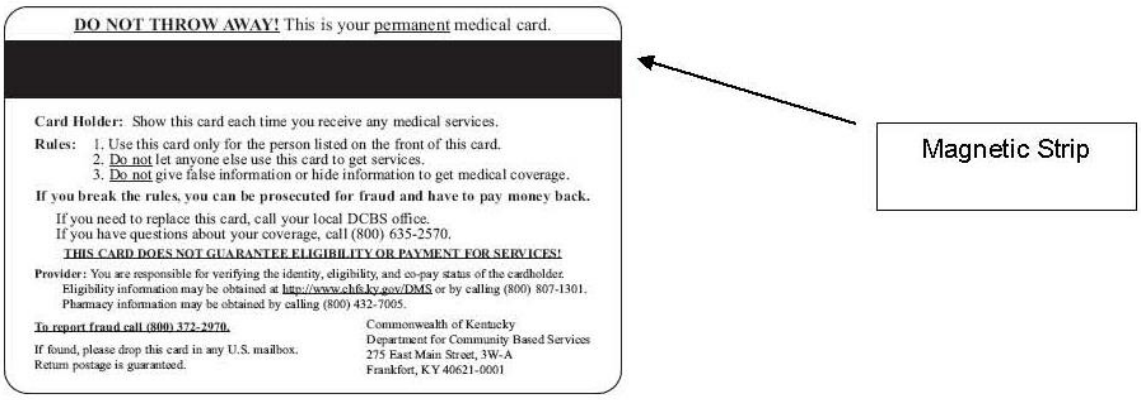
Members should apply for Medicaid eligibility through kynect (kyenroll.ky.gov), by phone at 1-855-4kynect (1-855-459-6328), or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through 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 utilize 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 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 Voice Response Eligibility Verification (VREV) system that provides member eligibility verification, as well as third party liability (TPL) information, Managed Care, PRO review, Card Issuance, Co-pay, provider check write, and claim status information.

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, check amount, claim status, and so on).
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 number) as soon as each prompt begins. The number of inquiries is limited to five per call. The VREV spells the member name and announces the dates of service. Check amount data is accessed through the VREV voice menu. The Provider's last three check amounts are available.

1.2.3.1.2 KY HealthNet Online Member Verification

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

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

2 Electronic Data Interchange (EDI)

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

2.1 How to Get Started

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

DXC Technology
P.O. Box 2100
Frankfort, KY 40602-2016

1-800-205-4696

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

2.2 Format and Testing

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

2.3 ECS Help

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

3 KY HealthNet

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

3.1 How to Get Started

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

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

3.2 KY HealthNet Companion Guides

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

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

4 General Billing Instructions for Paper Claim Forms

4.1 General Instructions

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

4.2 Imaging

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

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

- USE BLACK INK ONLY;
- Do not use glue;
- Do not use more than one staple per claim;
- Press hard to guarantee strong print density if claim is not typed or computer generated;
- Do not use white-out or shiny correction tape; and,
- Do not send attachments smaller than the accompanying claim form.

4.3 Optical Character Recognition

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

5 Additional Information and Forms

5.1 Claims with Dates of Service More than One Year Old

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

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

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

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

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

- A screen print from KY HealthNet verifying eligibility issuance date and eligibility dates must be attached behind the claim;
- A screen print from KY HealthNet verifying filing within 12 months from date of service, such as the appropriate section of the Remittance Advice or from the Claims Inquiry Summary Page (accessed via the Main Menu's Claims Inquiry selection);
- A copy of the Medicare Explanation of Medicare Benefits received 12 months after service date but less than six months after the Medicare adjudication date; and,
- A copy of the commercial insurance carrier's Explanation of Benefits received 12 months after service date but less than six months after the commercial insurance carrier's adjudication date.

5.2 Retroactive Eligibility (Back-Dated) Card

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

5.3 Unacceptable Documentation

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

5.4 Third Party Coverage Information

5.4.1 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 KY HealthNet 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.**

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

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

_____

_____

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

_____

_____

_____

13. Signature _____ 14. Date _____

DMS Approved: January 10, 2011

5.8 Cash Refund Documentation Form

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

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

Please keep the following points in mind when refunding:

- Attach the Cash Refund Documentation Form to a check made payable to the KY State Treasurer.
- Attach applicable documentation, such as a copy of the remittance advice showing the claim for which a refund is being issued.
- If refunding all claims on an RA, the check amount must match the total payment amount on the RA. If refunding multiple RAs, a separate check must be issued for each RA.

DXC Technology

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

CASH REFUND DOCUMENTATION

1 Check Number	**2. Check Amount**	
3. Provider Name/ID/Address	**4. Member Name**	
	5. Member Number	
6. From Date of Service	**7. To Date of Service**	**8. RA Date**

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

Research for Refund: (Check appropriate blank)

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

_____ **b.** **Billed in error**

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

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

_____ **e.** **Paid to wrong provider**

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

_____ **g.** **Other** _____

Contact Name _____ **Phone** _____

DMS Approved: January 10, 2011

5.9 Return to Provider Letter

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

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

- Provider ID;
- Member Identification number;
- Member first and last names; and,
- EOMB for Medicare/Medicaid crossover claims.

Other reasons for return may include:

- Illegible claim date of service or other pertinent data;
- Claim lines completed exceed the limit; and,
- Unable to image.

DXC

RETURN TO PROVIDER LETTER

Date: _____ - _____ - _____

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

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

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

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

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

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

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

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

08) Other Reason

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

Helpful Hints When Billing for Services Provided to a Medicaid Member

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

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

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

Initials of Clerk _____

Provider Name _____

Provider Number _____

Reason Code _____

5.10 Provider Representative List

5.10.1 Phone Numbers and Assigned Counties

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

- **NOTE – Out-of-state providers contact the Representative who has the county closest bordering their state, unless noted above.**
- **Provider Relations contact number: 1-800-807-1232**

6 Form Requirements

Additional forms may be required for reimbursement of Intermediate Care Facility for Individuals with Intellectual Disabilities or Developmental Disabilities.

. Some of the forms are, but may not be limited to, the following:

- MAP-24
  Memorandum to the Department for Community Based Services

- MAP-552
  Notice of Available Income for Long Term Care

Note: MAP-552s are issued through the Member's local Department for Community Based Services (DCBS) office. This form is not completed by the provider, but the member must have a current form on file.

- MAP-573
  Request Form for Drugs Prior-Authorized for Nursing Facility Members

- MAP-350
  Long Term Care Facilities and Home and Community Based Program Certification Form

Forms can be obtained by accessing the following website:

http://www.kymmis.com , select Provider Relations and then Forms

6.1 MAP-552 – Notice of Available Income for Long Term Care

MAP-552p
(03/98)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR SOCIAL INSURANCE

NOTICE OF AVAILABILITY OF INCOME FOR LONG TERM CARE/WAIVER AGENCY/HOSPICE

MEMBER IDENTIFICATION NUMBER:_____ ( ) CORRECTION
( ) INITIAL
PROGRAM: _____ ( ) CHANGE

CLIENT'S NAME:_____ DATE OF BIRTH:_____

PROVIDER NUMBER:_____

ADMISSION DATE:_____ DISCHARGE DATE:_____ DEATH DATE:_____

LEVEL OF CARE_____ LTC INELIGIBLE DATE:_____

FAMILY STATUS:_____ SPOUSE STATUS:_____

INCOME COMPUTATION:

UNEARNED INCOME SOURCE	AMOUNT	
RSDI	$_____	
SSI	$_____	
RR	$_____	
VA	$_____	
STATE SUPPLEMENTATION	$_____	
OTHER	$_____	
SUB-TOTAL UNEARNED INC.	$_____	
		CASE STATUS
EARNED INCOME	AMOUNT	ACTIVE CASE:_____
WAGES	$_____	IF ACTIVE, EFF. MA DATE:_____
EARNED INC. DEDUCTION	$_____	IF DISC. EFF. MA DATE:_____
SUB-TOTAL EARNED INC.	$_____	
TOTAL INCOME	$_____	NOTIF. FORM:_____
		NOTIF. FORM DATE:_____
DEDUCTIONS	AMOUNT	
PERSONAL NEEDS ALLOWANCE	$_____	EFF. DATE OF CORR:_____
INCREASED PNA	$_____	ENDING DATE OF CORR:_____
SPOUSE/FAMILY MAINT.	$_____	
SMI	$_____	PRIVATE PAY PATIENT
HEALTH INS	$_____	FROM:_____ THRU_____
INCURRED MEDICAL EXPENSES	$_____	
TOTAL DEDUCTIONS	$_____	
VA AID AND ATTENDANCE	$_____	
THIRD PARTY PAYMENTS	$_____	
AVAILABLE INCOME	$_____	
AVAILABLE INCOME (ROUNDED)	$_____	
AVAILABLE MONTHLY INCOME	$_____	EFFECTIVE DATE:_____

WORKER CODE:_____ CASELOAD CODE:_____ UPDATE DATE:_____

6.2 MAP-350 NF (3/2009)

6.2.1 Long Term Care Facilities and Home and Community Based Program Certification Form

MAP-350 NF (3/2009) Department for Medicaid for Services

DIVISION OF HEALTHCARE FACILITIES MANAGEMENT

MAP – 350 NF INSTRUCTIONS

Purpose of MAP – 350 NF

Center for Medicare and Medicaid Services (CMS) requires that all individuals seeking admission to a nursing facility, ICF/MR/DD facility or a Home and Community Based (HCB) waiver program be given the choice of receiving services in an institution or through Home and Community Based Services.

The MAP – 350 NF is to document that each Medicaid recipient has been given the choice of receiving care in an institution or in a Home and Community Based (HCB) waiver program.

The MAP – 350 NF is required to be completed for each Medicaid recipient prior to admission to a nursing facility or an ICF/MR/DD facility, and annually thereafter.

The original copies of the MAP – 350 NF shall be maintained in the medical record. A copy is to be provided to the recipient/legal representative.

Instructions for Completing the MAP – 350 NF Certification Form

---

I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER.

PLEASE NOTE: COMPLETE (A-D) ONLY THE ONE/ONES THAT ARE APPROPRIATE FOR THE RECIPIENT.

A. The HCBS waiver program is for the aged and disabled individual that requires nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for the HCBS program as an alternative to NF placement ***is requested*** _____***;***
is not requested _____***. Sign and date the section.***

B. The Supports for Community Living (SCL) waiver program is for individuals with mental retardation/developmental disabilities that require intermediate care facility for the mentally retarded or developmentally disability (ICF/MR/DD) level of care.

The recipient/legal representative must check their choice. Consideration for the waiver program as an alternative to ICF/MR/DD ***is requested*** _____***;***
is not requested _____***. Sign and date the section, if applicable.***

C. The Model Waiver II program is for individuals that are ventilator dependent and require nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for Model Waiver II program as an alternative to NF placement ***is requested*** _____***;***
is not requested _____***. Sign and date the section, if applicable.***

1

D. The Acquired Brain Injury waiver program is for individuals aged twenty-one (21) to sixty-five (65) that have sustained a traumatic brain injury and require nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for the ABI Waiver Program as an alternative to NF or NF/ABI placement ***is requested _____; is not requested _____. Sign and date the section, if applicable.***

II. FREEDOM OF CHOICE OF PROVIDER

The recipient/legal representative that elected to receive Home and Community Based waiver services shall be informed that services may be requested from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from the Department for Medicaid Services.
Sign and date the section, if applicable.

III. RESOURCE ASSESSMENT CERTIFICATION

The recipient/legal representative must ***sign and date the section*** to certify that they have been informed of the availability of resource assessments to assist with financial planning provided by the Department for Community Based Services (DCBS).

IV. RECIPIENT INFORMATION

- Enter the Medicaid recipient's name as it appears on the current medical assistance identification (MAID) card:
- Enter the full address where recipient lives:
- Enter the phone number of the recipient:
- Enter the ten digit Medicaid number found on the recipient's MAID card:
- Enter the name (if applicable) of the responsible party/legal representative appointed to make decisions for the recipient. This person would have completed/signed the appropriate sections of this form:
- Enter the full address where the responsible party/legal representative (if applicable) lives:
- Enter the phone number for the responsible party/legal representative (if applicable):
- Enter the signature and title of person assisting with completion of the form:
- Enter the name of the agency/facility that the individual assisting with the completions of the form is employed:
- Enter the full address of the agency/facility:

DIVISION OF HEALTHCARE FACILITIES MANAGEMENT

I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, ACQUIRED BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement ***is requested _____; is not requested _____.***

_____ _____/_____/_____
Signature ***Date***

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD ***is requested _____; is not requested _____.***

_____ _____/_____/_____
Signature ***Date***

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement ***is requested _____; is not requested _____.***

_____ _____/_____/_____
Signature ***Date***

D. ACQUIRED BRAIN INJURY (ABI) WAIVER - This is to certify that I/legal representative have been informed of the ABI Waiver Program. Consideration for the ABI Waiver Program as an alternative to NF or NF/ABI placement ***is requested _____;***
Is not requested _____.

_____ _____/_____/_____
Signature ***Date***

II. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____/_____/_____
Signature ***Date***

1

III. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____/_____/_____

Signature ***Date***

IV. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

_____

Phone: (_____)_____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: (_____)_____

Signature and Title of Person Assisting with Completion of Form:

_____

Signature ***Title***

Agency/Facility:

_____

Address:

_____

_____

6.3 MAP-24

MAP-24 is required to be sent to the local DCBS office and the Community Based Services Branch of KY Medicaid when a client is terminated.

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

_____
(Date)

MEMORANDUM

TO: Local Office
Department for Community Based Services
Cabinet for Health and Family Services

FROM: _____ Provider #: _____
(Facility/Waiver Agency)

SUBJECT: _____
(Member Name) (Social Security/Medicaid Number)

_____
(Previous Address)

_____
(Responsible Relative's Name & Address)

This is to notify you that the above-referenced member

☐ was admitted to this facility/waiver agency _____
(Date)
is in Title _____ Payment Status, and was placed in a
(XVIII or XIX)

☐ NF bed ☐ ICF/MR/DD bed ☐ MH bed ☐ EPSDT Bed

☐ Home & Community Based Waiver Service ☐ SCL Waiver Service and/or

☐ was discharged from this facility/waiver agency on _____
(Date)
and went to _____,
(Home Address/Name & Address of New Facility/Waiver Agency)
and/or expired on _____.
(Date)

☐ was re-instated to Home & Community Based or SCL waiver services within 60 days of the
NF admission. _____
(Date Re-Instated)

For Home & Community Based waiver Clients only – last date service was provided _____.
(Date)

_____
(Signature)

MAP-24 (Rev. 02/2001)

6.4 MAP-573 – Prior Authorization for Nursing Facility Members

MAP-573 (REV. 12/03)

KENTUCKY MEDICAID PROGRAM REQUEST FORM
FOR DRUGS PRIOR-AUTHORIZED FOR NURSING FACILITY MEMBERS

MEMBER IDENTIFICATION Number	Member Name
Facility Name	Facility Address
Facility Provider Number	

Admission Date_____ Effective Date _____

This certifies that the above member is (is expected to be) in Kentucky Medicaid vendor payment status in a Medicaid certified nursing facility. Prior authorization is requested for the additional drugs that can be prior authorized as a group.

Authorized Representative of Facility _____

This certifies my request that the above named member be authorized to receive drugs prior authorized for nursing facility members.

Name of Physician _____ License Number _____

Signature of Physician _____ Date _____

The facility completes the form and obtains the signature of the physician, retains one (1) copy in the member's records and provides the pharmacy with the remaining two (2) copies. The pharmacy sends the original copy to EDS. After processing, EDS will notify the Pharmacy by letter.

Pharmacy Provider Number	Pharmacy Name
Pharmacy Address	
City/State/Zip	

THIS FORM MUST BE COMPLETED FOR EACH ADMISSION

CAUTION: THE ABOVE MEMBER MUST BE KENTUCKY MEDICAID ELIGIBLE ON THE DATE OF SERVICE VERIFY BY CHECKING THE MEMBER'S MEDICAID CARD. THIS PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT.

Mailroom use	MAP-552 Continuing Income Information not on file Date: _____

6.5 Completion of Prior Authorization for Nursing Facility Members (MAP-573)

Field	Description
Member Identification Number	Enter the KY Medicaid number.
Member Name	Enter the member's name.
Facility Name	Enter the facility name.
Facility Address	Enter the facility address.
Facility Provider Number	Enter the facility provider number.
Admission Date	Enter the member's admission date.
Effective Date	Enter the date the prior authorization starts.
Authorized Representative of Facility	The signature of the facility's authorized representative is required.
Name of Physician	Enter the Physician's name.
License Number	Enter the Physician's license number.
Signature of Physician	The Physician's signature is required.
Date	Enter the date of Physician's signature.
Nursing Facility Services Provider Number	Enter the dispensing Nursing Facility Service's KY Medicaid provider number.
Nursing Facility Services Name	Enter the dispensing Nursing Facility Services name.
Nursing Facility Services Address	Enter the dispensing Nursing Facility Services street address.
City/State/Zip	Enter the dispensing Nursing Facility Services city/state/zip code.
Mailroom use	Please leave the following field for DXC Technology and DMS utilization.
MAP-552 Continuing Income Information not on file	Checked if there is no long term eligibility segment on file for that member.
Date	Date reviewed by medical policy staff.

7 Completion of UB-04 Claim Form with NPI

7.1 UB-04 with NPI Billing Instructions

Following are form locator numbers and form locator instructions for billing nursing facility services on the UB-04 billing form. Only the instructions for form locators required for DXC Technology processing or for Medicaid Program information are included. Instructions for Form Locators not used by DXC Technology or the Medicaid Program can be found in the UB-04 Training Manual. The UB-04 Training Manual may be obtained from the address listed below. You may also obtain the UB-04 billing forms from the address listed below.

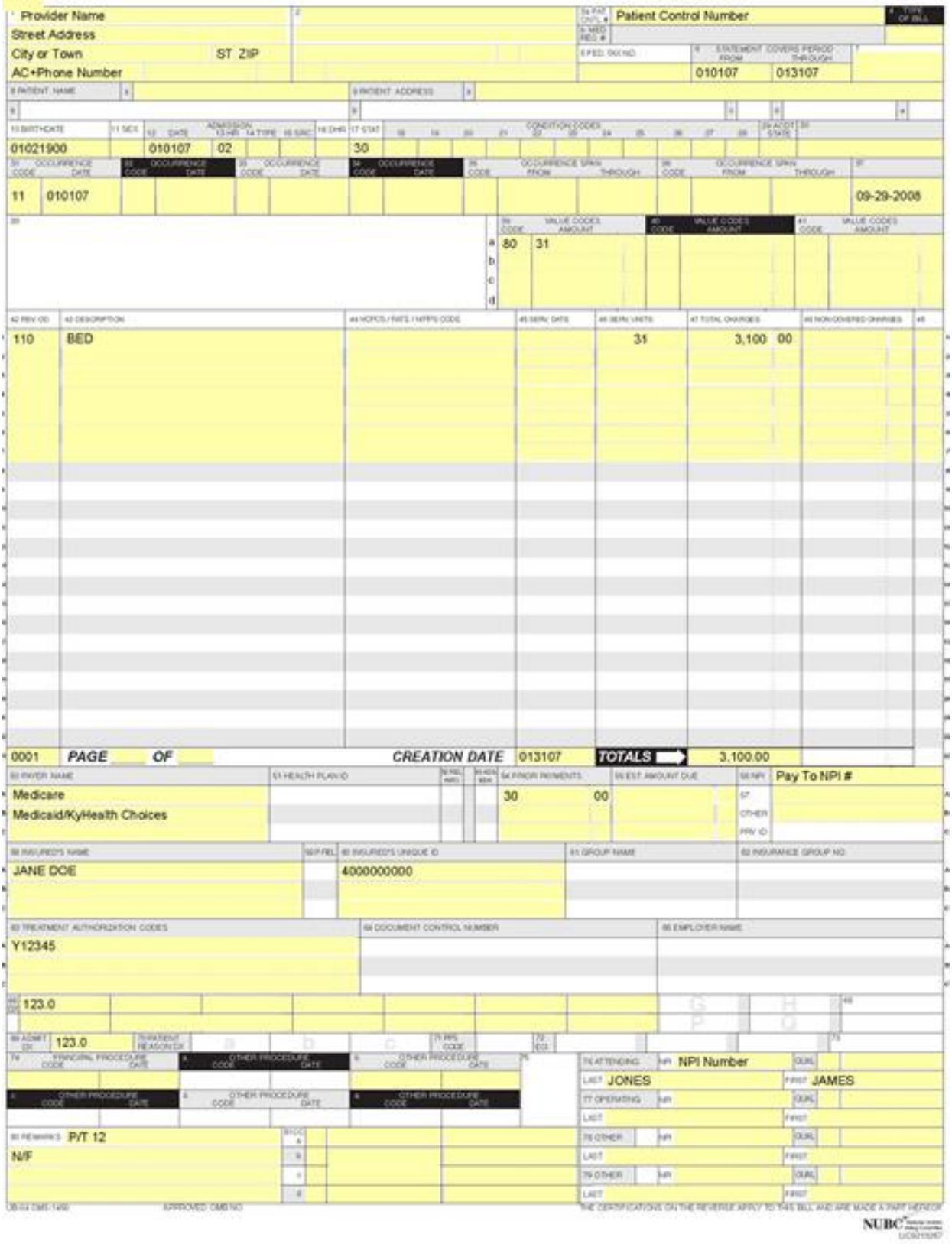
Kentucky Hospital Association
P.O. Box 24163
Louisville, KY 40224
Telephone: 1-502-426-6220

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

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

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

7.2 UB-04 Claim Form with NPI and Taxonomy



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

7.3.1 Detailed Instructions

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

FORM LOCATOR NUMBER	FORM LOCATOR NAME AND DESCRIPTION	
1	**Provider Name, Address and Telephone**	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	**Patient Control Number**	
	Enter the patient control number. The first 14 digits (alpha/numeric) appear on the remittance advice as the invoice number.	
4	**Type of Bill**	
	Enter the appropriate code to indicate the type of bill.	
	Examples of Valid Types of Bill for ICF/IID/DD facilities	
	0651	Admit through Discharge/Death
	0652	Interim bill, First claim
	0653	Interim bill, Continuing claim
	0654	Interim bill, Final claim
	Note: See past Type of Bill list in Appendix H.	
6	**Statement Covers Period**	
	FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY). **NOTE: Claims must be billed calendar month pure except in the case of Bed Hold during the month.**	
10	**Date of Birth**	
	Enter the member's date of birth.	
12	**Admission Date**	
	Enter the date on which the Member was admitted to the facility in numeric format (MMDDYY).	
13	**Admission Hour**	

	Enter the code for the time of admission to the facility, if applicable.			
	Code Structure			
	CODE	**TIME A.M.**	**CODE**	**TIME P.M.**
	00	12:00 – 12:59 midnight	12	12:00 – 12:59 noon
	01	01:00 - 01:59	13	01:00 - 01:59
	02	02:00 - 02:59	14	02:00 - 02:59
	03	03:00 - 03:59	15	03:00 - 03:59
	04	04:00 - 04:59	16	04:00 - 04:59
	05	05:00 - 05:59	17	05:00 - 05:59
	06	06:00 - 06:59	18	06:00 - 06:59
	07	07:00 - 07:59	19	07:00 - 07:59
	08	08:00 - 08:59	20	08:00 - 08:59
	09	09:00 - 09:59	21	09:00 - 09:59
	10	10:00 - 10:59	22	10:00 - 10:59
	11	11:00 - 11:59	23	11:00 - 11:59

17	**Patient Status Code**	
	Enter the appropriate two-digit patient status code indicating the disposition of the member as of the THROUGH date in Form Locator 6.	
	Status Codes Accepted by KY Medicaid	
	01	Discharged to Home or Self Care (Routine Discharge)
	02	Discharged or Transferred to Acute Hospital
	03	Discharged or Transferred to Skilled Nursing Facility (SNF) or NF
	04	Discharged or Transferred to Intermediate Care Facility (ICF)
	05	Discharged or Transferred to Another Type of Institution
	06	Discharged or Transferred to Home Under Care of Organized Home Health Service Organization
	07	Left Against Medical Advice
	10	Discharged or Transferred to Mental Health Center or

		Mental Hospital
	20	Expired
	30	Still a Member
	Note: **Example 1** **When billing discharged or expired patient status codes, the last day of the statement covers period is not a covered day. The calculation of covered days is as follows:** **PS Thru minus From equals Total Days** **02 08/29/2006 - 08/01/2006 = 28** **Example 2** **Billing patient status code 30, still a patient, the last day of the statement covers period is a covered day. The calculation of covered days is as follows:** **PS Thru Minus From Plus Equals Total Days** **30 08/29/2006 - 08/01/0303 + 1 = 29**	
37	**Medicare EOMB Date**	
	Enter the EOMB date from Medicare, if applicable.	
39-41	**Value Codes**	
	80 = Covered Days Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46. 82 = Coinsurance Days Enter the number of coinsurance days billed to the KY Medicaid during this billing period. 83 = Life Time Reserve Days Enter the Lifetime Reserve days the patient has elected to use for this billing period. A1 = Deductible Payer A Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. A2 = Coinsurance Payer A Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due. B1 = Deductible Payer B Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due.	

	B2 = Coinsurance Payer B Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due.
42	**Revenue Codes**
	Enter the three-digit revenue code identifying specific accommodation and ancillary services. A list of revenue codes covered by KY Medicaid is located in Appendix A of this manual.
	Description — **Revenue Code** Accommodation — 110,120,130,140,150,160 Audiology — 470 Bed Reserve - Home/Other* — 180 Bed Reserve - Hospital* — 185 Clinic — 510-512 EKG/ECG — 730 Laboratory — 300 – 307, 309-314, 319 IV Therapy — 260 X-Ray — 320 Oxygen — 410 Physical Therapy — 420-424, 429 Professional Fees — 960 Pulmonary Function — 460 Occupational Therapy — 430-433, 439 Other Therapeutic Services — 942 Speech Therapy — 440-444 Psychiatric/Psychological Service — 910-918 *Bed Reserve days must be billed on separate UB-04 claim forms from in-facility days. **NOTE:** **Total charge Revenue code 0001 must be the final entry in column 42, line 23.** **Total charge amount must be shown in column 47, line 23.**

43	**Description**
	Enter the standard abbreviation assigned to each revenue code.
44	**HCPCS / RATES**
	Enter the appropriate procedure code for the services performed. (PT 11 is not required to use these codes for billing purposes)
45	**Detail Date of Service (Ancillary Services only)**
	Enter the date of service (MMDDYY format) that the ancillary service is rendered. *Required with revenue codes which begin with 4.
45	**Creation Date**
	Enter the invoice date or invoice creation date.
46	**Unit**
	Enter the quantitative measure of services provided per revenue code.
47	**Total Charges**
	Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry “total charges. Claim total must be shown in field 47, line 23.
48	**Non-Covered Charges**
	Enter the charges from Form Locator 47 that is non-payable by KY Medicaid.
50	**Payer Identification**
	Enter the names of payer organizations from which the provider receives payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.* * KY Medicaid is payer of last resort. **Note: If you are billing for a replacement policy to Medicare, Medicare needs to be indicated instead of the name of replacement policy.**
54	**Medicare Paid Amount**
	Enter the paid amount from Medicare, if applicable. Enter the amount paid, if any, be a private insurance.

56	**NPI**
	Enter the PAY TO NPI number.
57	**Taxonomy**
	Enter the PAY TO Taxonomy number.
57B	**Other**
	Enter the facilities zip code.
58	**Insured's Name**
	Enter the Member's name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the Member's name exactly as it appears on the Member Identification card in last name and first name format.
60	**Identification Number**
	Enter the Member Identification number in Form Locators 60 A, B, and C that relates to the Member's name in Form Locators 58 A, B, and C. Enter the 10 digit Member Identification number exactly as it appears on the Member Identification card.
63	**Treatment Authorization Number**
	Enter the 10 digit prior authorization number assigned by Carewise Health, Inc. designating that the treatment covered by the bill is authorized.
66	**Diagnosis Indicator**
	Enter the appropriate ICD indicator. 9= ICD 9 0= ICD-10
67	**Principal Diagnosis Code**
	Enter the ICD-10 code describing the principal diagnosis.
67A-Q	**Other Diagnosis Code**
	Enter additional diagnosis codes that co-exist at the time the service is provided.
69	**Admitting Diagnosis**
	Enter the diagnosis code describing the admitting diagnosis.
76	**NPI**

	Enter the Attending Physician NPI number.
78	**Other (NPI)**
	Enter DN (to denote referring) and the Referring Physician NPI number, if applicable.
80	**Remarks**
	Enter the Attending Physician taxonomy, if applicable. (paper claim submission only.)

7.4 Duplicate or Inappropriate Payments

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

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

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

8 Medicare Deductibles and Coinsurance

Billing for Medicare Part A coinsurance days, Medicare Part B deductible or coinsurance and Title XIX services must be on separate billing forms. If the member was covered by Medicare Part A, Medicare Part B, and KY Medicaid, three UB-04 billing forms must be submitted for payment for the three types of benefits.

KY Medicaid PRO certification is not required on Medicare deductible and coinsurance claims. If all Medicare benefits are exhausted and Title XIX days are being billed, KY Medicaid PRO certification for those KY Medicaid days is necessary.

For nursing facility services, KY Medicaid pays Medicare coinsurance and deductibles up to the KY Medicaid maximum amount. At that point, KY Medicaid considers the provider as "paid in full". If the provider notes that Medicare has reimbursed more on a claim than the KY Medicaid maximum, it is not necessary to bill the KY Medicaid program. As always, the provider must not bill the KY Medicaid member for any differences between charges and payments.

8.1 Electronic Crossover of Medicare Claims

The following Medicare tape transferred claims WILL NOT BE PROCESSED by KY Medicaid:

- Claims for which there is no deductible or coinsurance amount due;
- * Medicare adjusted claims; and,
- ** Claims that indicate a third party payer source.

*If KY Medicaid has made payment for a deductible or coinsurance amount that has been Medicare adjusted, you should file an adjustment with KY Medicaid in the usual manner. If the Medicare adjustment indicates that a deductible or coinsurance amount is not due, a refund must be made to KY Medicaid in the usual manner. If KY Medicaid has not made payment on the claim that Medicare adjusts, you should submit a UB-04 billing form to KY Medicaid for the corrected amount.

**Claims that have third party payer involvement should be submitted to KY Medicaid on the UB-04 billing form in the usual manner.

The same edits and audits apply to Medicare tape transferred claims that are applied to paper claims. Listed below are some of the claims that **WILL AUTOMATICALLY BE DENIED** by KY Medicaid and must be appropriately resubmitted on a paper UB-04 billing form:

- Claims for dates of service prior to the effective date of your current KY Medicaid provider ID (these claims will deny under your current provider ID);
- Claims on which the "Statement Covers Period" is more than one calendar month (a KY Medicaid claim must be calendar month pure); and,
- Medicare Part A claims on which the "Statement Covers Period" is for dates of service inclusive of Medicare full-costs days and Medicare coinsurance days (the "Statement Covers Period" on a KY Medicaid claim, in relation to the type of bill, must equal Form Locator 7).

If a Medicare tape-transferred claim has not appeared on your KY Medicaid Remittance Advice within 30 days of the Medicare adjudication date, you should submit a claim to Kentucky Medicaid.

9 Appendix A

9.1 Revenue Codes Descriptions

9.1.1 Accommodations

110	Room & Board, private
120	Room & Board, semi private - two beds
130	Room & Board, semi private - three or four beds
140	Room & Board, private - deluxe
150	Room & Board, ward
160	Room & Board, Infectious Diseases
180	Bed Reserve Days, home or other
185	Bed Reserve Days, hospital

9.1.2 IV Therapy

260	IV Therapy (effective 7/1/18)

9.1.3 Laboratory

300	Laboratory, general
301	Chemistry
302	Immunology
303	Renal (effective 4/1/19)
304	Non-Routine Dialysis (effective 4/1/19)
305	Hematology (effective 4/1/19)
306	Bacteriology & Microbiology (effective 4/1/19)
307	Urology (effective 4/1/19)
309	Other Laboratory (effective 4/1/19)
310	Laboratory-Pathological, general
311	Cytology

312	Histology
314	Biopsy
319	Other Laboratory Pathology (effective 4/1/19)

9.1.4 X-Ray

320	X-Ray

9.1.5 Oxygen

410	Oxygen

9.1.6 Pulmonary Function

460	Pulmonary Function (effective 1/1/2019)

9.1.7 Physical Therapy

420	Physical Therapy
421	Physical Therapy
422	Physical Therapy
423	Physical Therapy
424	Physical Therapy
429	Physical Therapy (effective 1/1/2019)

9.1.8 Occupational Therapy

430	Occupational Therapy
431	Occupational Therapy
432	Occupational Therapy
433	Occupational Therapy
439	Occupational Therapy (effective 1/1/2019)

9.1.9 Speech Therapy

440	Speech Therapy

441	Speech Therapy
442	Speech Therapy
443	Speech Therapy
444	Speech Therapy

9.1.10 Psychiatric/Psychological Services

910	Psychiatric/Psychological Services, general
914	Psychiatric/Psychological Services, individual therapy
915	Psychiatric/Psychological Services, group therapy
918	Psychiatric/Psychological Services, testing

9.1.11 Audiology

470	Audiology, general (effective 7/1/2017)

9.1.12 Clinic

510	Clinic, general (effective 7/1/2017)
511	Clinic/Chronic Pain (effective 7/1/2017)
512	Dental Clinic (effective 7/1/2017)

9.1.13 EKG/ECG

730	EKG ECG Electrocardiogram, general (effective 7/1/2017)

9.1.14 Other Therapeutic Services

942	Other Therapeutic Services (effective 7/1/2017)

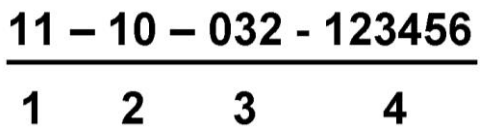
9.1.15 Professional Fees

960	Pro Fee, general (effective 7/1/2017)

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:



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 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.

11.1.1 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.

11.2 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.

11.3 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
RA#: 9999999

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

DATE: 01/23/2007
PAGE: 1

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

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

Commonwealth of Kentucky

REPORT: CRA-IPPD-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB CLAIMS PAID

DATE: 01/30/2007
PAGE: 2

PROVIDER
5555 ANY STREET
CITY, KY 55555-5555

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

--ICN-- / PAT.ACCT NUM.	ATTENDING PROV.	SERVICE DATES FROM	THRU	DAYS	ADMIT DATE	BILLED AMT	ALLOWED AMT	SPENDDOWN / COPAY AMT	TPL AMT	PAID AMT
MEMBER NAME: JANE DOE		MEMBER NO.: MBRID99999								
ICN9999999999	NPI9999999	030806	031006	2	030806	6,307.35	0.00	0.00	0.00	3,488.25
PATACCT 99999999999								0.00		

HEADER EOBS: 9932 00A2

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

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

HEADER EOBS: 9932 0018

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
120		030806	DEF	2.00	1,700.00	0.00	9932 0018 0275 0015
250		030806	DEF	48.00	653.90	0.00	9932 0015 0883 00
258		030806	DEF	7.00	275.30	0.00	9932 0018
270		030806	DEF	67.00	386.15	0.00	9932 0018
300		030806	DEF	12.00	292.00	0.00	9932 0018
310		030806	DEF	3.00	177.00	0.00	9932 0018
360		030806	DEF	1.00	2,148.00	0.00	9932 0018
370		030806	DEF	1.00	299.00	0.00	9932 0018
710		030806	DEF	1.00	376.00	0.00	9932 0018

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

11.4 Paid Claims Page

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

REPORT: CRA-IPDN-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB CLAIMS DENIED

DATE: 01/25/2007
PAGE: 11

PROVIDER
5555 ANY STREET
SUITE 555
CITY, KY 55555-0000

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

--ICN-- PATIENT ACCT.	ATTENDING PROV. NUM.	SERVICE DATES FROM	THRU	DAYS	ADMIT DATE	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.: MBRID99999						
ICN9999999999 PATACCT9999	NPI9999999	021706	022106	4	021706	10,212.66	0.00	0.00

HEADER EOBS: 2660 0092

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

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

HEADER EOBS: 2198 0016

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

TOTAL UB CLAIMS DENIED:	21,015.12	200.00	0.00

11.5 Denied Claims Page

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

REPORT: CRA-IPSU-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB CLAIMS IN PROCESS

DATE: 01/25/2007
PAGE: 17

PROVIDER
5555 ANY STREET
SUITE 555
CITY, KY 55555-0000

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

--ICN-- PATIENT ACCT. NUM.	ATTENDING PROV.	SERVICE DATES FROM	SERVICE DATES THRU	DAYS	ADMIT DATE	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JOHN DOE		MEMBER NO.: MBRID99999						
ICN9999999999 NPI9999999		062206	062406	2	062206	4,010.60	0.00	0.00
PATACCT9999								

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

TOTAL UB CLAIMS IN PROCESS:	4010.60	0.00	0.00

11.6 Claims in Process Page

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

REPORT: CRA-IPPD-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB CLAIMS RETURNED

DATE: 01/30/2007
PAGE: 2

PROVIDER
5555 ANY STREET
CITY, KY 55555-5555

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

--ICN--	REASON CODE
9999999999999	01

CLAIMS RETURNED: 01

11.7 Returned Claim

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

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

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

PROVIDER
55555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID

--ICN-- / --PATIENT NUMBER--	ATTEND PROV.	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	SPENDDOWN AMOUNT	PAID AMOUNT
MEMBER NAME: JOHN DOE		MEMBER NO.: 9999999999							
9999999999999 99999999999999	MCD 9999	030106	033106	(3,886.47)	(0.00)	(0.00)	(0.00)	(0.00)	(3,592.90)
9999999999999 99999999999999	MCD 9999	030106	033106	3,886.47	0.00	0.00	0.00	0.00	0.00

HEADER EOBS: 0053 00A1

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

TOTAL NO. OF ADJ: 1

TOTAL UB ADJUSTMENT CLAIMS:	0.00	0.00	0.00	
		0.00	0.00	-3,592.90

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

11.8 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--	--AMOUNT--	REASON CODE	RENDERING PROVIDER	SVC DATE FROM	SVC DATE THRU	MEMBER NO.	MEMBER NAME

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

--CCN--	--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		

11.9 Financial Transaction Page

11.9.1 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.

11.9.2 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.

11.9.3 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.

11.10 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.

11.10.1 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.

12 Appendix D

12.1 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

13 Appendix E

13.1 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
57	Acct Recv – Advance Payment
58	Recoupment – Advance Payment
59	Non Claim Related Overage
60	Provider Initiated Adjustment
61	Provider Initiated CLM Credit

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

14 Appendix F

14.1 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

15 Appendix G

15.1 Types of Bills No Longer Used

Type of Bill	Provider Type
0671-0674 0621-0624	ICF/IID/DD