



# **Commonwealth of Kentucky KY Medicaid**

## **Provider Billing Instructions for Community Mental Health Services Provider Type – 30**

Version 6.2

February 7, 2020

## Document Change Log

Document Version	Date	Name	Comments
1.0	10/12/2005	EDS	Initial creation of DRAFT Community Mental Health Services Provider Type – 30.
1.1	12/13/2005	EDS	Update revisions that DMS made.
1.2	01/19/2006	EDS	Updated Provider Rep list.
1.3	02/08/2006	Carolyn Stearman	Updated with revisions requested by DMS.
1.4	04/12/2006	Lize Deane	Updated with revisions requested by Commonwealth.
1.5	06/06/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.6	08/16/2006	Ron Chandler	Updated with revisions requested by Stayce Towles for new system.
1.7	08/28/2006	Ann Murray	Updated with revisions requested by Stayce Towles.
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4.5	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
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4.7	10/25/2012	Stayce Towles Sandy Berryman	Appendix A – Updated CMS 1500 Crossover EOMB Form and Instructions DMS Approved 10/29/2012, Jennifer L. Smith
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5.3	06/3/14	Stayce Towles	Updated place of service - POS 15 should be added along with POS 33.

Document Version	Date	Name	Comments
			POS 27 and 28 is being removed
5.4	03/15/2015	Stayce Towles	Added section 15 Appendix I- Targeted Case Management. Approved on 4/1/15, by Kristina Hayden, DMS.
5.5	07/08/2015	Stayce Towles	Updated detailed instructions for field 21 – diagnosis indicator. Approved by John Hoffmann, OATS, 7/6/15.
5.6	07/16/2015	Stayce Towles	Updated place of service codes per CO 24859
5.7	02/01/2017	Vicky Hicks	Added Place of service code 19 per CO 26401. 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 <a href="http://www.kymmis.com">www.kymmis.com</a> under Companion Guides and EDI Guides.” Approved by Charles Douglass, DMS, 2/1/17 Added information for form locators 17 and 17B regarding Referring and Ordering Providers. Approved by Charles Douglass, DMS, 2/8/2017 Changed Appendix H 16.1.1 H0006 from unit per month to event per Ann Hollen, DMS
5.8	09/05/2017	Vicky Hicks	Updated Employee ID information per CO 27964.
5.9	02/11/2019	Vicky Hicks	Replaced Appendix G and H 14.1 per Jacob Wilson, DMS Replaced all instances of HP and HPE with DXC Technology. Updated Rep list and Provider Inquiry form. Per CO29475 added Place of Service code 02- Telehealth.
6.0	05/17/2019	Vicky Hicks Mary Larson	Updated: 1) Provider Rep Table, 2) all forms, 3) DMS URLs in Introduction, 4) Added Place of Service code 02 – Telehealth per CO29475
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6.2	02/07/2020	Vicky Hicks	Added Place of Service code 58 per CO31058.

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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](http://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

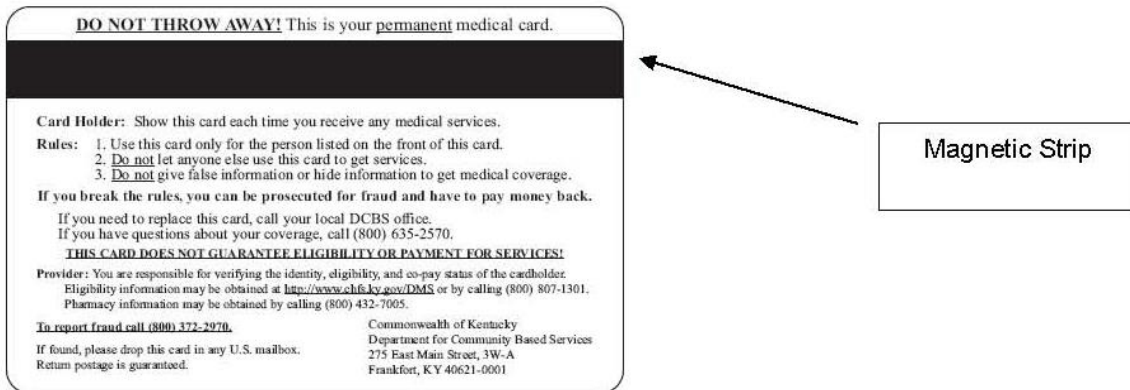
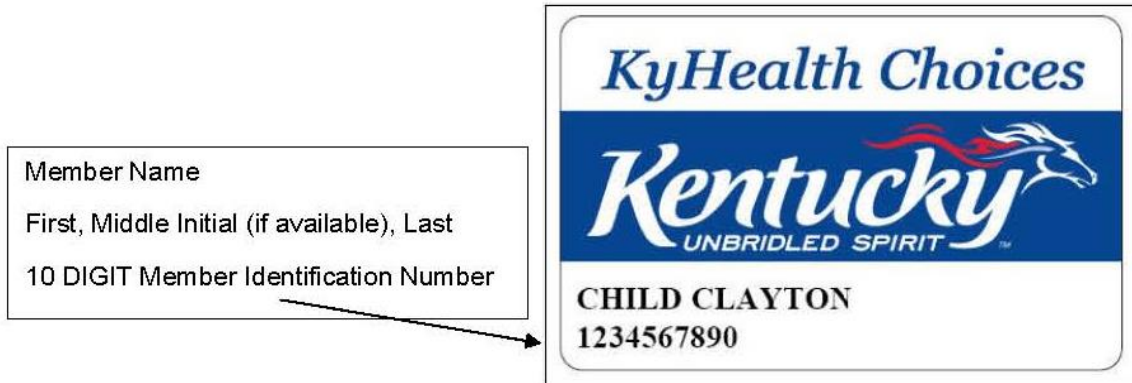
Members should apply for Medicaid eligibility through kynect ([kyenroll.ky.gov](http://kyenroll.ky.gov)), by phone at 1-855-4kynect (1-855-459-6328), or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570,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

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

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



### 1.2.1 Plastic Swipe KY Medicaid Card



Through a vendor of your choice, the magnetic strip can be swiped to obtain eligibility information.

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

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## 1.2.2 Member Eligibility Categories

### 1.2.2.1 QMB and SLMB

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

### 1.2.2.2 Managed Care Partnership

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

### 1.2.2.3 KCHIP

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

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

### 1.2.2.4 Presumptive Eligibility

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

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

- PE for pregnant women
- PE for hospitals

#### 1.2.2.4.1 PE for Pregnant Women

##### 1.2.2.4.1.1 Eligibility

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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://sso.kymmis.com>;
- The Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except holidays.

#### 1.2.3.1.1 Voice Response Eligibility Verification (VREV)

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

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.
2. Prompt the caller to select the type of inquiry desired (eligibility, TPL, Managed Care, PRO reviews, Card Issuance, Co-pay, provider check write, claim status, etc.).
3. Prompt the caller for the dates of service (enter four digit year, for example, MMDDCCYY).
4. Respond by providing the appropriate information for the requested inquiry.
5. Prompt for another inquiry.
6. Conclude the call.

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

#### 1.2.3.1.2 KY HealthNet Online Member Verification

KY HealthNet online access can be obtained at <https://sso.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 EDH\\_Helpdesk@dx.com](mailto:KY_EDH_Helpdesk@dx.com) or 1-800-205-4696.

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

## **2 Electronic Data Interchange (EDI)**

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

### **2.1 How to Get Started**

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

DXC TECHNOLOGY  
P.O. Box 2100  
Frankfort, KY 40602-2100  
1-800-205-4696

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

### **2.2 Format and Testing**

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

### **2.3 ECS Help**

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

### **3 KY HealthNet**

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

#### **3.1 How to Get Started**

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

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

#### **3.2 KY HealthNet Companion Guides**

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

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



## **4 General Billing Instructions for Paper Claim Forms**

### **4.1 General Instructions**

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

### **4.2 Imaging**

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

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

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

### **4.3 Optical Character Recognition**

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

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## 5 Additional Information and Forms

### 5.1 Claims with Dates of Service More than One Year Old

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

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

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

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

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

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

### 5.2 Retroactive Eligibility (Back-Dated) Card

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

### 5.3 Unacceptable Documentation

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

## 5.4 Third Party Coverage Information

### 5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

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

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

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

1. Remittance statement from the insurance carrier that includes:
  - Member name;
  - Date(s) of service;
  - Billed information that matches the billed information on the claim submitted to Medicaid; and,
  - An indication of denial or that the billed amount was applied to the deductible.

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

2. Letter from the insurance carrier that includes:
  - Member name;
  - Date(s) of service(s);
  - Termination or effective date of coverage (if applicable);
  - Statement of benefits available (if applicable); and,
  - The letter must have the signature of an insurance representative, or be on the insurance company's letterhead.
3. Letter from a provider that states they have contacted the insurance company via telephone. The letter must include the following information:
  - Member name;
  - Date(s) of service;
  - Name of insurance carrier;
  - Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached;
  - Termination or effective date of coverage; and,
  - Statement of benefits available (if applicable).
4. A copy of a prior remittance statement from an insurance company may be considered an acceptable form of documentation if it is:

- For the same Member;
- For the same or related service being billed on the claim; and,
- The date of service specified on the remittance advice is no more than six months prior to the claim's date of service.

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

5. Letter from an employer that includes:

- Member name;
- Date of insurance or employee termination or effective date (if applicable); and,
- Employer letterhead or signature of company representative.

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

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

#### **5.4.4 For Accident and Work Related Claims**

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

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

**5.4.4.1 TPL Lead Form**

DXC Technology

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

**Third Party Liability Lead Form**

Provider Name: \_\_\_\_\_ Provider #: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

From Date of Service: \_\_\_\_\_ To Date of Service: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Date Claim was Filed with Insurance Carrier: \_\_\_\_\_

Please check the one that applies:

\_\_\_\_\_ No Response in over 120 Days

\_\_\_\_\_ Policy Termination Date: \_\_\_\_\_

\_\_\_\_\_ Other: Please explain in the space provided below

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Telephone #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DMS Approved: January 10, 2011

## 5.5 Provider Inquiry Form

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

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

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

- Send the completed form to DXC TECHNOLOGY. A copy is returned with a response;
- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;
- A toll free DXC Technology number **1-800-807-1232** is available in lieu of using this form; and,
- To check claim status, call the DXC Technology Voice Response on **1-800-807-1301** or you may use the KY HealthNet by logging into <https://sso.kymmis.com>.

**Provider Inquiry Form**

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

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

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

Providers Message

\_\_\_\_\_  
 Signature/Date

**DXC TECHNOLOGY RESPONSE:**

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

Other: \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature/Date

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

## 5.6 Prior Authorization Information

- The prior authorization process does NOT verify anything except medical necessity. It does not verify eligibility or age.
- The prior authorization letter does not guarantee payment. It only indicates that the service is approved based on medical necessity.
- If the individual does not become eligible for Kentucky Medicaid, loses Kentucky Medicaid eligibility, or ages out of the program eligibility, services will not be reimbursed despite having been deemed medically necessary.
- Prior Authorization should be requested prior to the provision of services except in cases of:
  - Retro-active Member eligibility
  - Retro-active provider number
- Providers should always completely review the Prior Authorization Letter prior to providing services or billing.

Access the kymmis website to obtain blank Prior Authorization forms.

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

Access to Electronic Prior Authorization request (EPA).

<https://sso.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.

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

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. Signature \_\_\_\_\_ 14. Date \_\_\_\_\_

DMS Approved: January 10, 2011

## 5.8 Cash Refund Documentation Form

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

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

Please keep the following points in mind when refunding:

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



## **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

<b>Martha Edwards</b> <b>502-209-3100</b> <b>Extension 2111045</b> <b>Martha.senn@dxc.com</b>			<b>Vicky Hicks</b> <b>502-209-3100</b> <b>Extension 2111016</b> <b>vicky.hicks@dxc.com</b>		
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	DAVISS	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**

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## 6 Completion of CMS-1500 Paper Claim Form

The CMS-1500 claim form is used to bill services for Community Mental Health. A copy of a completed claim form is shown on the following page.

Providers may order CMS-1500 claim forms from the:

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

**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](http://www.kymmis.com) under Companion Guides and EDI Guides.**



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



## HEALTH INSURANCE CLAIM FORM

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

PICA												PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000000000	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John						3. PATIENT'S BIRTH DATE MM DD YY SEX 12 01 2000 M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) IF OTHER INSURANCE MAKES PAYMENT						10. IS PATIENT'S CONDITION RELATED TO: IF APPLICABLE			11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER IF OTHER INSURANCE MAKES PAYMENT						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME IF OTHER INSURANCE MAKES PAYMENT						10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED DATE						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
17b. NPI						17c.		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. 12345 B. C. D. E. F. G. H. I. J. K. L.					
22. RESUBMISSION CODE ORIGINAL REF. NO.						23. PRIOR AUTHORIZATION NUMBER IF APPLICABLE							
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
1 05 24 13		99	90887	EI 0201 UI UD			A	\$100 00	1	ZZ	XYZ9990000	1234567890	
2		NPI	NPI	NPI			NPI	NPI	NPI	NPI	NPI	NPI	
3		NPI	NPI	NPI			NPI	NPI	NPI	NPI	NPI	NPI	
4		NPI	NPI	NPI			NPI	NPI	NPI	NPI	NPI	NPI	
5		NPI	NPI	NPI			NPI	NPI	NPI	NPI	NPI	NPI	
6		NPI	NPI	NPI			NPI	NPI	NPI	NPI	NPI	NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO. 14 DIGITS			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ \$100 00		29. AMOUNT PAID \$ IF APPLICABLE		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ralph Smidlap DATE 10/01/13			32. SERVICE FACILITY LOCATION INFORMATION If Applicable			33. BILLING PROVIDER INFO & PH # ( ) Your Place 100 Broadway Anytown, KY 40000							
a.			b.			a. *Pay to* NPI		b. ZZ Taxonomy					

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

Of "Rendering Provider" for both ZZ and NPI

---

## 6.2 Completion of New CMS-1500 (02/12) Claim Form with NPI and Taxonomy

### 6.2.1 Detailed Instructions

Claims are returned or rejected if required information is incorrect or omitted. Handwritten claims must be completed in black ink ONLY. The following fields must be completed:

FIELD NUMER	FIELD NAME AND DESCRIPTION
<b>1A</b>	<b>Insured's I.D. Number</b>
	Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card.
<b>2</b>	<b>Patient's Name</b>
	Enter the member's last name, first name and middle initial exactly as it appears on the Member Identification card.
<b>3</b>	<b>Date of Birth</b>
	Enter the date of birth of the member.
<b>9</b>	<b>Other Insured's Name</b>
	Enter the Insured's Name. Required only if member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim.
<b>9A</b>	<b>Other Insured's Policy Group Number</b>
	Required only if member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. If this field is completed, also complete Fields 9D and 29.  NOTE: If other insurance denies the submitted claim, leave Fields 9, 9A, 9D and 29 blank and attach denial statement from other insurance carrier to the CMS-1500 (02/12) claim.
<b>9D</b>	<b>Insurance Plan or Program Name</b>
	Enter the Member's insurance carrier name. Complete only if entry in 9.
<b>10</b>	<b>Patient's Condition</b>
	Required if member's condition is related to employment, auto accident or other accident. Check the appropriate block if member's condition relates to any of the above.

<b>17</b>	<b>Name of Referring Provider or Other Source</b>
	Enter the qualifier and the name of the Referring Provider or Ordering Provider, if applicable.  <b>Qualifiers:</b>  DN – Denotes Referring Provider  DK – Denotes Ordering Provider
<b>17B</b>	<b>Referring Provider</b>
	Enter the Referring or Ordering Provider NPI, if applicable.
<b>21</b>	<b>Diagnosis or Nature of Illness or Injury</b>
	Enter an ICD indicator in the upper right corner to indicate the type of diagnosis being used.  9= ICD-9 0= ICD-10  Twelve diagnosis codes may be entered.
<b>23</b>	<b>Prior Authorization</b>
	Enter the appropriate Prior Authorization number, if applicable.  <b>NOTE: See section 4.6 for details about prior authorization.</b>
<b>24A</b>	<b>Date of Service (Non-Shaded Area)</b>
	Enter the date in month, day, year format (MMDDYY). Only one date of service per claim form.
<b>24A</b>	<b>NDC (Shaded Area)</b>
	Enter in the following order: NDC qualifier (N4) 11-digit NDC code, one space, unit/basis of measurement qualifier (see list below), quantity  The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (99999999.999). If entering a whole number, do not use a decimal. Do not use commas.  <b>F2= International Unit</b> <b>ME= Milligram</b> <b>UN= Unit</b> <b>GR= Gram</b> <b>ML= Milliliter</b>
<b>24B</b>	<b>Place of Service (Non-Shaded Area)</b>
	Enter the appropriate two digit place of service code which identifies the

	location where services were rendered.
02	Telehealth effective 1/1/18
03	School Facility effective 6/1/14
04	Homeless Shelter effective 6/1/14
11	Office effective 6/1/14
12	Home
13	Assisted Living effective 6/1/14
14	Group effective 6/1/14
15	Mobile Crisis effective 6/1/14
16	Temporary Lodging (effective date of service 7/1/15)
18	Worksite effective 6/1/14
19	Off Campus Outpatient Hospital effective 1/1/2016
22	Outpatient Hospital (effective date of service 7/1/15)
23	Emergency Room (effective date of service 7/1/15)
33	Personal Care Home effective 6/1/14
53	CMHC
55	Residential Substance Abuse Treatment Facility (effective date of service 7/1/15)
57	Non-residential Substance Abuse Treatment Facility (effective date of service 7/1/15)
58	Non-Residential Opioid Treatment Facility
99	Other – obsolete 5/31/14
<b>24D</b>	<b>Procedures, Services or Supplies CPT/ HCPCS (Non-Shaded Area)</b>
	Enter the appropriate HIPAA compliant HCPCS or CPT-4 procedure code identifying the service or supply provided to the member. <b>NOTE: See Appendix H.</b>
	<b>Modifier (Shaded Area)</b>
	Enter “EI” for Employee Identifier followed by the employee ID number. Valid values for Employee ID numbers are 0001 through 9999, 00001 through 99999, and 000001 through 999999.

	<b>Modifier (Non-Shaded Area)</b>
	Enter the appropriate modifier. *Note - See Appendix G.
<b>24E</b>	<b>Diagnosis Code Indicator (Non-Shaded Area)</b>
	Enter the diagnosis pointers A-L to refer to a diagnosis code in field 21. Do not enter the actual diagnosis code.
<b>24F</b>	<b>Charges (Non-Shaded Area)</b>
	Enter the usual and customary charge for the service being provided to the member.

<b>24G</b>	<b>Days or Units (Non-Shaded Area)</b>
	Enter number of units of service provided for the member on this date of service.
<b>24I</b>	<b>ID Qualifier (Shaded Area)</b>
	Enter a ZZ to indicate Taxonomy.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>
<b>24J</b>	<b>Rendering Provider ID# (Shaded Area)</b>
	Enter Taxonomy Number.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>
	<b>(Non-Shaded Area)</b>
	Enter the appropriate NPI Number.
<b>26</b>	<b>Patient's Account No.</b>
	Enter the patient account number. DXC Technology types the first 14 or fewer digits. This number appears on the remittance statement as the invoice number.
<b>28</b>	<b>Total Charge</b>
	Enter the total of all individual charges entered in Field 24F. Total each claim separately.
<b>29</b>	<b>Amount Paid</b>
	Enter the amount paid, if any, by a private insurance carrier. Do not enter Medicare paid amount. Also, complete Fields 9, 9A and 9D.  <b>NOTE: If other insurance denies the claim, leave these fields blank and attach the denial statement from the carrier to the submitted claim.</b>
<b>31</b>	<b>Date</b>
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
<b>32</b>	<b>Service Facility Location Information</b>
	If the address in Form Locator 33 is not the address of where the



	service was rendered, Form Locator 32 must be completed.
--	--

<b>33</b>	<b>Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number</b>
	Enter the provider's name, address, zip code and phone number.
<b>33A</b>	<b>NPI</b>
	Enter the appropriate NPI Number.
<b>33B</b>	<b>(Shaded Area)</b>
	Enter ZZ followed by the appropriate Taxonomy Number.  <b>NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.</b>



---

### **6.3 Helpful Hints for Successful CMS-1500 (02/12) Filing**

- Any required documentation for claims processing must be attached to each claim. Each claim is processed separately.
- Be sure to include the “AS OF” date and “EOB” code when copying a remittance advice as proof of timely filing or for inquiries concerning claim status.
- Please follow up on a claim that appears to be outstanding after four weeks from your submission date.
- Field 24B (Place of Service) requires a two digit code.
- Field 24E (Diagnosis Code Indicator) is a one digit only field.
- If any insurance other than Medicare/KY Medicaid makes a payment on services you are billing, complete Fields 9, 9A, 9D, and 29 on the CMS-1500 (02/12) claim form.
- If insurance does not make a payment on services you are billing, attach the private insurance denial to the CMS-1500 claim form. Do not complete Fields 9, 9A, 9D, and 29 on the CMS-1500 (02/12) claim form.
- When billing the same procedure code, for the same date of service, you must bill on one line indicating the appropriate units of service.
- If you are submitting a copy of a previously submitted claim on which some line items have paid and some denied, mark through or delete any line(s) on the claim already paid. If you mark through any lines, be sure to re-compute your total charge in Field 28 to reflect the new total charge billed.

### **6.4 Mailing Information**

Send the CMS-1500 (08/05) claim form to DXC Technology for processing as soon as possible after the service is rendered. Retain a copy in the office file.

Mail completed claims to:

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

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## 7 Appendix A

### 7.1 Resubmission of Medicare/Medicaid Part B Claims

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

1. For services denied by Medicare, attach a copy of Medicare's denial to the claim.
2. If a service was allowed by Medicare, submit a CMS-1500 (08/05) or a CMS 1500 (02/12), which should be submitted to KY Medicaid according to Medicaid guidelines. To this claim, the provider must attach the corresponding Medicare Coding Sheet.

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

#### 7.1.1 Medicare Coding

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

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

The Medicare Coding Sheet may be accessed at [www.kymmms.com](http://www.kymmms.com). You may type in the Medicare information into the PDF and print the coding sheet so you don't have to hand write the required information. The PDF will not save your changes in the coding sheet.

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

- Black ink only. No colored ink, pencils or highlighters;
- No white out. Correction tape is allowed;
- If a service is paid in full by Medicare, code the paid in full charges the way they appear on the EOMB (3.00 allowed, no coins, no deductible, 3.00 provider payment);
- If using the CMS-1500 (08/05), block 30 of the claim form must match the provider payment Medicare EOMB (leave block 30 blank if using the CMS -1500 (02/12);
- When billing a multiple page CMS 1500, the total charge is entered on the last claim form;
- When using the coding sheet, you will put the line # in sequential order. When using two coding sheets, the second coding sheet will begin with line # 7;
- When writing zeros do not put a line through the zero; and,
- The documents must be listed in the following order:
  - Claim form;
  - Coding sheet; and,

- 
- Any other attachments that may be needed. Medicare EOMB is not required to be attached to the claim.

## 7.1.2 Medicare Coding Sheet

### CMS1500 CROSSOVER EOMB FORM

Member Name: 1 Member ID: 2  
 EOMB Date: 3

Line 4 Deduct/Pat Resp Amt      Coinsurance and/or Co-pay Amt      Provider Pay Amt

5		6		7	
8					

Line 4 Deduct/Pat Resp Amt      Coinsurance and/or Co-pay Amt      Provider Pay Amt

5		6		7	
8					

Line 4 Deduct/Pat Resp Amt      Coinsurance and/or Co-pay Amt      Provider Pay Amt

5		6		7	
8					

Line 4 Deduct/Pat Resp Amt      Coinsurance and/or Co-pay Amt      Provider Pay Amt

5		6		7	
8					

Line 4 Deduct/Pat Resp Amt      Coinsurance and/or Co-pay Amt      Provider Pay Amt

5		6		7	
8					

Line 4 Deduct/Pat Resp Amt      Coinsurance and/or Co-pay Amt      Provider Pay Amt

5		6		7	
8					

---

### 7.1.3 Medicare Coding Sheet Instructions

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

---

## 8 Appendix B

### 8.1 Internal Control Number (ICN)

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

**11 – 10 – 032 - 123456**

**1      2      3      4**

#### 3. 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

#### 4. Year of Receipt

5. 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.

#### 6. Batch Sequence Used Internally

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## 9 Appendix C

### 9.1 Remittance Advice

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

#### 9.1.1 Examples of Pages in Remittance Advice

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

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

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>Returned Claims</b>	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.
<b>Paid Claims</b>	This section lists all claims paid in the cycle.
<b>Denied Claims</b>	This section lists all claims that denied in the cycle.
<b>Claims In Process</b>	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.
<b>Adjusted Claims</b>	This section lists all claims that have been submitted and processed for adjustment or claim credit transactions.
<b>Mass Adjusted Claims</b>	This section lists all claims that have been mass adjusted at the request of the Department for Medicaid Services (DMS).
<b>Financial Transactions</b>	This section lists financial transactions with activity during the week of the payment cycle.
	<b>NOTE: It is imperative the provider maintains any A/R page with an outstanding balance.</b>

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<b>Summary</b>	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.
<b>EOB Code Descriptions</b>	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.**



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## 9.2 Title

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

REPORT: CRA-XBPD-R  
RA#: 9999999

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

DATE: 01/25/2007  
PAGE: 2

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

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

## 9.3 Banner Page

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

REPORT: CRA-BANN-R  
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 99999999  
ISSUE DATE 01/26/2007

Commonwealth of Kentucky

REPORT: CRA-BANN-R  
 RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 PROVIDER REMITTANCE ADVICE  
 CMS 1500 CLAIMS PAID

DATE: 01/23/2007  
 PAGE: 1

PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

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

--ICN--	SERVICE DATES	BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE	MEMBER NO.: 9999999999						
999999999999	060606 060606	200.00		0.00			0.00
99999999XXX			18.05		0.00	2.00	16.05

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

TOTAL CMS 1500 CLAIMS PAID: 200.00  
 18.05 0.00 0.00 16.05

## 9.4 Paid Claims Page

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

REPORT: CRA-BANN-R  
 RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 PROVIDER REMITTANCE ADVICE  
 CMS 1500 CLAIMS DENIED

DATE: 01/23/2007  
 PAGE: 1

PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

PAYEE ID 99999999  
 NPI ID  
 CHECK/EFT NUMBER 000999999  
 ISSUE DATE 01/26/2007

--ICN--	SERVICE DATES	BILLED	TPL	SPENDDOWN
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE				
MEMBER NO.: 9999999999				
2007017999999	060606 060606	200.00	0.00	0.00
99999999XXX				

HEADER EOBS: 3015 0011

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	DETAIL EOBS
				FROM THRU	PROVIDER	AMOUNT	
22	88304	TC	1.00	060606 060606	MCD 64000000	200.00	0145 0011
TOTAL CMS 1500 CLAIMS DENIED:				200.00	0.00	0.00	

## 9.5 Denied Claims Page

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

REPORT: CRA-BANN-R  
 RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 PROVIDER REMITTANCE ADVICE  
 CMS 1500 CLAIMS IN PROCESS

DATE: 01/23/2007  
 PAGE: 1

PROVIDER  
 555 ANY STREET  
 CITY, KY 55555-0000

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

--ICN--	SERVICE DATES	BILLED	TPL
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE			
MEMBER NO.: 9999999999			
999999999999	060606 060606	200.00	0.00
99999999XXX			

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

TOTAL CMS 1500 CLAIMS IN PROCESS: 200.00 0.00

## 9.6 Claims in Process Page

FIELD	DESCRIPTION
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 13-digit unique system-generated identification number assigned to each claim by DXC Technology.
<b>CLAIM SERVICE DATE FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>EOB</b>	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.



REPORT: CRA-IPPD-R  
RA#: 9999999

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

DATE: 01/30/2007  
PAGE: 2

PROVIDER  
5555 ANY STREET  
CITY, KY 55555-5555

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

--ICN-- REASON CODE  
999999999999 01

CLAIMS RETURNED: 01

**9.7 Returned Claim**

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

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

REPORT: CRA-PRAD-R  
 RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 PROVIDER REMITTANCE ADVICE  
 CMS CLAIM ADJUSTMENTS

DATE: 12/14/2006  
 PAGE: 2

HEALTH SERVICES  
 ATTN: JANE DOE  
 555 ANY STREET  
 CITY, KY 55555-0000

PAYEE ID 99999999  
 NPI ID

--ICN--		SERVICE DATES		BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID	
--PATIENT NUMBER--		FROM	THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	
MEMBER NAME: JANE DOE				MEMBER NO.: 9999999999						
999999999999		031103	031103	(20.00)		(0.00)		(0.00)		
99999					(20.00)		(0.00)		(20.00)	
999999999999		031103	031103	20.00		0.00		0.00		
99999					20.00		0.00		20.00	
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES RENDERING			BILLED	ALLOWED	DETAIL	EOBS
99	WP101		1.00	031103	031103	MCD 40097065	20.00	20.00	0102	0029
TOTAL NO. OF ADJ: 1										
TOTAL CMS 1500 ADJUSTMENT CLAIMS:				0.00			0.00		0.00	
					0.00		0.00		0.00	

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Billing Instructions).

If a cash refund is submitted, an adjustment **CANNOT** be filed.  
 If an adjustment is submitted, a cash refund **CANNOT** be filed.

## 9.8 Adjusted Claims Page

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

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

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

REPORT: CRA-TRAN-R  
 RA#: 9999999

COMMONWEALTH OF KENTUCKY  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 PROVIDER REMITTANCE ADVICE  
 FINANCIAL TRANSACTIONS

DATE: 12/26/2006  
 PAGE: 2

PROVIDER J  
 PO BOX 5555  
 CITY, KY 55555-5555

PAYEE ID 99999999  
 NPI ID 99999999

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

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

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

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

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

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

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

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

## 9.9 Financial Transaction Page

### 9.9.1 Non-Claim Specific Payouts to Providers

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

### 9.9.2 Non-Claim Specific Refunds from Providers

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

### 9.9.3 Accounts Receivable

FIELD	DESCRIPTION
A / R NUMBER / 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.

<b>RECOUPED THIS CYCLE</b>	The amount of money recouped on this financial cycle.
<b>ORIGINAL AMOUNT</b>	The original accounts receivable transaction amount owed by the provider.
<b>TOTAL RECOUPED</b>	This amount is the total of the provider's checks and recoupment amounts posted to this accounts receivable transaction.
<b>BALANCE</b>	The system generated balance remaining on the accounts receivable transaction.
<b>REASON CODE</b>	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 COMMONWEALTH OF KENTUCKY (M1) DATE: 02/01/2007  
 RA#: 9999999 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 14  
 PROVIDER REMITTANCE ADVICE  
 EOB CODE DESCRIPTIONS

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

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

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

## 9.10 Summary Page

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>CLAIMS PAID</b>	The number of paid claims processed, current month and year to date.
<b>CLAIM ADJUSTMENTS</b>	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.
<b>PAID MASS ADJ CLAIMS</b>	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.
<b>CLAIMS DENIED</b>	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
<b>CLAIMS IN PROCESS</b>	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

### 9.10.1 Payments

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

<b>OTHER FINANCIAL</b>	
<b>NET EARNINGS</b>	The 1099 amount.

**EXPLANATION OF BENEFITS**

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

**EXPLANATION OF REMARKS**

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

**EXPLANATION OF ADJUSTMENT CODE**

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

**EXPLANATION OF RTP CODES**

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

## 10 Appendix D

### 10.1 Remittance Advice Location Codes (LOC CD)

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

- A Active
- B Hold Recoup - Payment Plan Under Consideration
- C Hold Recoup - Other
- D Other-Inactive-FFP-Not Reclaimed
- E Other – Inactive - FFP
- F Paid in Full
- H Payout on Hold
- I Involves Interest – Cannot Be Recouped
- J Hold Recoup Refund
- K Inactive-Charge off – FFP Not Reclaimed
- P Payout – Complete
- Q Payout – Set Up In Error
- S Active - Prov End Dated
- T Active Provider A/R Transfer
- U DXC Technology On Hold
- W Hold Recoup - Further Review
- X Hold Recoup - Bankruptcy
- Y Hold Recoup - Appeal
- Z Hold Recoup - Resolution Hearing

## **11 Appendix E**

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

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

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



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

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## 12 Appendix F

### 12.1 Remittance Advice Status Code (ST CD)

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

- A Active
- B Hold Recoup - Payment Plan under Consideration
- C Hold Recoup - Other
- D Other-Inactive-FFP-Not Reclaimed
- E Other – Inactive - FFP
- F Paid in Full
- H Payout on Hold
- I Involves Interest – Cannot Be Recouped
- J Hold Recoup Refund
- K Inactive-Charge off – FFP Not Reclaimed
- P Payout – Complete
- Q Payout – Set Up In Error
- S Active - Prov End Dated
- T Active Provider A/R Transfer
- U DXC Technology On Hold
- W Hold Recoup - Further Review
- X Hold Recoup - Bankruptcy
- Y Hold Recoup - Appeal
- Z Hold Recoup - Resolution Hearing

## 13 Appendix G

### 13.1 CMHC Approved Modifiers (Revised 1/1/2019)

<b>Modifier</b>	<b>Practitioner</b>
<b>AF</b>	Psychiatrist
<b>AM</b>	MD/DO
<b>U3</b>	Psy Resident
<b>SA</b>	APRN
<b>AH</b>	Licensed Psychologist
<b>AJ</b>	LCSW
<b>U8</b>	LPP, CPsy w/ Auto. Funct.
<b>HO</b>	LPCC, LMFT, LPAT, LBA, LCADC
<b>U4</b>	CSW, LPA, CPSy, LPCA, MFTA, LPATA, LABA, LCADCA
<b>U1</b>	PA
<b>U2</b>	Psy RN
<b>TD</b>	RN
<b>HN</b>	PE
<b>HM</b>	Prevention Specialist
<b>U5</b>	MHA
<b>U6</b>	CADC
<b>U7</b>	Peer Support Specialist
<b>UC</b>	CSA, RBT
<b>UD</b>	Preg. Wom
<b>U9</b>	Per Diem

### 13.2 Additional Modifiers

<b>ADDITIONAL MODIFIER</b>	<b>DESCRIPTION</b>
<b>UK</b>	Collateral Relationship
<b>GT</b>	Telehealth Services effective 12/1/2003

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## 14 Appendix H

### 14.1 CMHC Covered Services Effective January 1, 2019

The services described below are included in Kentucky's State Plan and have been approved by CMS. This is not an exhaustive list of billable codes for CMHCs- all billable codes are included on the CMHC rate spreadsheets <http://chfs.ky.gov/dms/fee.htm>.

Procedure Code	Procedure Code Description	Unit of Service	Modifiers allowed
90785	Interactive Complexity	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5
90791	Psych Diagnostic Evaluation	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5
90792	Psych Diagnostic Evaluation with Medical Services	Event	AF, AM, U3, SA, U1
90832	Psychotherapy PT &Family	30 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
90833	Psychotherapy PT &Family with E&M Service	30 Min.	AF, AM, U3, SA, U1
90834	Psychotherapy PT &Family	45 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
90836	Psychotherapy PT &Family with E&M Service	45 Min.	AF, AM, U3, SA, U1
90837	Psychotherapy PT &Family	60 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
99354	Prolonged Services (First Hour, Use with 90837)	30-60 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
99355	Prolonged Services (After 60 minutes of prolonged, Use with 90837 & 99354)	15-30 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
90838	Psychotherapy PT &Family with E&M Service	60 Min.	AF, AM, U3, SA, U1
90845	Psychoanalysis	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5
90846	Family Psychotherapy w/out Patient	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
90847	Family Psychotherapy w/Patient	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
90853	Group Psychotherapy	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
90865	Narcosynthesis for psych diagnostic & therapeutic purposes	Event	AF, AM, U3, SA, U1
90870	Electroconvulsive Therapy	Event	AF, AM
90875	Individual Psychophysiological therapy incorporating biofeedback training by any modality, w/ psychotherapy	30 Min	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5
90876	Individual Psychophysiological therapy incorporating biofeedback training by any modality, w/ psychotherapy	45 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5
90887	Collateral Therapy	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5, U6
90899	Unlisted psychiatric service or procedure	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
96105	Assessment of Aphasia, w/ interpretation and report, per hour	60 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5
96110	Developmental Screening, w/ scoring and documentation, per standardized instrument	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5
96112	Developmental test administration, by physician or other qualified HP, with interpretation and report, first hour	60 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5
96113	Each additional 30 minutes (Use with 96112)	30 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5
96116	Neurobehavioral Status Exam, Psychologist or Physician, per hour, both face-to-face time with the patient and time interpreting test results and preparing the report	60 Min.	AF, AM, AH, U8
96121	Each additional hour (Use with 96116)	60 Min.	AF, AM, AH, U8
96125	Standardized Cognitive Performance Testing, per hour of the Physician or Qualified HP's time, both face-to-face time administering tests and time interpreting test results and preparing the report	60 Min.	AF, AM, AH, U3, SA, AJ, U8, HO, U4, U1, U2, HN, U5
96127	Brief Emotional/Behavioral Assessment, with scoring and documentation, per standard instrument	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, HN, U5
96130	Psychological Testing Evaluation Services by Physician or other Qualified HP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making,	60 Min.	AF, AM, AH, U8

	treatment planning and report, and feedback to the patient, family member(s) or caregiver(s), first hour		
<b>96131</b>	Each additional hour (Use with 96130)	60 Min.	AF, AM, AH, U8
<b>96132</b>	Neuropsychological Test Evaluation Services by Physician or other Qualified HP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and feedback to the patient, family member(s) or caregiver(s), first hour	60 Min.	AF, AM, AH
<b>96133</b>	Each additional hour (Use with 96132)	60 Min.	AF, AM, AH
<b>96136</b>	Psychological or Neuropsychological Testing Administration and Scoring by Physician or other Qualified HP, two or more tests, any method; first 30 minutes	30 Min.	AF, AM, AH, U8
<b>96137</b>	Each additional 30 minutes (Use with 96136) *96136 and 96137 may be used with 96130, 96131, 96132, 96133 on the same or different days	30 Min.	AF, AM, AH, U8
<b>96138</b>	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	30 Min.	AF, AM, AH, U8
<b>96139</b>	Each additional 30 minutes (Use with 96138) *96138 and 96139 may be used with 96130, 96131, 96132, 96133 on the same or different days	30 Min.	AF, AM, AH, U8
<b>96146</b>	Psychological or Neuropsychological test administration, with single automated, standardized instrument via electronic platform, w/ automated result only	Event	AF, AM, AH, U8
<b>96150</b>	Health & Behavior Assessment; Initial Assessment	15 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5
<b>96151</b>	Health & Behavior Assessment; Re-assessment	15 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5
<b>97151</b>	Behavior identification assessment, administered by a physician or other qualified HP, each 15 minutes of the practitioner's time face-to-face with patient and/or guardian(s)/ caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	15 Min.	AF, AM, HO, U4
<b>97152</b>	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified HP, face-to-face with the patient	15 Min.	AF, AM, HO, U4, UC
<b>97153</b>	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified HP, face-to-face with one patient	15 Min.	AF, AM, HO, U4, UC
<b>97154</b>	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified HP, face-to-face with two or more patients	15 Min.	AF, AM, HO, U4, UC
<b>97155</b>	Adaptive behavior treatment with protocol modification, administered by physician or other qualified HP,	15 Min.	AF, AM, HO, U4

	which may include simultaneous direction of technician, face-to-face with one patient		
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified HP (with or without the patient present), face-to-face with guardian(s)/caregiver(s)	15 Min.	AF, AM, HO, U4
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified HP (without the patient present), face-to-face with multiple sets of guardian(s)/caregiver(s),	15 Min.	AF, AM, HO, U4
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified HP, face-to-face with multiple patients	15 Min.	AF, AM, HO, U4
99203	Evaluation & Management of a new patient, moderate severity (Requiring these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity)	Event	AF, AM, U3, SA, U1
99204	Evaluation & Management of a new patient, moderate to high severity (Requiring these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity)	Event	AF, AM, U3, SA, U1
99205	Evaluation & management of a new patient, moderate to high severity (Requiring these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity)	Event	AF, AM, U3, SA, U1
99213	Evaluation & management of an established patient, low to moderate severity (Requiring at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused evaluation; Medical decision making of low complexity)	Event	AF, AM, U3, SA, U1
99214	Evaluation & management of an established patient, moderate to high severity (Requiring at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity)	Event	AF, AM, U3, SA, U1
99215	Evaluation & management of an established patient, moderate to high severity (Requiring at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity)	Event	AF, AM, U3, SA, U1
99406	Smoking & Tobacco Use Cessation counseling visit; Intermediate, greater than 3 mins. up to 10 mins.	3-10 Min.	AF, AM, SA, U1
99407	Smoking & Tobacco Use Cessation counseling visit; Intensive, greater than 10 mins.	10 Min. or more	AF, AM, SA, U1
99408	Alcohol and/or Substance Abuse structured screening and brief intervention, referral to treatment	15-30 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
99409	Alcohol and/or Substance Abuse Screening and brief intervention, referral to treatment	30 Min. or more	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
H0001	Alcohol and/or Drug Assessment	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
H0002	Behavioral Health Screening	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6

H0006	Alcohol and/or Drug Services CM	15 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HM, U6, HN, U5
H0012	Alcohol and/or Drug Services; Subacute detox	Event	AF, AM, U3, SA
H0015	Alcohol and/or Drug Services IOP	Per Diem	U9
H0018	Alcohol and/or Drug Services; Short-Term Residential	Per Diem	U9
H0019	Alcohol and/or Drug Services; Long-Term Residential	Per Diem	U9
H0024	Alcohol and/or Drug Prevention	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6, HM
H0025	Alcohol and/or Drug Prevention	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6, U7, HM
H0031	Mental Health Assessment by non-physician	Event	U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
H0032	Mental Health Service Plan Development by non-physician	Event	U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
H0035	Partial Hospitalization under 24 hrs.	Per Diem	U9
H0038	Self Help/Peer Services, per 15 min	15 Min.	U7
H0040	Assertive Community Treatment program- 4 Prof Team	Monthly	U9
H0040 UB	Assertive Community Treatment program- 10 Prof Team	Monthly	U9
H0046	Mental Health Service, NOS	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U2, HN, U5
H0049	Alcohol and/or Drug Screening and brief intervention, less than 15 minutes	1-14 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
H2011	Crisis Intervention Service	15 Min.	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
H2012	Behavioral Health Day Treat, per hr.	1 Hour	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
H2015	Comprehensive Community Support Services	15 min.	AH, AJ, U8, HO, U4, HN, UC
H2020	Therapeutic Behavioral Service	Per Diem	U9
H2027	Psychoeducational Service	15 Min.	AH, AJ, U8, HO, U4, HN
S9480	Intensive Outpatient Psychiatric Services, per diem	Per Diem	U9
S9484	Crisis Intervention (Mobile Crisis), per hour	1 Hour	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U2, TD, HN, U5, U6
S9485	Crisis Intervention (CSU), per diem	Per Diem	U9
T1007	Service Planning for Substance Abuse Services	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
T2023	Targeted Case Management for individuals with SED or SMI; Modifier UA will designate SED population	1 Month	Targeted Case Manager
T2023	Targeted Case Management for Individuals with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues; Requires modifier TG	1 Month	Targeted Case Manager
T2023	Targeted Case Management for Individuals with Substance Use Disorders; Requires modifier HF	1 Month	Targeted Case Manager



### 14.1.1 CMHC Services for Pregnant Women

<b>Codes</b>	<b>Descriptions</b>	<b>Unit</b>	<b>Modifier</b>	<b>2<sup>nd</sup> Modifier</b>
<b>H0006</b>	Case Management	Event	AF, AM, U3, SA, AH, AJ, U8, HO, U4, HN, U5	UD
<b>H0024</b>	Behavioral Prevention Information Dissemination Service	15 min	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6	UD
<b>H0025</b>	Behavioral Health Prevention Education Service	15 min	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6, U7	UD

## 15 Appendix I

### 15.1 Targeted Case Management Services effective September 1, 2014

All TCM services are limited to one (1) unit per member, per month. Below, please find the established codes and modifiers for TCM services provided through traditional Medicaid:

Procedure Code	Code Description	Modifier
T2023	Targeted Case Management – Individuals with Substance Use Disorder as defined in 907 KAR 15:040E, per month	HF
T2023	Targeted Case Management – Individuals with co-occurring Severe Mental Illness (SMI), Severe Emotional Disability (SED) or Substance Use Disorders and Chronic or Complex Physical Health Issues as defined in 907 KAR 15:050E, per month	TG
T2023	Targeted Case Management – Individuals with Severe Emotional Disability (SED) as defined in 907 KAR 15:060E, per month	UA
T2023	Targeted Case Management – Individuals with Severe Mental Illness (SMI) as defined in 907 KAR 15:060E, per month	HE